3.2.1 Information to Include Behind Tab 1:

Transmittal Letter.

The transmittal letter serves as a cover letter for the Bid Proposal. It must consist of an executive summary that briefly reviews the strengths of the bidder and key features of its proposed approach to meet the specifications of this RFP. Please provide an overview of the proposal which summarizes the proposed approach to delivering high quality healthcare services. The overview should highlight how the approach will meet the State's goals.
The transmittal letter shall be in the form of a standard business letter and be written on the letterhead of the Bidder submitting the proposal. An individual authorized to legally bind the Bidder must sign the letter.

The State of Iowa is embarking on a comprehensive modernization effort for its Medicaid program that involves nearly all populations including TANF/CHIP, elderly care, seven waiver programs, long-term supports and services, and behavioral health across all 99 counties. Molina is passionately committed, uniquely positioned, and truly experienced to implement a focused, local community-based system of health care coordination and integration to achieve the goals expressed by the Department of Human Services (Agency).

We have personally met with dozens of leading advocacy groups, providers and individuals in Iowa who are fully dedicated to caring for Medicaid eligibles in their communities. When asked about the experiences and challenges they face in Iowa, they describe their health care environment as: siloed; fragmented; costly; rigid; biased towards institutionalization; organized around funding sources rather than common services; fostering gaps in care; and that the significantly rural geography makes access difficult for many. All of these challenges are those that Molina has successfully helped Medicaid agencies across the nation conquer as they transitioned from a fee-for-service to a managed care environment. To help the Agency quickly achieve success with the managed care transition, Molina will leverage its 35+ years' experience managing state programs with similar populations to significantly impact your success in achieving the Centers for Medicare and Medicaid Services' (CMS) Triple Aim to:

- Improve population health;
- Enhance the patient care experience; and
- Reduce the per capita cost of care.

Molina Healthcare of Iowa understands and fully supports the CMS Triple Aim initiative to improve quality, cost, and patient satisfaction across the state's Medicaid and other low-income programs. To be most successful in achieving the Triple Aim goals, we must collaborate as partners with many of Iowa's state agencies, coordinate and integrate care across all disciplines, develop meaningful relationships and effective collaborations with preeminent local providers, improve access to care, and remove barriers to care and support systems. A challenge that we have already begun to undertake!

Our systems of care, backing of local providers, and relationships with many other support groups, individuals and mechanisms will ultimately enhance member choice, and support their independence in the home and community. Toward this end, Molina is partnering with Veridian, a local company offering a consumer choices program that gives Iowan's on Medicaid who are aging or have a disability, the freedom to choose service providers to assist them with their unique needs. Instead of institutionalization, members will be less reliant on facilities for care, which all will lead to happier, healthier people in the community.

Molina is grateful for the many written Letters of Intent and/or verbal commitments we have received

over the past months, as we successfully built significant relationships resulting in more than 9,639 providers in 719 locations in Iowa, including the leading organizations in the state. Additionally, Molina has secured Letters of Support or verbal endorsement from key organizations that demonstrate their preference for Molina Healthcare of Iowa.

Improving Quality
Molina's key principles include a pervasive commitment to the quality of its providers and the care received by its members. Molina has achieved National Committee for Quality Assurance (NCQA) accreditation for nine of its 12 health plans (California, Florida, Michigan, New Mexico, Texas, Ohio, Utah, Washington and Wisconsin). Molina is committed to achieving NCQA accreditation for all of its health plans and will pursue NCQA accreditation in the State of Iowa with the goal to improve Iowa's ranks in national health outcomes.

Molina Healthcare NCQA TOP 100

Molina is the only MCO with NCQA accreditations in 9 or more states to have all of its existing NCQA-accredited plans ranked in the top 100 nationally.

The health plans most recently added to the Molina family located in Illinois, South Carolina and the Commonwealth of Puerto Rico are not yet accredited, however, accreditation will be pursued as soon as possible. Molina is committed to achieving NCQA accreditation for all of its health plans and will pursue NCQA accreditation in the State of Iowa with the goal to improve Iowa's ranks in national health outcomes. We applaud, and intend to champion Iowa's Healthiest State initiative.

Creating Greater Efficiency – Coordinating Integrated Care Management (ICM)
Molina is well prepared to address the unique needs of Iowa's diverse population by conducting functional assessments to ensure successful whole-person, patient-centered plans of care are developed,

coordination of all health care and support services are provided, and growth of Medical and Behavioral Health Homes are responsive to the physical, behavioral, social, and preventive health needs of all members. Many Molina members receive a broad spectrum of care that often requires integration of overlapping services, such as primary and specialty care, acute care, pharmacy, dental, behavioral health, substance abuse and long-term care services and supports. Molina's managed care and integrated care coordination approach is designed to address members' unique health circumstances and is especially effective in providing a high degree of care management for members who have multiple or complex conditions.

Recognizing that successful interdisciplinary integration is rooted in building sound relationships with all providers; we have already developed crucial strategic relationships in Iowa to support our managed care plan. [redacted]

Targeting ICM for Iowa

Molina recognizes that approximately 28% of the state's Medicaid enrollees (elderly and disabled) generate about 71% of the cost. Therefore, a well-defined strategic plan focused on these high-need, fragile populations is fundamental to the success of our managed care approach and a requirement to the success of Iowa's initiative. The Targeted ICM Program for Iowa is specifically designed to improve quality, health outcomes and control costs in the State of Iowa. Our vision is to combine the strengths and knowledge of local clinical experts with our national experience in managing these complex elderly and waiver populations to create the best opportunity to improve health and outcomes for these often frail and chronically ill populations.

The Targeted ICM Program will identify the optimal care plan for these high-need, fragile members by: engaging preeminent providers in the community: creating and implementing care plans that meet member needs accordingly; measuring outcomes to stay on course, and rewarding Triple Aim performance.

Molina has also engaged many leading providers in the community to share information on our interdisciplinary integration of care concept and received resounding support. [redacted]

CONFIDENTIAL

[redacted]

Molina Healthcare of Iowa will incentivize these organizations to align their economic interests with the best quality, cost, and satisfaction results for our members. To facilitate effective interdisciplinary care, members' Care Plans will be monitored, and detailed data will be shared with all organizations involved in their care. Member-specific results will be analyzed, measured and appropriate modifications will made with the goal to improve outcomes. The Iowa Medicaid providers who contribute to achieving improved member health will be rewarded based on outcomes data analysis.

Member Incentives and Improving Patient Satisfaction
Molina offers member incentive programs that encourage members to receive timely preventive services. We have an online member rewards system which offers members an intuitive, user-friendly interface to select rewards based on the points they earn for having completed specific preventive services, such as annual physicals, prenatal care, and immunizations, through Molina's online platform. Examples of reward items include diapers, car seats, baby wipes, books, exercise equipment, as well as health-related items. The Molina Member Rewards program is designed to help support Iowa's goal of efficient, coordinated and high-quality health care that promotes member choice and accountability in healthcare coordination.

Another component of providing the highest impact to achieving improved member health and satisfaction is the requirement to sustain a strong technology underpinning. This strategy incorporates web-based tools for members, providers, and data systems, such as data analytics and predictive modeling that support easy-to-use smart technology. Our patient data reports are not collected solely for the purposes of being compliant, but are intensely analyzed and used to make meaningful decisions to improve population health. At Molina, the digitization of health care information has allowed patient data to not only to be collected, but used smartly to improve health outcomes which in turn improves patient satisfaction.

Developing Effective Provider Incentive Programs
Molina has also developed provider focused Pay for Performance programs that encourage provider participation in improving quality and lowering costs of covered services.

In addition to achieving NCQA accreditation in the State of Iowa as soon as the health plan is eligible, Molina recommends implementing the following quality-related programs:

[redacted]

CONFIDENTIAL

About Molina

Molina Healthcare of Iowa, a local and wholly owned subsidiary health plan of Molin Healthcare, Inc., proposes to administer the health care benefits for the State of Iowa High Quality Healthcare Initiative for the Iowa Medicaid (including long-term care and dual eligible recipients), Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa (hawk-i) programs, along with providing services for individuals qualifying of Iowa Department of Public Health (IDPH) funded substance use disorder services as described in the Request for Proposal No. MED-16-009. Molina has experience implementing managed care programs in the timelines required by Iowa.

Molina is a well-funded, multi-state managed care organization. The singular focus of all Molina health plans is in providing quality health services to financially vulnerable families and individuals covered by government-sponsored programs, such as Medicaid, SCHIP, and Medicare. Molina Healthcare of Iowa expects to add an estimated 250 jobs for Iowans, depending on enrollment, to support its integrated care coordination and quality initiatives, and to ensure provider access to members in all regions throughout Iowa. This new health plan will be built on Molina's core values dating back to 1980 when our founder, Dr. C. David Molina, cared for many patients in the Emergency Room who were on Medicaid and did not have a family doctor. He firmly believed that everyone deserved high-quality medical care regardless of their ability to pay and turned his life's mission toward caring for the vulnerable and underserved.

Never wavering from Dr. Molina's original mission, Molina Healthcare is now one of the top 500 companies in the U.S., with an ever-growing network of trusted providers and health plans that meet a vast range of patients' physical and behavioral health needs. Molina is proud to have been chosen in six states in coordination with CMS, by far the most of any health plan in the country, for dual eligible demonstration programs which manage some of the most complex and chronic care of any population.

CONFIDENTIAL

Molina Healthcare of Iowa's local health plan operations coupled with the cost-effective combination of shared resources provided by its parent will ensure that the same caring treatment we offered in that first clinic will also be administered in communities across the State of Iowa with primary care, urgent care and long-term care for individuals and families. From those with special needs, to moms and babies, to senior citizens, everything we do continues to fulfill Dr. Molina's mission to provide access to high-quality medical care to every person. Every day we continue to treat the same kinds of patients we have been serving for over three decades, and in every community where we operate we are pleased to take an active role. The people we care for trust us with their lives and we care about their health and wellbeing because it is the right thing to do. We are excited to have the opportunity for Iowa to become a part of the Molina family.

Molina is prepared to develop a meaningful and committed partnership with the Agency to seamlessly address benefit changes; adhere to new requirements; be fiscally responsible stewards of public funds; bring innovative program to both providers and members; and operate Iowa's programs effectively. With this proposal, we hope to make Molina Healthcare of Iowa a part of the family of healthcare companies chosen to support the success of the State of Iowa's High Quality Healthcare Initiative.

The Transmittal Letter shall include:

- ***The following assurances:***
  - ***A statement that the bidder will furnish the services required by Enrollees as promptly as is appropriate and that the services provided will meet the Agency's quality standards;***

Molina agrees and understands that it will furnish the services required by its members as promptly as is appropriate and that the services provided will meet the Agency's quality standards.

  - ***A statement that the capitation rates will cover all services required by Enrollees and meet the Medical Loss Ratio requirements as listed in Attachment 1: Scope of Work, Section 2.7;***

Molina agrees and understands that capitation rates will cover all services required by its member's and will meet the Medical Loss Ratio requirements as listed in Attachment 1: Scope of Work, Section 2.7.

  - ***A statement acknowledging that liquidated damages, as described in Exhibit E to Attachment 1: Scope of Work, may be imposed for failure to perform as set forth in this RFP; and***

Molina agrees and understands that liquidated damages, as described in Exhibit E to Attachment 1: Scope of Work may be imposed for failure to perform as set forth in this RFP.

  - ***A statement acknowledging that the contract will be performance-based and both incentives and disincentives may apply to the Contractor's performance as set forth in this RFP.***

Molina agrees and understands that the contract will be performance-based and both incentives and disincentives may apply to the Molina's performance as set forth in this RFP.

Bid Proposal Security.

The bidder shall submit a bid bond, a certified or cashier's check, or an irrevocable letter of credit in favor of or made payable to the Agency in the amount of $100,000.00. The bid proposal security must be valid beginning on the Bid Proposal due date for 180 days. The bidder understands that if the bidder elects to use a bond, a surety licensed to do business in Iowa must issue the bond on a form acceptable to the Agency. The bidder understands that the bid proposal security shall be forfeited if the bidder is chosen to receive the contract and withdraws its Bid Proposal after the Agency issues a Notice of Intent to Award, does not honor the terms offered in its Bid Proposal, or does not negotiate contract terms in good faith. The bidder further understands that the bid proposal security submitted by bidders will be returned, if not forfeited for reasons stated above, when the Bid Proposals expire, are rejected, or the Agency enters into a contract with the successful bidder, whichever is earliest.

Molina Healthcare, Inc. (parent) guarantees Molina Healthcare of Iowa's (bidder) performance of each and every obligation, warranty, covenant, term and condition of the Contract with no maximum financial limit. The address of Molina Healthcare, Inc. is: 200 Oceangate, Suite 100, Long Beach, CA 90802.

Molina Healthcare of Iowa's bid bond in the amount of $100,000.00 is enclosed in its Request for Proposal located in a pouch behind Tab 1.

Liberty Mutual. SURETY

Interchange Corporate Center
450 Plymouth Road, Suite 400
Plymouth Meeting, PA. 19462-1644
Ph. (610) 832-8240

BID BOND

Bond Number: N/A

KNOW ALL MEN BY THESE PRESENTS, that we Molina Healthcare, Inc.

_____, as principal (the "Principal"), and LIBERTY MUTUAL FIRE INSURANCE COMPANY, a company organized under the laws of the State of Wisconsin, as surety (the "Surety"), are held and firmly bound unto Iowa Department of Human Services, as obligee (the "Obligee"), in the penal sum of One Hundred Thousand and 00/100 Dollars ($ 100,000.00), for the payment of which sum well and truly to be made, the said Principal and the said Surety, bind ourselves, our heirs, executors, administrators, successors and assigns, jointly and severally, firmly by these presents.

WHEREAS, the Principal has submitted a bid for: Iowa High Quality Healthcare Initiative

NOW, THEREFORE, if the Obligee shall accept the bid of the Principal within the period specified therein, or, if no period be specified, within sixty (60) days after opening, and the Principal shall enter into a contract with the Obligee in accordance with the terms of such bid or in the event of the failure of the Principal to enter into such contract if the Principal shall pay to the Obligee the difference in money not to exceed the penal sum hereof between the amount specified in said bid and such larger amount for which the Obligee may in good faith contract with another party to perform the work covered by said bid, then this obligation shall be null and void; otherwise to remain in full force and effect. In no event shall the liability hereunder exceed the penal sum thereof.

PROVIDED AND SUBJECT TO THE CONDITION PRECEDENT, that any claim by Obligee under this bond must be submitted in writing by registered mail, to the attention of the Surety Law Department at the address above, within 120 days of the date of this bond. Any suit under this bond must be instituted before the expiration of one (1) year from the date of this bond. If the provisions of this paragraph are void or prohibited by law, the minimum period of limitation available to sureties as a defense in the jurisdiction of the suit shall apply.

DATED as of this 10th day of April, 2015.

WITNESS / ATTEST

_____

Molina Healthcare, Inc.
(Principal)

By: Paul Muench, President (Seal)
Name:
Title:

LIBERTY MUTUAL FIRE INSURANCE COMPANY
(Surety)

By: _____ (Seal)
Brenda Wang Attorney-in-Fact

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Los Angeles

On APR 10 2015 before me, Kari Davis, Notary Public
personally appeared, Brenda Wong
who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that she executed the same in her authorized capacity, and that by her signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SIGNATURE OF NOTARY

KARI DAVIS
Commission # 2042909
Notary Public - California
Los Angeles County
My Comm. Expires Sep 26, 2017

Notary Public Seal

OPTIONAL

Though the data below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent reattachment of this form.

DESCRIPTION OF ATTACHED DOCUMENT:

TITLE OR TYPE OF DOCUMENT: _____

NUMBER OF PAGES: _____ **DOCUMENT DATE:** _____

CAPACITY(IES) CLAIMED BY SIGNER(S)

Signer's Name: _____

☐ INDIVIDUAL

☐ CORPORATE OFFICER
Title(s)_____

☐ PARTNER(S) ☐ LIMITED ☐ GENERAL

☒ ATTORNEY-IN-FACT

☐ TRUSTEE(S)

☐ GUARDIAN/CONSERVATOR

☐ OTHER: _____

Signer is representing:

NAME OF PERSON(S) OR ENTITY(IES)

_____

Signer's Name _____

☐ INDIVIDUAL

☐ CORPORATE OFFICER
Title(s)_____

☐ PARTNER(S) ☐ LIMITED ☐ GENERAL

☐ ATTORNEY-IN-FACT

☐ TRUSTEE(S)

☐ GUARDIAN/CONSERVATOR

☐ OTHER: _____

Signer is representing:

NAME OF PERSON(S) OR ENTITY(IES)

_____

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS PRINTED ON RED BACKGROUND.
This Power of Attorney limits the acts of those named herein, and they have no authority to bind the Company except in the manner and to the extent herein stated.

Certificate No. 6333210

American Fire and Casualty Company
The Ohio Casualty Insurance Company
Liberty Mutual Insurance Company
West American Insurance Company

POWER OF ATTORNEY

KNOWN ALL PERSONS BY THESE PRESENTS: That American Fire & Casualty Company and The Ohio Casualty Insurance Company are corporations duly organized under the laws of the State of New Hampshire, that Liberty Mutual Insurance Company is a corporation duly organized under the laws of the State of Massachusetts, and West American Insurance Company is a corporation duly organized under the laws of the State of Indiana (herein collectively called the "Companies"), pursuant to and by authority herein set forth, does hereby name, constitute and appoint, Brenda Wong; Irene Lau; Jeffrey Strassner; Kari Davis; Kathy R. Mair; Mechelle Larkin; Natalie K. Trofimoff; Patricia S. Talavera; Tenzer V. Cunningham

all of the city of Los Angeles, state of CA each individually if there be more than one named, its true and lawful attorney-in-fact to make, execute, seal, acknowledge and deliver, for and on its behalf as surety and as its act and deed, any and all undertakings, bonds, recognizances and other surety obligations, in pursuance of these presents and shall be as binding upon the Companies as if they have been duly signed by the president and attested by the secretary of the Companies in their own proper persons.

IN WITNESS WHEREOF, this Power of Attorney has been subscribed by an authorized officer or official of the Companies and the corporate seals of the Companies have been affixed thereto this 30th day of October, 2013.

American Fire and Casualty Company
The Ohio Casualty Insurance Company
Liberty Mutual Insurance Company
West American Insurance Company

By: _____
Gregory W. Davenport, Assistant Secretary

STATE OF WASHINGTON ss
COUNTY OF KING

On this 30th day of October, 2013, before me personally appeared Gregory W. Davenport, who acknowledged himself to be the Assistant Secretary of American Fire and Casualty Company, Liberty Mutual Insurance Company, The Ohio Casualty Company, and West American Insurance Company, and that he, as such, being authorized so to do, execute the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my notarial seal at Seattle, Washington, on the day and year first above written.

By: KD Riley
KD Riley, Notary Public

This Power of Attorney is made and executed pursuant to and by authority of the following By-laws and Authorizations of American Fire and Casualty Company, The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company which resolutions are now in full force and effect reading as follows:

ARTICLE IV – OFFICERS – Section 12. Power of Attorney. Any officer or other official of the Corporation authorized for that purpose in writing by the Chairman or the President, and subject to such limitation as the Chairman or the President may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Corporation to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact, subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Corporation by their signature and execution of any such instruments and to attach thereto the seal of the Corporation. When so executed, such instruments shall be as binding as if signed by the President and attested to by the Secretary. Any power or authority granted to any representative or attorney-in-fact under the provisions of this article may be revoked at any time by the Board, the Chairman, the President or by the officer or officers granting such power or authority.

ARTICLE XIII – Execution of Contracts – SECTION 5. Surety Bonds and Undertakings. Any officer of the Company authorized for that purpose in writing by the chairman or the president, and subject to such limitations as the chairman or the president may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Company by their signature and execution of any such instruments and to attach thereto the seal of the Company. When so executed such instruments shall be as binding as if signed by the president and attested by the secretary.

Certificate of Designation – The President of the Company, acting pursuant to the Bylaws of the Company, authorizes Gregory W. Davenport, Assistant Secretary to appoint such attorneys-in-fact as may be necessary to act on behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations.

Authorization – By unanimous consent of the Company's Board of Directors, the Company consents that facsimile or mechanically reproduced signature of any assistant secretary of the Company, wherever appearing upon a certified copy of any power of attorney issued by the Company in connection with surety bonds, shall be valid and binding upon the Company with the same force and effect as though manually affixed.

I, David M. Carey, the undersigned, Assistant Secretary, of American Fire and Casualty Company, The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company do hereby certify that the original power of attorney of which the foregoing is a full, true and correct copy of the Power of Attorney executed by said Companies, is in full force and effect and has not been revoked.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the seals of said Companies this _____ day of APR 10 2015, 20_____.

By: _____
David M. Carey, Assistant Secretary

Not valid for mortgage, note, loan, letter of credit, currency rate, interest rate or residual value guarantees.

To confirm the validity of this Power of Attorney call 1-610-832-8240 between 9:00 am and 4:30 pm EST on any business day.

LMS_12873_092012

3.2.2 Information to Include Behind Tab 2: Proposal Table of Contents

The Bid Proposal must contain a table of contents.

Tab 1
Transmittal Letter 1
Bid Proposal Security 9
Tab 2
Table of Contents 10
Tab 3
Bidders Apprach to Meeting the Scope of Work 15
Section 1 – RFP Purpose and Background 24
Section 2 – Administrative Requirements 34
2.1 Licensure/Accreditation 34
2.2 Subcontracts 36
2.3 Financial Stability 40
2.4 Maintenance of Records 41
2.5 Disclosures 42
2.6 Debarred Individuals 44
2.8 Organizational Structure 45
2.9 Staffing 50
2.11 Coordination with Other State Agencies and Program Contractors 62
2.13 Written Policies and Procedures 63
2.14 Participation in Readiness Review 64
2.15 Confidentiality of Member Medical Records and Other Information 67
2.16 Material Change to Operations 68
Section 3 – Scope and Covered Benefits 218
3.2.2 Benefit Packages 218
3.2.4 Integrated Care 220
3.2.5 Emergency Services 221
3.2.6 Pharmacy Services 226
3.2.7 EPSDT Services 232
3.2.8 Behavioral Health Services 238
3.2.9 Health Homes 253

3.2.10 Chronic Condition Health Homes 257
3.2.11 1915(i) Habilitation Services and 1915(c) Children's Mental Health (CMH) Services 258
3.2.13 Iowa Health and Wellness Plan Benefits 261
3.2.14 Value-Added Services 262
3.3 Continuity of Care 270
3.4 Coordination with Medicare 271
Section 4 – Long Term Services and Supports 275
4.1 General 280
4.2 Level of Care Assessments 282
4.3 Community-Based Case Management Requirements 287
4.3.12 Nursing Facilities and ICF/IDs 306
4.4 1915(c) HCBS Waivers 312
Section 5 – Billing and Collections 353
5.1 General Provisions 355
5.2 Reserved 355
5.3 Copayments 355
5.4 Patient Liability 356
5.5 IDPH Sliding Scale 356
Section 6 – Provider Network Requirements 357
6.1 General Provisions 357
6.1.2 Provider Agreements 372
6.1.3 Provider Credentialing 374
6.1.4 Cultural Competence 378
6.1.6 Provider Relations and Communications 381
6.1.8 Notification of Provider Disenrollment 393
6.1.9 Medical Records 394
6.1.10 Availability of Services 397
6.1.11 Provider Compliance 397
6.2 Network Development and Adequacy 401
6.3 Requirements by Provider Type 410
Section 7 – Enrollment 419
7.4 Member Disenrollment 421
Section 8 – Member Services 423

8.1 Marketing 423
8.2 Member Communications 424
8.3 Member Services Helpline 430
8.4 Nurse Call Line 434
8.5 Electronic Communications 435
8.6 Member Website 437
8.7 Health Education and Initiatives 439
8.8 Cost and Quality Information 441
8.10 Member Rights 441
8.11 Redetermination Assistance 442
8.12 Member and Stakeholder Engagement 442
8.13 Stakeholder Education 444
8.14 Implementation Support 445
8.15 Grievances, Appeals, and State Fair Hearings 446
Section 9 – Care Coordination 534
9.1 General 535
9.1.1 Initial Screening 536
9.1.2 Comprehensive Health Risk Assessment 538
9.1.3 Care Coordination 540
9.1.4 Risk Stratification 544
9.1.5 Member Identification 548
9.1.6 Care Plan Development 549
9.1.7 Tracking and Reporting 553
9.1.8 Monitoring 554
9.1.9 Reassessments 555
Section 10 – Quality Management And Improvement Strategies 592
10.1 Contractor Quality Management/Quality Improvement Program 593
10.2 State Quality Initiatives 608
10.3 Incentive Programs 612
10.4 Critical Incidents 616
10.5 Provider Preventable Conditions 618
Section 11 – Utilization Management 653
11.1 Utilization Management Programs 653
11.2 Prior Authorization 674

Section 12 – Program Integrity 716
Section 13 – Information Technology 767
13.1 Information Services & System 767
13.2 Contingency and Continuity Planning 793
13.3 Data Exchange 794
13.4 Claims Processing 796
13.5 Encounter Claims Submission 806
13.6 TPL Processing 815
13.7 Health Information Technology 817
Section 14 – Performance Targets And Reporting Requirements 938
Section 15 – Termination 949
Tab 4
Bidder's Background 951
Experience 951
Personnel 961
Termination, Litigation and Investigation 968
Tab 5
Attachments 975
Tab 6
RFP Forms 993
Financial Statements 1012
Resumes 1016
Contract Lists 1023
Select Attachments Not Included in Page Count 1104

This page reserved for Section 3.2.3 per RFP Amendment 2.

3.2.4 Information to Include Behind Tab 3: Bidder's Approach to Meeting the Scope of Work

The bidder shall address the requirements in Attachment 1: Scope of Work that the successful Contractor will perform as listed in Attachment 1: Scope of Work and Attachment 5: Technical Proposal Response Form, detailing the bidder's planned approach. Bid responses should provide sufficient detail so that the Agency can understand and evaluate the bidder's approach, and should not merely repeat the requirements or Deliverables.

Bidders are given wide latitude in the degree of detail they offer or the extent to which they reveal plans, designs, examples, processes, and procedures. Bidders do not need to address any responsibilities that are specifically designated as Agency responsibilities.

Note:

- ***Responses shall be in the same sequence as presented in Attachment 1: Scope of Work and should follow the instructions in Attachment 5: Technical Proposal Response Form.***
- ***Bid Proposals shall identify any deviations from the specifications the bidder cannot satisfy.***
- ***Bid Proposals shall not contain promotional or display materials unless specifically required.***
- ***Bidders shall not submit more than one Bid Proposal.***

The bidder shall provide the information set forth in this section regarding its experience and background.

Core Strengths and Key Features of our Proposed Approach

The following detail demonstrates Molina's understanding Iowa members' needs, describes our experience and key strengths relevant to each category, and shares our recommendations to ensure successful implementation of programs designed to improve health outcomes while controlling costs. The core strengths that Molina will implement in Iowa are:

Access to Quality Health Care

Challenges – Iowa's growing number of older individuals covered under the traditional fee-for-service approach often receive overtreatment, unnecessary Emergency Room visits, and unnecessary medical tests and procedures, all leading to higher uncontrolled costs. Taking into consideration that 28% of the Iowa Medicaid elderly and disabled population drives 71% of the related costs, we are confident that our core strengths, applied in the State of Iowa, will result in improved care management, better coordination of services across all providers of care and enhanced cost control management.

Solutions – To this day, access to quality healthcare remains a guiding principle for all Molina health plans. We were founded on a deep understanding of the social, economic and cultural environments and circumstances of Medicaid populations and have repeatedly demonstrated the ability to anticipate utilization requirements and enrollment needs in our networks and medical plans to offset unexpected cost control challenges. Nine of Molina's 12 health plans are ranked in the top 100 nationwide by the National Committee for Quality Assurance (NCQA) and it is Molina's mission to achieve the highest NCQA accreditation for all of its health plans as soon as they become eligible.

Molina also serves a diverse range of Medicaid and Medicare D-SNP populations, which demand a high level of complex benefit management and comprehensive quality performance. Molina is also the leading MCO nationwide in Medicare-Medicaid Plan (Dual Eligible) Demonstration participation, serving Dual Eligible populations in six states, more than any other MCO. As of January 15, 2015, Molina served nearly 40,000 Dual Eligible members and nationally reported data indicates that Molina currently has the second largest enrollment of Dual Eligible individuals among all MCOs nationwide.

In addition, Molina leverages cutting edge technologies to provide the deep data analysis needed to solve hard problems and improve the way we administer care. Molina offers an industry-leading suite of business intelligence and data-mining tools that allow Molina to manage and analyze massive amounts of information from disparate sources. Molina utilizes this information to uncover trends and outliers that can be translated into valuable care management opportunities for its members.

Recommendations – [redacted]

CONFIDENTIAL

CONFIDENTIAL

[redacted]

Access to Physicians and Other Health Professionals

Challenges – While Iowa Medical Society data indicates Iowa has been ranked 6th nationally in family physicians per resident, Iowa ranks 44th among the states in the ability of residents to easily get care from a direct care physician. Iowa is ranked 50th in the nation in Emergency Medicine, Neurological Surgery, OB/Gyn, and Physical Medicine/Rehab. Other specialties ranked between 44th and 49th include Plastic Surgery, Internal Medicine, Pediatrics, Orthopedic Surgery, Urology, and Psychiatry.

According to the Des Moines University, who recently spoke at a state budget hearing, at least 44 percent of Iowa practicing physicians are over 50. Typically as physicians' age, their tendency is to see fewer patients as they transition into retirement.

Accessing care, particularly specialty and subspecialty care, is also a challenge in Iowa's rural areas. Often specialists require a minimum number of residents in their communities to ensure sufficient patient volume to open, maintain, and/or expand an office and many Iowa communities do not have sufficiently sized populations to attract these physician offices. Cities like Chicago, Minneapolis, Kansas City, and Omaha will use their major metropolitan status to compete with Iowa's more rural environment for physician recruitment.

Typically, physicians and potentially other providers make business decisions of whether to continue to provide services to Medicaid enrollees based on economics. Due to the increase in Medicaid eligibles that occurred with Medicaid Expansion, there will be certain Iowa physicians with capacity constraints who will choose to limit Medicaid patient access or not accept new patients. Although Iowa is one of only a handful of states that have acted to continue the ACA's payment increase for Medicaid PCP's, provider shortages still exist because some providers will not accept Medicaid patients due to lower payments compared to other insurance programs.

Iowa also has an aging population which economists predict will require increased services. Iowa ranks in the top 3 in the nation for individuals 85 years and older and in the top 4 in the nation in persons aged 65 and older. An aging population often requires a higher level of care and the rural nature of Iowa will add to this challenge.

Additionally, Molina's discussions with providers have revealed that certain types of community care services are in short supply. We learned that there are only 2 adult day care centers in the greater Des Moines area due to low provider reimbursements. There is also a shortage of certain behavioral health services and in several cases there is only one provider of care, such as in the case of certain children's specialty behavioral health services provided by Orchard Place. On with Life is another example of a unique provider for brain injury care in the state.

According to the Kaiser Family Foundation, Iowa ranks 17th in the nation for the most primary care Health Professional Shortage Areas (HPSA) with only 68% of the need being met. Iowa is also ranked 22nd in the nation for the most behavioral health HPSA with only 61% of the need being met. For dental care, Iowa is ranked 16th with 53% of the need being met.

Solutions – Pressures from this growing, aging and increasingly insured population call for state interventions and MCO support to increase the number of available physicians. Molina's shared concern of improving access to needed medical services, improving quality of care, and improving efficiencies and cost effectiveness is critical and necessary given the challenges Iowa's beneficiaries face when trying

CONFIDENTIAL

to access health care services, especially in rural areas. To help mitigate the serious gap in primary care services, Molina has developed an aggressive recruitment strategy for generalists, specialists and nurse practitioners. To achieve these important objectives, we are building key relationships with strategic health systems and are focused on securing agreements with integrated health systems statewide. Following are two examples of Molina's experience in building adequate networks in rural areas:

1. As the only Utah-based health plan offering both CHIP and Medicaid plans since 1997, Molina Healthcare of Utah has built one of the largest provider networks in Utah's sparsely populated Non-Wasatch Front service area, specifically rural southeast Utah, a region historically underserved. For this service area, Molina Healthcare of Utah has a vast network of more than 1,800 providers, including 50 unique health care facilities. To meet that state's rural network access and availability standards, the health plan's comprehensive network encompasses providers in the states of Arizona, Colorado, Idaho, New Mexico, Nevada and Wyoming, providing comprehensive services to Molina members residing in rural border communities.

2. Molina Healthcare of New Mexico is the leading MCO in providing care to members living in that state's sparsely populated Frontier, Rural and Tribal areas. In building its statewide network for the state's Centennial Care Medicaid program, Molina focused heavily on contracting with targeted Rural, Frontier and Tribal area providers encompassing the spectrum of physical, behavioral, long-term care, and community and home-based services providers. Molina Healthcare of New Mexico is currently contracted with all Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). Molina currently contracts with a FQHC specializing in providing health care for the homeless and another FQHC serving Native Americans. Since the launch of Centennial Care in January 2014, the health plan's ongoing monitoring and contracting efforts continue to ensure all Molina members, regardless of extreme geographic isolation, are adequately served.

Recommendations – [redacted]

[redacted]

CONFIDENTIAL

[redacted]

- [redacted]

- [redacted]

Integrated Care Management

Challenges – Iowa, like many other states, faces the significant challenge of controlling ever-increasing costs while managing the fragmentation of care that often leads to poor quality. Care fragmentation is the result of actions focused on individual components of the care continuum without adequately addressing the whole-person relationship between primary care, acute care, behavioral health care, long-term services and supports and other care delivery systems that beneficiaries need to nurture overall health improvements.

The historical economic rewards system of paying for volume and not value has not encouraged integration. Our challenge will be to implement a pay for value system and align ourselves with our provider community to reward Triple Aim outcomes.

The lack of accountability for improved health outcomes has limited the integration of patient care. Without clear lines of accountability, exactly who has responsibility to coordinate the most appropriate care for the patient and what role the patient plays in their own healthcare will remain blurred. Iowa's rural geography also creates many provider access challenges. In Iowa, it will be important to create a clinical structure that identifies provider shortages and implements strategies on how to integrate specialty care across large distances in an effective manner.

Education is also important for full integration of care. For example, Molina's behavioral health partners have advised us of the need to educate Primary Care Physicians (PCP) on effective treatment of behavioral health and substance abuse. While it is difficult and expensive to correct drug regimens that have been initiated with less than accurate diagnosis and care plans, Molina will dedicate considerable resources toward medical and behavioral health care communication and coordination through our relationships with Community Mental Health Centers (CMHC) and the Iowa Primary Care Association (IPCA).

CONFIDENTIAL

Additionally, the lack of a singular and transportable patient health record has also been a barrier to integration. Providers may not be aware of some or all past diagnosis and treatment which can create under- or over-use of services. We welcome Iowa's efforts in establishing the Iowa Health Information Network to create an appropriately accessible health record.

Solutions - Molina's integrated health care management model supports its diverse physical, behavioral and social service offerings using evidence-based clinical practices to influence member behavior, improve health outcomes, and contain costs. To improve continuity and coordination of care, Molina will perform an initial screening and assessment for all enrollees within 90 days from the date of enrollment to identify pregnancy, chronic conditions, barriers to obtaining health care (such as transportation) and special or significant health care needs. Molina will also have procedures in place to coordinate services with the goal to prevent duplication of services. The following examples demonstrate Molina's experience in the integration of care management services within its sister health plans:

1. In 2012, Molina Healthcare of Michigan brought behavioral health in-house to implement an integrated care approach to care management for its members. This approach provides a comprehensive and seamless member experience through a single integrated care solution. Molina has developed a comprehensive behavioral health care management team to address the unique and complex needs of its Medicaid and D-SNP populations. The team is comprised of a clinical psychiatrist, licensed clinical social workers, registered nurses, and case managers all with extensive behavioral health experience and expertise. Molina Healthcare of Michigan facilitates its members' ability to better self-manage their chronic disease conditions through coaching, guidance, motivation and collaboration with Molina staff, and by providing or facilitating access to effective community resources for self-management education. This approach has resulted in a significant reduction in hospital utilization by its Medicaid and D-SNP members. Average length of stay was reduced from 9.5 days in July 2012 to just over 6.5 days as of November 2014. Meanwhile, the rate of admissions per thousand was reduced from 6.8 per 1000 in July 2013 to 4.4 per 1000 as of November 2014.

2. For nearly a decade, Molina Healthcare of Washington has been a leader in the integration of primary and behavioral health services, gaining valuable experience through its partnership with Health Care Authority (HCA) and the Washington Medicaid Integration Partnership (WMIP) program. Launched in January 2005 and concluded in 2014, the WMIP program was an innovative model that significantly improved the integration of program enrollee care by combining the financing and management of all components of care. As the only MCO to join HCA in this landmark pilot, Molina demonstrated its core commitment to the integration of all care needs, including physical and behavioral health and long-term care, to produce better health outcomes and a better member experience, while generating significant cost reductions.

   Through its WMIP experience, Molina utilized lessons learned to optimize program operations and identify opportunities for innovations to improve service provision to populations with high needs and multiple chronic conditions. For example, Molina recognized that high needs populations benefit from care management services with strong interventions and a fully integrated care coordination process. Molina further recognized the immense value in ensuring coordination across providers, community support systems and even state entities. In addition, information sharing and the availability of interoperable systems to share health record information emerged as critical issues to ensuring successful coordination across services, care settings, and stakeholders. Experience in this program further highlighted the need for dedicated staff to be located in the areas where enrollees are served to provide face-to-face care coordination interventions, as needed.

Recommendations – [redacted]

CONFIDENTIAL

CONFIDENTIAL

[redacted]

CONFIDENTIAL

Molina's sole focus on government funded medical programs for the nation's most vulnerable citizens is at the core or our managed care programs and strategic partnerships that give emphasis to empowering members and providers.

SECTION 1 - RFP PURPOSE AND BACKGROUND

Please explain how you propose to execute Section 1 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience. To the extent that a more detailed description of your qualifications and relevant experience for this section is described in more detail later in your proposal, a brief summary will suffice.

Molina understands, agrees and will comply with all requirements in accordance with Section 1 of Attachment 1—Scope of Work.

Molina Healthcare of Iowa will execute Section 1 in its entirety by delivering high quality and cost-effective Medicaid-related solutions to meet the health care needs of the Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (hawk-i) programs. Molina Healthcare, Inc., the parent organization of Molina Healthcare of Iowa, is a multi-state healthcare organization focused exclusively on Medicaid, Medicare, and other government-sponsored healthcare programs for low income families and individuals. Molina Healthcare of Iowa will leverage the administrative and legal structure of its parent and sister health plans to administer a cost-effective combination of local plan operations and shared corporate resources, while maintaining a holistic, person-centered, outcomes-focused approach to managed care services.

Molina has administered government-sponsored healthcare programs for more than 34 years, demonstrating the capacity to coordinate care and quality outcomes for Medicaid and Children's Health Insurance Program (CHIP) populations by providing integrated, individualized and coordinated health care for low-income families and individuals.

Molina operates licensed health plans in California, Florida, Illinois, Michigan, New Mexico, Ohio, South Carolina, Texas, Utah, Washington, Wisconsin and the commonwealth of Puerto Rico. In aggregate, these 12 health plans serve more than 3.2 million Medicaid, Medicare and Marketplace members through a variety of managed care programs and commit to providing a seamless transition for Iowa Medicaid program members to managed care. Molina is also participating in Medicare-Medicaid Plan (Dual Eligible) demonstrations in five states, the most of any managed care organization in the nation. Our managed care programs have the capacity to serve the Iowa Medicaid and CHIP populations and can also provide services for individuals qualifying for Iowa Department of Public Health (IDPH) funded substance use disorder services. This section demonstrates Molina's unique qualifications to serve Iowa's Medicaid population and to execute Section in its entirety.

Goals

Committed Partner. Molina appreciates the opportunity to partner with the State of Iowa and will approach its contractual relationship with Iowa Department of Human Services (DHS) with flexibility and willingness to be an agent of service, change, and innovation. Molina will deliver the covered benefits, including physical health, behavioral health and long-term services and supports (LTSS) in a highly coordinated manner by integrating care and improve quality outcomes and efficiencies across the healthcare delivery system, in turn decreasing costs through the reduction of unnecessary, inappropriate, and duplicative services.

Robust and Diverse Provider Network. Molina's broad, robust provider network of physicians,

Behavioral health professionals, clinics, hospitals and acute and Long Term Services and Supports (LTSS) providers will cover the Iowa Medicaid and Children's Health Insurance Program (CHIP) populations to meet their acute care and LTSS needs.

Quality Focused. Through its partnership with DHS, Molina will work to improve the quality of care and health outcomes for Medicaid and CHIP members while leveraging the strength and success of current DHS initiatives. Molina's key principles include a pervasive commitment to the quality of its providers and the care received by members. For the Iowa Medicaid and Children's Health Insurance Program (CHIP) members, quality of care will be critical and will necessitate effective coordination of care among all providers when complex care is necessary. Molina has achieved National Committee for Quality Assurance (NCQA) accreditation for nine of its 12 health plans (California, Florida, Michigan, New Mexico, Texas, Ohio, Utah, Washington and Wisconsin) for evaluation standards that assure policies, procedures and daily practices provide relevant high quality care and patient advocacy. The health plans most recently added to the Molina family located in Illinois, South Carolina and the Commonwealth of Puerto Rico are not yet accredited, however, accreditation will be pursued as soon as possible.

Service Coordination. Molina is well prepared to provide high quality healthcare services, and address Iowa Medicaid program members' unique needs by emphasizing member choice, access, safety, independence, and responsibility; and conduct functional assessments to ensure a successful person-centered plan of care, coordination of all health care and support services, and the establishment of Health Homes. Molina's Service Coordination Program will help Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (hawk-i) programs members obtain and maintain their desired quality of life and health status delivered in the least restrictive, cost-effective setting appropriate to members' health and functional status.

These key principles and Molina's person-centered approach, presented in further detail throughout this proposal, offers Iowa Medicaid, Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (hawk-i) programs the highest quality care in the most professional, ethical and cost effective manner.

1.4 General Contractor Responsibilities

1. Indicate your ability to comply with all Federal and State Laws and Regulations that may affect this Contract.

Federal and State Laws and Regulations

In accordance with State of Iowa MED-16-009, Iowa High Quality Healthcare Initiative Contract, Molina has the ability and will meet all applicable requirements under all Federal and State laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act; and Section 1903(m) and 1932 of the Social Security Act, as well as the implementing regulations set forth in 42 CFR 438, as may be amended. Molina will observe and comply at all times with all, then current, Federal and State Law related to or affecting this RFP and/or the Iowa High Quality Healthcare Initiative Contract, including any Law that may be enacted during the term of this RFP or the Contract.

Molina ensures compliance with all applicable Federal and State Law pertinent to member confidentiality and rights and ensure that its staff, network providers and subcontractors take those rights into account when furnishing services to members.

Molina understands its responsibility to remain aware of changes in Federal and State Laws and Regulations as they affect Molina's duties and responsibilities under this RFP and/or the Iowa High Quality Healthcare Initiative Contract. In the event of a conflict between any Law and this RFP or the

Contract, the Law shall govern the agreement, but all remaining terms and conditions of the Contract shall remain unchanged.

2. Summarize how you are qualified to provide the services listed in Section 1.4.2

1.4.2 Qualifications

Molina ensures that it, and its proposed subcontractor(s) is experienced in the business of furnishing Medicaid and CHIP capitated services comparable in size and complexity to those specified in the Iowa High Quality Healthcare Initiative. Through this proposal, Molina demonstrates the following qualifications:

1.4.2.1Work with existing and additional provider networks and stakeholders to successfully meet the needs of members with a wide range of physical, social, functional, behavioral and LTSS needs.

Molina has extensive experience working with existing and additional provider networks and stakeholders through the establishment and maintenance of provider networks of compassionate physical, social, functional, behavioral health/substance use disorder and LTSS providers, along with FQHCs and RHCs. Our Iowa High Quality Healthcare Initiative provider network will include PCPs, specialists, large provider groups, behavioral health providers and related entities, targeted hospitals, nursing facilities, urgent care facilities, family planning and maternal/child health centers, FQHCs/RHCs and other long-term services and supports, safety net and, home and community-based providers, creating a robust statewide network secured by binding provider contracts. Molina's provider network development and contracting strategy is wholly focused on coordinating the health care needs of Iowa's wide range of eligible populations, including meeting the comprehensive physical, social, behavioral health and preventive needs of all members.

1.4.2.2 Manage all statewide physical, LTSS and behavioral health services for Iowa residents who meet the eligibility requirements defined in this RFP.

Molina will manage all statewide physical, LTSS and behavioral health services for Iowa residents that are eligible by collecting and integrating data across Molina's health care delivery system and internal functional units.

To ensure coordination and continuity of care with providers, Molina promotes integration and coordination of physical, behavioral health and LTSS providers through Molina's Integrated Care Management program and approach, as documented in written policies and procedures; transparency of information; and innovative programs and models.

Molina's Integrated Care Management program is a result of the dynamic relationship of assessment, review of acuity and intensity of needs, intervention with reassessment and outcomes evaluation. To ensure effective coordination of services and reduce duplication and fragmentation of care, Molina Case Management staff coordinates the process, which includes involving the member, the member's family and/or caregivers, treating physicians, therapists, counselors, social workers and other practitioners in the Interdisciplinary Care Team (ICT) providing member's care.

Case Management staff utilizes the ICT platform as a tool to help arrange for necessary physical, specialty care, community-based services, LTSS and behavioral health needs. The staff ensures and establishes an adequate provider network to accommodate this care to help achieve the balance between resource utilization, communication and functional needs to achieve person-centered goals.

Case Management staff maintains the responsibility of coordinating physical, LTSS and behavioral health services throughout the member's continuum of care. The staff incorporates the member's preferences while effectively reducing costs during all ongoing communications.

1.4.2.3 Operate in a manner that results in eligible individuals receiving services that are timely and effective in reducing problems and symptoms and how proposed operations will maximize member functioning and quality of life.

Molina operates in a manner that ensures members are delivered the right care, at the right time, in the right setting, and maximize members functioning and quality of life through its Care Management programs, which operate in a manner resulting in eligible individuals receiving services that are timely and effective in reducing problems and symptoms.

Molina's Care Management delivery approach to integrate care coordination for members includes the following programs and services, which are all critical to ensuring the comprehensive integration of health care services:

- **Care Coordination programs** that integrate an array of health care services that are designed to improve health outcomes for chronically ill members who are aged and/or disabled, including individuals with AIDS; Acquired Brain Injury; Children with Mental Health Conditions; or who are part of the HCBS Elderly, Health and Disability (HD), Intellectual Disability (ID) and Physical Disability (PD) waivers who need long term care support services; and individuals with acute, behavioral health and/or substance use disorder issues;
- **Disease Management programs** that are designed to actively engage members in addressing their own health care needs, and which have been proven effective in reducing inpatient admissions, readmissions and Emergency Room utilization;
- **Case Management programs** that are designed to risk-stratify members with complex medical conditions for dynamic assessment of needs, interventions, reassessment and evaluation of outcomes;
- **Utilization Management programs** that are designed to ensure quality, cost-effective and medically necessary services are delivered across the continuum of care;
- **A dedicated Nurse Advice Line** service available 24 hours per day, seven days per week that is staffed by registered nurses who provide comprehensive and personalized physical health and behavioral health telephone services with a goal of decreasing inappropriate Emergency Room utilization; and
- **Establish a transportation program** and strategy designed to reduce the potential for missed services or unmet needs for members including those in rural Iowa.

1.4.2.4 Establish a comprehensive, accessible provider network that offers a choice of providers in all areas of the state.

Molina's provider network development and contracting strategy is wholly focused on establishing a comprehensive, accessible provider network that offers a choice of providers in all areas of the state, and encourages members' freedom of choice and participation in decisions about their health, including the ability to choose their own PCP.

The network composition of Molina's Iowa High Quality Healthcare Initiative will ensure:

- A sufficient number, mix and geographic distribution of providers in accordance with General Access Standards set forth in Exhibit B, General Access Standards;
- Compliance with the state's plan to work with existing Medicaid providers who wish to participate in supporting the goals of the Initiative;

- That Molina's provider network will meet all applicable requirements of Iowa law and have the necessary and current licenses, certifications and accreditation and/or designation approval per state requirements; and
- Our robust network meets all 42CFR 438.206 requirements for the delivery of services in a culturally competent manner and will permit members to choose providers based on cultural preference.

We also provide comprehensive information to beneficiaries and/or their representatives regarding our provider network in advance of initial enrollment to allow for time to review options and select a PCP.

1.4.2.5 Offer a coordinated array of services to eligible individuals.

Molina is committed to offering a coordinated array of services to eligible individuals through its person-centered Care Management model that integrates whole-person needs inclusive of physical, LTSS and behavioral health services.

To provide coordinated care to eligible individuals, Molina uses a person-centered integrated care management approach based on empirically validated best practices that have demonstrated positive results in its numerous managed care markets to ensure that members receive high-quality care. Molina's Care Management model uses Interdisciplinary Care Teams (ICT) to provide individualized coordinated care, which includes the coordination of physical health, behavioral health and LTSS. Molina's Interdisciplinary Care Team approach to providing services to members with special health care needs ensures that the needs of the member are coordinated with members of the care team including the PCP, specialty providers and ancillary providers.

The Interdisciplinary Care Team (ICT) provides holistic care to members to address all member needs. The team communicates those needs to all appropriate providers of care to ensure continuity of care through a broad array of services that includes the coordination of physical, LTSS and behavioral health, and social services, and assisting members with special health care needs to navigate the health care system. With a thorough understanding of the member's needs, the Service Coordinator creates an Individualized Service Plan. The ultimate goal is to keep the member safe, satisfied and healthy in the least restrictive setting.

Features of Molina's person-centered model of care services include general and specialized pediatric assessment tools; predictive modeling; and interdisciplinary care teams who develop and adhere to an evolving Individualized Service Plan to meet the needs of a high-cost, high-risk, complex population. Molina's person-centered managed care model is specifically designed to drive comprehensive care while allowing flexible tailored care for each member's specific needs based on the following goals:

- Preserve the member's dignity and promote the member's autonomy;
- Improve the member's functional independence and quality of life;
- Ensure quality of care by utilizing best practice guidelines with providers;
- Prevent hospitalization, Emergency Room visits and nursing facility placement;
- Coordinate palliative care and hospice; and
- Support caregivers with disease management tools, appropriate respite care and education about special needs.

Molina's person-centered approach to care engages and empowers the member at every opportunity, assigning resources based on specific member needs, promoting self-care and keeping members safely in the community.

Key features of Molina's person-centered model of care are as follows:

- In-home assessments;

- Shared service plan;
- Interdisciplinary Care Team conferences;
- Personal Experience Outcomes model (captures member satisfaction and assists members in achieving their desired individual quality of life outcomes, such as, I decide where and with whom I live; I make decisions regarding my supports and services; I feel safe; and I am free from abuse and neglect);
- Medication management;
- Care transitions;
- Intensive behavioral health integration;
- De-institutionalization; and
- End-of-life care.

1.4.2.6 Improve the quality of care provided to members.

To improve the quality of care provided to members, Molina's established, proven, integrated health care management system will deliver critical physical health, behavioral health and social services to its Iowa High Quality Healthcare Initiative members. Molina health plans operate under the guidance of core managed care principles that emphasize a careful balance of providing positive member outcomes with cost-effective quality care across the health care continuum. These principles include:

- Improving quality of care by encouraging member participation in their own care; leveraging innovative preventive care programs; and streamlining care coordination and continuity of care;
- Ensuring appropriate care settings through provision of private physician office care in lieu of time-consuming, costly Emergency Room care;
- Leveraging evidence-based member data (e.g., HEDIS, CAHPS) to optimize quality of care and personal health outcomes;
- Ensuring appropriate use of HCBS to avoid or reduce nursing facility usage and encourage independence; and
- Investing in process improvements, provider network adequacy and other resources necessary to ensure holistic, coordinated and integrated care for every member in all appropriate care settings. Molina has established a key provider foundation in Iowa.

1.4.2.7 Improve outcomes across the healthcare delivery system.

Molina is experienced in the delivery of high quality care with the primary goal of improving the health outcomes and quality of life of its members. Our Quality Assessment and Performance Improvement (QAPI) program is committed to the provision of accessible, appropriate, cost-effective, high quality, integrated health care services for members across our healthcare delivery system and throughout the entire range of care. Molina assists members as they move through the managed care system, coordinating care across different health care settings, reducing and/or eliminating barriers to care, and supporting members in maintaining independence and reach optimal health. Our QAPI Program provides the organizational structure and supporting processes that enable Molina to fulfill its commitment to achieving clinical and operational excellence to improve outcomes across the healthcare delivery system.

Molina's QAPI staff works with the Quality Improvement Committee, subcommittees and other workgroups to plan, design, develop and implement policies and procedures and activities designed to improve quality outcomes, including methods, timelines and roles and responsibilities for completing various tasks. Molina evaluates the quality of care and services provided to members through continuous oversight of performance, assessments and corrective action/improvement plans. Molina will develop and

maintain delegation policies and procedures, and makes recommendations regarding delegation to the Quality Improvement Committee.

The Quality Improvement department investigates the potential quality of care issue in accordance with its internal guidelines covering all critical tasks, from documenting the grievance for tracking and trending, to a site visit at a provider's office, when applicable. The Quality Improvement and Appeals and Grievance departments then coordinate appropriately to resolve the grievance.

Care Coordination programs provided by Molina are also integral, which integrate an array of health care services that are designed to improve health outcomes for chronically ill members who are aged and/or disabled, including individuals with AIDS; Acquired Brain Injury; Children with Mental Health Conditions; or who are part of the HCBS Elderly, Health and Disability (HD), Intellectual Disability (ID) and Physical Disability (PD) waivers who need long term care support services; and individuals with acute, behavioral health and/or substance use disorder issues.

Molina will also collaborate with the 22 statewide Iowa EPSDT Coordinators on their historical experiences and opportunities to identify additional strategies to improve outcomes. Molina will also continue dialogue with key organizations, such as Charles Bruner and the Iowa Child and Family Policy Center about EPSDT improvement strategies, Kristie Oliver from Coalition for Family, and Children's Services in Iowa.

Molina was proud to be a sponsor at this year's 38th Annual Governor's Conference on Substance Abuse and was pleased to engage Iowans on opportunities to improve substance abuse outcomes.

The successful operation of Health Homes in Iowa will improve health outcomes for members, increase member satisfaction and control costs through improved integration, member engagement and better service delivery. The operational success of Health Homes will also depend on workforce development. Health Homes are intended to serve a targeted group with historically poorer outcomes, sometimes due to disparities in treatment regarding their physical and behavioral health needs. While community Behavioral Health providers have expertise in several required core competencies, including case management and care coordination, their focus has often been in the areas of mental health, substance use and social services. Conversely, physical health settings, such as FQHCs, have core competencies around primary care and understand the potential impact of behavioral health on physical health but do not always have the integrated skills or resources to bridge those gaps in care.

1.4.2.8 Ensure the delivery of services to members that are readily accessible and provided in the least restrictive environment likely to result in the desired outcomes.

To ensure that the delivery of services to members are readily accessible and the needs of members are provided in the least restrictive environment, Molina has a fully integrated Interdisciplinary Care Team composed of a Molina Medical Director, Case Manager, Utilization Management nurse, and pharmacy, behavioral health and long-term care staff that works with the member to achieve the results desired. This team meets biweekly and as needed to develop strategies for care management. Additionally, the Interdisciplinary Care Team typically incorporates the member's PCP and specialists (if applicable) in care decisions and in the development of effective care strategies. Molina's Integrated Care Management Team includes medical and behavioral health clinicians, along with ancillary agencies and community agencies actively coordinating the member's care. The Interdisciplinary Care Team will provide the following coordinated care benefits for members requiring LTSS:

- Creation of a team-oriented, multidisciplinary comprehensive care coordination model for the member, which has been demonstrated to produce better outcomes when compared to the fragmented care coordination services delivered under FFS or less comprehensive models;

- Promotion of the development, implementation and maintenance of individualized person-centered care plans, and the establishment of a point-of-contact that facilitates the coordination of care between providers and other stakeholders, resulting in prioritized delivery of necessary services;
- Improvement of programmatic evaluation capabilities from all stakeholders' perspectives;
- Improvement of access to care by leveraging the contracted network of providers, including those specializing in services for children; and
- Alignment with managed care organization and regulatory incentives by preventing unnecessary and/or long-term admissions to nursing facilities and promoting increased utilization of Home and Community-Based Services (HCBS), thus accomplishing the objectives of reducing costs while providing care in the least restrictive setting.

Molina Case Managers utilize a person-centered approach to collaboratively develop a comprehensive plan of care that maximizes the member's desired health outcomes and promotes the highest level of functioning while living in the least restrictive setting. The Care Management team is comprised of physical health Case Managers and licensed behavioral health professionals who work together to address the whole-person health needs of members, which may include primary behavioral health interventions or the identification of behavioral health issues that are secondary to primary physical health conditions. Behavioral health issues are reviewed to identify any barriers to treatment that often go unrecognized due to broader medical complaints. One of Molina's fundamental Care Management principles is to ensure every member has a choice of options and is empowered to achieve or maintain the highest level of self-sufficiency. Molina believes true consumer engagement encourages members to play an active role in their treatment by allowing members to voice their opinions and goals, and participate in the establishment of care plans.

1.4.2.9 Provide all covered benefits and administrative functions as required in the RFP.

Molina is qualified to provide all covered benefits and administrative functions to members that are covered under the Iowa High Quality Healthcare Initiative Contract.

Molina will administer all covered benefits and services using a person-centered, cost-effective combination of its local health plan operations and shared resources provided by its parent, Molina Healthcare, Inc. To ensure the provision of all covered benefits and administrative functions as required by the Iowa High Quality Healthcare Initiative we will:

- Administer an efficient managed care model that provides quality services in a sustainable manner while meeting all state, regulatory and other requirements;
- Implement Molina's scalable IT system that supports compliance and growth requirements, and is capable of handling the complex data produced by the Iowa High Quality Healthcare Initiative population;
- Continue to build a robust service delivery network focused on contracting with Primary Care Physicians (PCPs) who support a Medical Home environment, as well as specialists, hospitals, long term services and supports, and ancillary providers, to ensure access to experienced practitioners; and
- Use flexible and innovative care management delivery approaches to integrate care coordination for members with disabilities, chronic medical conditions, and behavioral health and substance use disorder issues to ensure delivery of the right care, at the right time, in the right setting. Care Management at Molina includes the following programs and services, which are all critical to ensuring the comprehensive integration of health care services:
  - Care Coordination programs, which integrate an array of health care services that are designed to improve health outcomes for chronically ill members who are aged and/or disabled, including

individuals with AIDS; Acquired Brain Injury; Children with Mental Health Conditions; or who are part of the HCBS Elderly, Health and Disability (HD), Intellectual Disability (ID) and Physical Disability (PD) waivers who need long term care support services; and individuals with acute, behavioral health and/or substance use disorder issues;

- Disease Management programs that are designed to actively engage members in addressing their own health care needs, and which have been proven effective in reducing inpatient admissions, readmissions and Emergency Room utilization;
- Case Management programs that are designed to risk-stratify members with complex medical conditions for dynamic assessment of needs, interventions, reassessment and evaluation of outcomes;
- Utilization Management programs that are designed to ensure quality, cost-effective and medically necessary services are delivered across the continuum of care;
- A dedicated Nurse Advice Line service available 24 hours per day, seven days per week that is staffed by registered nurses who provide comprehensive and personalized physical health and behavioral health telephone services with a goal of decreasing inappropriate Emergency Room utilization; and
- Establish a transportation program and strategy designed to reduce the potential for missed services or unmet needs for members including those in rural Iowa.

[redacted]

1.4.2.10 Operate in a manner that promotes efficiency in the service delivery system while offering the highest quality services.

Molina operates in a manner that promotes efficiency in its service delivery system while offering the highest quality of services by consistently evaluating the appropriateness of its service delivery to ensure members receive the right care, at the right time, and in the right setting. Molina's evaluation process further ensures compliance with contractual requirements and accreditation standards related to care and services for utilization review, continuity of care and quality of care, including evaluation of onsite and telephonic review processes.

Molina's Quality Improvement and Utilization Management committees provide oversight and manage the evaluation of Utilization Management department functionality and efficacy. For the Iowa High Quality Healthcare Initiative, Molina will create written Utilization Review criteria in specific compliance with Contract and Scope of Work requirements. These criteria will be based on sound medical evidence; updated regularly, reviewed and approved annually; and consistently applied within the context of CMS regulations, guidance and processes. These criteria will further provide necessary guidelines for consistent monitoring and evaluation of Molina's service delivery to its members.

1.4.2.11 Coordinate, integrate and be accountable for all services proposed.

Molina is accountable for coordination, integration, and delivery of care and member experience for all services, and will work with members to educate them and maximize the benefits available to them and facilitate the provision of seamless care. Case Managers research all services available to members by assessing available plan benefits and available community-based services based on each member's unique coverage and needs. Case Managers communicate regularly with the member's PCP to jointly develop

CONFIDENTIAL

Care Plans, engage the PCP in the Interdisciplinary Care Team, monitor progress and coordinate necessary care. Case Managers will reach out and coordinate appropriate services for members, including those with medical, behavioral, social, and long-term care needs.

Molina Healthcare of Iowa is prepared to immediately begin implementation and management of innovative programs and solutions that support the goals and objectives of the Iowa High Quality Healthcare Initiative.

SECTION 2 – ADMINISTRATIVE REQUIREMENTS

Please explain how you propose to execute Section 2 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Molina understands, agrees and will comply with all Administrative Requirements in accordance with Section 2 – Administrative Requirements of Attachment 1—Scope of Work.

To ensure administrative performance and efficiency for the Iowa High Quality Healthcare Initiative, Molina will apply its extensive experience in strategic planning, large complex project development and implementation through the proven results of successful administration of its 12 licensed health plans to execute Section 2 – Administrative Requirements. Molina has established an administrative office in Des Moines, Iowa to provide the full spectrum of healthcare services through face-to-face interactions with members and the health care community.

Molina Healthcare of Iowa ("Molina") is a wholly-owned subsidiary of Molina Healthcare, Inc., a Delaware corporation ("Parent"). The Parent is a publically-traded corporation with multistate, subsidiary health plans with experience in arranging for the delivery of health care services to persons eligible for Medicaid, Medicare, the Children's Health Insurance Program (CHIP) and other government-sponsored health care programs for low-income families and individuals. The subsidiaries include licensed state health plans contracted to provide government-sponsored health care services in the following states: California, Florida, Illinois, Michigan, New Mexico, Ohio, South Carolina, Texas, Utah, Washington and Wisconsin and the Commonwealth of Puerto Rico. This experience demonstrates Molina's unique qualifications to deliver high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (hawk-i) program members.

Molina's mission is to promote health and provide high quality health care services to families and individuals who are low-income and covered by government programs. This mission focuses Molina's efforts and values on coordinating care and establishing quality outcomes for member's that are culturally, ethnically and linguistically diverse. In Iowa, Molina will focus on the operation of a fully integrated system that supports providing members with the highest level of care and satisfaction.

Prior to the Contract effective date, Molina will be licensed and in good standing in the State of Iowa as a Health Maintenance Organization (HMO) in accordance with Iowa Administrative Code 191 Chapter 40. Molina will apply to become a qualified health plan (QHP) issuer certified by the Iowa Health Insurance Exchange, as defined at 45 CFR 155.20 to facilitate continuity of care for members who move between Medicaid and premium tax credit eligibility.

2.1 Licensure/Accreditation

1. Indicate if you are currently licensed as an HMO in the State of Iowa. If you are not currently licensed, describe your plan to achieve licensure.

Molina Healthcare of Iowa is not currently licensed as a HMO in the state of Iowa; however, we are actively pursuing a Certificate of Authority (COA) to operate as an HMO in accordance with Iowa

Administrative Code 191 Chapter 40. Molina has filed its application for a COA to operate an HMO with the Commissioner of Insurance (COI) on April 24, 2015. We are working closely with the COI to complete the application process and expect to obtain licensure by or before the Contract effective date.

2. Indicate whether you are currently a qualified health plan (QHP) issuer certified by the Iowa Healthcare Exchange.

Molina currently participates in healthcare exchanges in nine of eleven states in which it operates to serve its members. Molina currently is not a qualified health plan (QHP) issuer certified by the Iowa State/Federal Partnership Health Insurance Exchange, however, Molina anticipates that upon award of a contract, it will review the opportunity to participate and intends to apply for QHP certification. Molina agrees that participating on the Iowa State/Federal Partnership Health Insurance Exchange would facilitate continuity of care for members who would move between Medicaid and those who would be eligible for premium tax credits under the Marketplace. [redacted]

3. Indicate whether you are currently accredited by the NCQA. If you are not currently accredited, describe your plan to achieve accreditation.

Molina Healthcare of Iowa is not currently accredited by the National Committee for Quality Assurance (NCQA); however, Molina has made the commitment that all of its eligible health plans will be accredited by NCQA and accordingly, we will apply for accreditation in Iowa, as soon as we are eligible, to ensure that member care is driven by the highest standards in the industry. Molina will submit audited HEDIS and CAHPS performance data as prescribed per contract and according to schedule once the contract is effective. Molina has not participated in an external quality review report (EQRO) review for Iowa or submitted external quality improvement activities and therefore, results of a comprehensive operational system review, performance measures validation and performance improvement project validation are not currently available.

National Accreditations and Certifications

Molina Healthcare, Inc. has NCQA accredited plans in nine states: Michigan, California, Florida, New Mexico, Ohio, Texas, Utah, Washington and Wisconsin. All nine of Molina Healthcare, Inc.'s health plans that it has operated for at least three years are accredited and nationally ranked. Molina Healthcare, Inc.'s health plans have been nationally ranked by NCQA for the last ten years, making Molina a national leader in quality among Medicaid focused plans.

Molina Healthcare, Inc. also qualifies for the NCQA Health Plan Accreditation (HPA) Corporate Survey, which streamlines the process for securing NCQA accreditation. The HPA Corporate Survey submission allows Molina Healthcare, Inc. to complete a single corporate survey for centralized functions developed or performed at Molina Healthcare, Inc. for all of its health plans seeking NCQA accreditation, eliminating duplication of efforts and reducing the time it takes to receive accreditation. The Corporate Survey will assist Molina Healthcare of Iowa achieve its NCQA accreditation more quickly than would otherwise be possible.

In addition, Molina Healthcare, Inc.'s 24/7 Nurse Advice Line call center is accredited by the Utilization Review Accreditation Commission (URAC). Molina's organization is staffed with experienced personnel dedicated to providing an integrated care delivery program.

CONFIDENTIAL

2.2 Subcontracts

1. Summarize your proposed subcontracts, including any with parent companies, and key work to be delegated under the subcontracted relationship.

Molina agrees, understands and will comply with all requirements in the Scope of Work, Section 2.2 Subcontracts.

For all subcontracted providers and vendors, Molina is accountable and retains responsibility to perform ongoing oversight through its Quality Improvement Program of delegated functions per 42 CFR 438.230, and as set forth in the written agreement between the parties to ensure all subcontractors are held to the Iowa High Quality Healthcare Initiative Contract requirements; including evaluating the subcontractor's ability to perform the activities to be delegated, including the firms and staff qualifications. Molina ensures that all written subcontracts meet the requirements of 42 CFR 434.6 and will incorporate by reference the applicable terms and conditions of the Contract. Molina will notify DHS in writing of all subcontracts relating to the deliverables to be provided under this Contract prior to the time the subcontract(s) become effective.

Molina Healthcare of Iowa will contract with Molina Healthcare, Inc. for shared local and centralized administrative functions, CVS Caremark for contracted pharmacy services, OptiCare Managed Vision, Inc. for contracted vision services, Quest Diagnostics for reference lab services, Focus Innovations for HCBS services, Total Transit for Transportation Services, and Veridian for Enrollee Financial Management Services to provide work activities in support of managed care plan administration obligations.

Molina Healthcare, Inc.
Molina Healthcare, Inc., as a subcontractor, provides resources for shared local and centralized administrative functions for claims processing, MIS functions, telephony, credentialing, disease management, Nurse Advice Line, call center, member materials, marketing assistance, outreach calls, professional liability insurance, legal, actuarial and accounting services for the managed care programs.

CVS Caremark Subcontractor
CVS Health is a pharmacy innovation company helping people on their path to better health. Through its 7,700 retail pharmacies, more than 900 walk-in medical clinics, a leading pharmacy benefits manager with more than 65 million plan members, and expanding specialty pharmacy services, CVS Health enables people, businesses and communities to manage health in more affordable, effective ways. This unique integrated model increases access to quality care, delivers better health outcomes, and lowers overall health care costs.

OptiCare Managed Vision, Inc., Subcontractor
OptiCare has been providing comprehensive and affordable eye care services for over 20 years and will partner with Molina to administer the added value enhancement to the covered eye benefits. OptiCare is one of the nation's largest medical eye care administrators. Founded by eye care professionals, OptiCare has become a nationally respected provider of fully integrated, risk based eye care programs. Continuous Quality Improvement across the full spectrum of administrative functions allowed OptiCare to become a premiere eye care plan administrator.

Quest Diagnostics
Quest Diagnostics products and services benefit patients, healthcare providers, pharmaceutical companies, life insurance companies and employers. Quest Diagnostics touch patients' lives approximately 150 million times each year — the story of Quest Diagnostics reach is in the numbers.

Quest Diagnostics offers convenient access to testing and services throughout the U.S., and its international presence is growing.

Total Transit
For 30 years, Total Transit has remained true to its Mission Statement to deliver the highest quality transportation service in the industry. Hard work and a commitment to excellence have earned them the coveted honor of being one of the preferred providers of transportation management services in the country. Having served Medicaid and Medicare Advantage health plans since 2002 as both a transportation provider and transportation manager, they have the experience and capabilities to serve our membership with safe, reliable, compassionate transportation services.

Veridian
Veridian has been in partnership with Iowa Medicaid Enterprise (IME) since 2007 and provides the Financial Management Services (FMS) for the Consumer Choices Option (CCO program). The CCO program gives Iowans on Medicaid who are aging or have a disability, the freedom to choose service providers to assist them with their unique needs. As the FMS, Veridian currently receive and disburse Iowa Medicaid's Home and Community Based Services waiver funds on behalf of CCO members. They are responsible for processing semi-monthly payroll for services provided and Medicaid-approved budget expenses; withholding and filing all employer payroll taxes; providing monthly statements; and submitting budget items that require approval from IME.

Finity
Finity is a leading provider of systems-based health technology and engagement solutions. Clients include State Medicaid agencies, public and private health insurance companies, hospital systems, and financial institutions. Finity is a CMS Health Care Innovation Awardee for EveryBODY Get Healthy, a population health management solution. Finity was also selected as the incentive and engagement technology provider for the first portable wellness and incentive system for the state of New Mexico's Medicaid demonstration project.

Refer to Attachment 2.2.1-1 through Attachment 2.2.1-8 Sample Subcontractor Agreements.

2. Indicate if any of the subcontracts are expected to be worth at least five percent (5%) of capitation payments under this contract.

Molina Healthcare, Inc. is expected to be worth at least five percent (5%) of capitation payments under this contract.

3. Describe the metrics used to evaluate prospective subcontractors' abilities to perform delegated activities prior to delegation.

Molina utilizes specific metrics to evaluate prospective subcontractors' ability to perform delegated activities prior to delegation and to ensure subcontractors are meeting Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (hawk-i) program requirements. Before delegating a function, Molina assesses the capability of the potential delegate to perform that function through the review of monthly and quarterly provider reports, including grievance and appeals, annual reviews and assessments of provider's performance of each delegated function or more frequently as required by state and federal law, delegate reporting, review of government sponsored program requirements, or other requirements as outlined in Molina's policies and procedures for each respective delegated functions.

Molina will monitor each subcontractor's performance on an ongoing basis including periodic formal reviews, on at least an annual basis, consistent with applicable NCQA standards and Iowa High Quality

Healthcare Initiative requirements. Molina will continually monitor subcontractor metrics and performance in order to recognize high quality performance, identify opportunities for improvement, and where deficient and necessary implement corrective action up to termination as necessary/warranted.

The Delegation Oversight Committee meets on an ongoing basis to discuss any performance issues that may arise. The Corporate Compliance Staff and other key staff are responsible for monitoring subcontractors who provide healthcare services for the plan to assure compliance with Molina and Iowa High Quality Healthcare Initiative policies and procedures.

4. Describe the policies and procedures used for auditing and monitoring subcontractors' performance.

Molina has policies and procedures in place to audit and monitor its subcontractors' data, data submission and performance; and has oversight mechanisms in place to monitor performance on an ongoing basis to ensure compliance with all Contract requirements. Molina will submit its policies and procedures to DHS for review and approval. Auditing and monitoring includes, at a minimum, formal reviews of monthly and quarterly provider reports, including grievance and appeals, annual reviews and assessments of provider's performance of each delegated function, or more frequently as required by state and federal law, delegate reporting, review of program requirements, or other requirements as outlined in Molina's policies and procedures for each respective delegated function. Molina conducts formal reviews quarterly, and has the right to conduct any such review or assessment on-site.

Auditing and monitoring of subcontractors performance is conducted by Molina's designated Delegation Oversight Committee which includes staff members from the departments who are involved in the daily management of subcontractors, or who are responsible for monitoring delegated activities.

The Delegation Oversight Committee staff evaluates the services performed by subcontractors using methods that include the following:

- Periodic performance audits;
- Review periodic management reports;
- Regular review of subcontractors' member and provider satisfaction surveys; and
- Regular review of provider and member complaints.

The Delegation Oversight Committee meets on an ongoing basis to discuss any performance issues that may arise. The Corporate Compliance Staff and other key staff are responsible for monitoring subcontractors who provide healthcare services for the plan to ensure compliance with Molina and Iowa High Quality Healthcare Initiative policies and procedures.

Molina will conduct, at a minimum, one annual site visit to audit and monitor each subcontractor per contract year to ensure compliance with the performance of all delegated functions. Molina will use a standard site visit tool. During the site visit Molina will review the policies, procedures, and applicable files and also interview subcontractor staff. Molina will invite DHS to attend these meetings or review meeting minutes if desired.

5. Describe the enforcement policies used for non-performance, including examples.

As outlined in Molina's subcontractor policies and procedures, which includes enforcement for non-performance, Molina performs ongoing oversight of delegated functions as set forth in the written agreement between the parties to ensure all subcontractors are held to its contract requirements. The written agreement specifies the activities and reporting responsibilities delegated to the subcontractor and provides remedies for non-performance by subcontractors. Enforcement of non-performance may take the

form of corrective action, sanctions, penalties (if contract contains performance guarantees) or revocation of delegated functions, or imposing other sanctions if the subcontractor's performance is inadequate. Whenever deficiencies or areas of improvement are identified, Molina and subcontractors will take corrective action. Molina will provide to DHS the findings of all subcontractor performance monitoring and reviews upon request and will notify DHS any time a subcontractor is placed on corrective action. Delegation may be revoked at Molina's discretion.

For example, although a Pharmacy Benefit Manager is used to perform pharmacy management functions, Molina recognizes that it is ultimately responsible for those functions and performs strict oversight on all such activities. This oversight is conducted both internally as well as through outside audit firms. CVS Caremark is required to demonstrate that it is performing all services as intended, and that it is meeting all obligations under its contract with Molina. Additionally, performance guarantees are built into its current contract with Molina such that non-performance or poor performance in certain areas will lead to significant financial penalties.

Below are examples of Performance Guarantees that are in place for non-performance:

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

CONFIDENTIAL

6. Describe how subcontracting relationships will provide a seamless experience for members and providers.

Molina ensures that all subcontractors it utilizes are contractually bound to ensure the seamless integration of subcontracted services in compliance with Molina's requirements, standards, policies and procedures, quality improvement goals, and performance improvement activities for members and providers. This includes, but is not limited to:

- Compliance with Molina's policies and procedures;
- Clear communication and training of all access standards;
- Recurring joint operations meetings between Molina and its subcontractor(s); and
- Mandatory corrective action procedures to address deficiencies within defined time periods.

Oversight of subcontractors providing health care services is conducted by Molina's Delegation Oversight Committee, which includes staff members from the local health plan departments who are involved in the daily management of subcontractors, or who are responsible for monitoring delegated activities, such as corporate compliance staff, Case Management team members, the Quality Manager, the Behavioral Health Manager and other key personnel. Specifically, Molina has a Delegation Oversight Manager who enlists appropriate departments to support and monitor integration of care between contracted agencies. The committee works to assure subcontractor compliance with Molina and DHS policies and procedures. Staff evaluates the services performed by subcontractors using methods that include:

- Periodic performance audits;
- Regular review of subcontractors' member and provider satisfaction surveys; and
- Regular review of provider and member complaints.

The Delegation Oversight Committee meets on an ongoing basis to discuss any performance issues that may arise.

2.3 Financial Stability

1. Provide verification of the financial requirements described in the subsections of Section 2.3.

To demonstrate financial viability, as of December 31, 2014, Molina Healthcare, Inc. and subsidiaries had cash and investment on hand of $1.54 billion, and net worth of $859 million.

Molina will comply with all requirements in Section 2.3 Financial Stability, Sections 2.3.1 Solvency requirements through funding from its parent Company, Molina Healthcare, Inc. Molina Healthcare, Inc., a publicly traded, NYSE listed Company; and is a well-known seasoned issuer of publicly traded securities with full access to the U.S. capital markets.

Molina Healthcare, Inc., the parent of Molina Healthcare of Iowa, guarantees it will provide financial resources to Molina Healthcare of Iowa, Inc. sufficient to maintain a 200% or higher RBC ratio as defined by the NAIC. This guarantee will be for the term of the Contract and will be submitted in writing to DHS prior to Contract signature.

In compliance with Section 2.3.5, Annual Independent Audit, Molina will submit an annual audited financial report that specifies its financial activities under the Contract within six (6) months following the end of each calendar year. Molina will also comply with Section 2.3.6, Quarterly Financing Report, and submit to DHS copies of the quarterly NAIC financial reports.

2. Describe how you will comply with the requirements for reinsurance. Will you obtain reinsurance contracts or submit a plan of self-insurance?

Molina agrees, understand and will comply with Scope of Work Section 2.3.2 Reinsurance and 14.2.6 Reinsurance requirements at Iowa Admin. Code r. 191-40.17(514B).

Molina will obtain a reinsurance contract and provide it to DHS. The health plan subsidiaries of Molina Healthcare, Inc. currently have high deductible reinsurance agreements with Reinsurance Group of America, Inc. to cover certain claims. Reinsurance Group of America, Inc. is currently rated AA- (Very Strong) by Standard & Poor's Insurance Rating Service; A+ (Superior) by A.M. Best Company; and A1 (Good) by Moody's Investor Services. Molina enters into these contracts to reduce the risk of catastrophic losses. Molina evaluates reinsurance opportunities and reviews reinsurance and risk management strategies on a regular basis.

2.4 Maintenance of Records

1. Describe your system for maintaining financial and medical records that fully disclose the extent of services provided to members.

Molina agrees, understand and will comply with all Scope of Work Section 2.4 Maintenance of Records, and 2.4.3 Response to Record Request requirements. Molina has stringent policies and a robust system in place to maintain and safeguard the confidentiality of financial and medical records (electronic and hard copy records).

Molina's system for maintaining financial and medical records complies with DHS requirements by maintaining and retaining electronic and hard copy records of clinical and financial records that fully disclose the extent of services provided to individuals under the Contract for a period of seven years, or for the duration of contested case proceedings, whichever is longer.

Molina's maintenance of records procedures includes sending all hard copy clinical and financial data offsite to its vendor, Iron Mountain which provides records management services. Iron Mountain specializes in financial and medical record storage and data management. Documents fall into two categories including permanent and non-permanent. Permanent documents include the following:

- Clinical chart documents;
- Executed Final Transaction Documents;
- Annual Director's Reports;
- Annual Financial Reports;
- Budgets;
- Policies;
- Audit Reports;
- Building Specifications; and
- Regulatory Filings.

Molina and its subcontractors will furnish DHS or designated agents with information as they may request regarding payments claimed for Medicaid services.

Electronic data is backed up and archived by leveraging industry leading solutions from Symantec – NetBackup and Enterprise Vault – to retain copies of electronic records and data. Molina's Infrastructure as a Service (IaaS) Operations team regularly backs up data critical to the organization. All data backup media are stored offsite in a secure location. Data recovery from backup media is exercised regularly.

Physical LTO-4 tape media is encrypted using hardware-based encryption with Quantum Encryption Key Management (Q-EKM) software consisting of two synchronized key servers that provide encryption services for the physical LTO-4 tape library within the environment. All media subject to offsite location must be LTO-4 tape media from an encryption enabled library. Molina's electronic data is backed up to LTO-4 tapes encrypted with 256-bit Advanced Encryption Standard (AES) encryption. No data backup media is removed or sent to offsite storage or any other location from Molina's Data Center without data encryption on the backup media. Tape media is sent offsite on Wednesdays for long-term secure storage after duplication of weekly backup images is completed. Multiple copies of each backup image are kept.

Backup images taken in the primary data center are stored on a DataDomain device within that data center, where they are retained for 35 days. These same backup images are replicated to a DataDomain device at the co-location data center, where they are also retained for 35 days.

Images requiring long-term storage, typically monthly and critical weekly backups are duplicated from the DataDomain in the primary data center to tape media, which are sent off-site for long-term secure storage.

The data backup and recovery policy is kept current through a formal change management process. The policy is reviewed at least annually or whenever major business or technical changes occur within Molina's environment.

2.5 Disclosures

1. Provide disclosures as described in the subsections of Section 2.5.

Molina agrees, understand and will comply with Scope of Work Section 2.5 Disclosures requirements.

Information on Persons Convicted of Crimes
Molina does not have any person convicted of a criminal offense including but not limited to offenses under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as required by 42 CFR 455.106.

Information Related to Business Transactions

Molina will comply with section 2.5.2 Information Related to Business Transactions.

Ownership Disclosures

Molina's enrollee board members and managing employees or any of their families do not have a financial interest of 5% or more in any legal entity which has a contract, agreement or other arrangement with Molina, a provider or any other person concerning a financial relationship with Molina. Molina's governing body members and managing employees sign Molina's Conflict of Interest Disclosure form.

A list of Molina Healthcare, Inc., a Delaware corporation (NYSE: MOH), ownership, executive officers, Board of Directors and members of the Committees of the Board of Directors is provided below. An organizational chart showing Molina Healthcare of California's parent corporation, Molina Healthcare, Inc., and subsidiaries, is provided below.

Ownership, Board, Management and Committee structure
Holders of More than 5% of Stock:

- John C. Molina, as Trustee
- William Dentino, as Trustee
- Curtis Pedersen, as Trustee
- Mary R. Molina Living Trust

- Molina Marital Trust
- BlackRock, Inc.
- Capital World Investors
- FMR LLC

Management, Board of Directors, and Committees of the Board

The Management of Molina Healthcare, Inc.

- President and Chairman of the Board – Joseph M. Molina, MD
- Chief Financial Officer – John C. Molina
- Chief Operating Officer – Terry P. Bayer
- Chief Legal Officer and Secretary – Jeff D. Barlow
- Chief Accounting Officer – Joseph W. White

The Board of Directors of Molina Healthcare, Inc.

- Joseph M. Molina, MD
- John C. Molina
- Garrey E. Carruthers, PhD
- Daniel Cooperman
- Frank E. Murray, MD
- John P. Szabo, Jr.
- Charles Z. Fedak
- Steven G. James
- Steven J. Orlando
- Ronne E. Romney
- Dale B. Wolf

Committees of the Board of Directors of Molina Healthcare, Inc.

Audit Committee

- Steven J. Orlando
- Charles Z. Fedak
- Steve G. James
- John P. Szabo, Jr.
- Daniel Cooperman

Compensation Committee

- Dale B. Wolf
- Charles Z. Fedak
- Steven J. Orlando
- Ronna E. Romney
- John P. Szabo, Jr.

Governance and Nominating Committee

- Daniel Cooperman
- Garrey E. Carruthers, PhD
- Frank E. Murray, MD
- Ronna E. Romney
- Dale B. Wolf

Compliance Committee

- Garrey E. Carruthers, PhD
- Frank E. Murray, MD
- Steven G. James
- John C. Molina

Financial Disclosures for Pharmacy Services

Molina will disclose all financial terms and arrangements for remuneration of any kind that apply between Molina and Molina's PBM subcontractor and any prescription drug wholesaler, manufacturer or labeler, including, without limitation, formulary management, education support, claims processing, pharmacy network fees, drug product sales or pricing agreements, data sales fees, and any other fees.

2.6 Debarred Individuals

1. Describe mechanisms to ensure compliance with requirements surrounding debarred individuals.

Molina certifies its organization does not include persons who are currently debarred, suspended or terminated from the Medicaid or Medicare program in its provider network or in the conduct of its affairs. Molina ensures that it does not employ or hold any contracts or arrangements with any individuals who have been debarred, suspended, or otherwise excluded under the Federal Acquisition Regulation as described in 42 CFR 438.610; including all individuals responsible for the conduct of Molina's affairs, or their immediate families, or any legal entity in which they or their families have a financial interest of 5% or more of the equity of the entity.

Molina will identify any providers who have been excluded, suspended or debarred from any state or federal health care benefit program, and will report the status of these providers to the Office of Program Integrity within three business days.

In addition, the Director of Compliance will notify the Director of Office of Program Integrity within three business days if Molina receives notice of an action being taken against Molina or any of the following:

- A director, officer or partner of Molina;
- A person with beneficial ownership of five percent or more of Molina;
- A person with an employment, consulting or other arrangement with Molina for the provision of items and services that are significant and material to Molina's obligations under the Contract; or
- Any provider providing services to members, or any subcontractor, which could result in exclusion, debarment, or suspension of Molina or a subcontractor from the Medicaid program, or any program listed in Executive Order 12549.

Molina ensures that relationships are checked against exclusion databases monthly.

2.8 Organizational Structure

1. Describe your proposed organizational structure and indicate which operational functions will be conducted in Iowa and which functions will be conducted out-of-state.

Molina's organizational and operational structure is capable of fulfilling all Iowa High Quality Healthcare Initiative Contract requirements. Molina's structure supports collection and integration of data across Molina's delivery system and internal functional units to accurately report our performance. Molina will have in place sufficient administrative and clinical staff and organizational components to will comply with all requirements in Section 2.8 Organizational Structures, Attachment 1 – Scope of Work.

The following Exhibit 2.8.1-1 Operational Functions Location describes which operational functions will be conducted in Iowa and which functions will be conducted out-of-state.

Exhibit 2.8.1-1 Operational Functions Location

Function	Location
Contract Administrator/CEO/COO (President)	Iowa
Medical Director	Iowa
Chief Financial Officer	Iowa
Compliance Officer	Iowa
Administrative and Fiscal Management	California and Iowa
Grievance and Appeals	Iowa
Quality Management and Improvement	California and Iowa
Utilization and Care Management	Iowa
Behavioral and Physical Health Management	Iowa
Member Services	Iowa
Provider Services	Iowa
Information Systems	California
Claims Administration	California
Care Coordination	Iowa
Long Term Care Management	Iowa
Marketing	Iowa
Provider Enrollment	Iowa
Network Development and Management	Iowa
Performance Data Reporting and Encounter Claims Submission	California and Iowa
Government Contracts	Iowa

Exhibit 2.8.1-2 displays the organizational structure for Molina Healthcare of Iowa that performs all services or functions that directly impact members, providers or state regulators at the local health plan. Functions performed at Molina Healthcare of Iowa's administrative office and headquarters located at Hub Tower, 699 Walnut Street, 4th Floor, Des Moines, Iowa, include the administration of core services to ensure that it meets contract and regulatory requirements. All Molina staff listed are subject matter experts in their specific health care areas and will achieve excellent operational performance through execution of ongoing process improvements to enhance responsiveness to member needs and fulfillment of all DHS goals and objectives. Molina will ensure timely replacement of personnel, as necessary, to ensure project continuity and will notify DHS of any change in key personnel in a timely manner.

Exhibit 2.8.1-3 displays the high-level organizational chart for Molina Healthcare Inc., the parent company of Molina Healthcare of Iowa. Molina Healthcare Inc. performs several functions for all of its subsidiaries in order to maximize administrative efficiencies and economies of scale. These shared services include claims processing, operating an integrated data warehouse, standardizing provider contracts within each state and running a company-wide Management Information System (QNXT™) on a single open architecture. The parent company's operations are based in Long Beach, California. Additionally, Molina Healthcare, Inc. also provides support backup services in other locations where it has health plan subsidiaries to ensure all of its health plans have adequate resources to meet its regulatory and contract obligations as well as member and provider needs.

Exhibit 2.8.1-2 Molina Healthcare of Iowa Health Plan

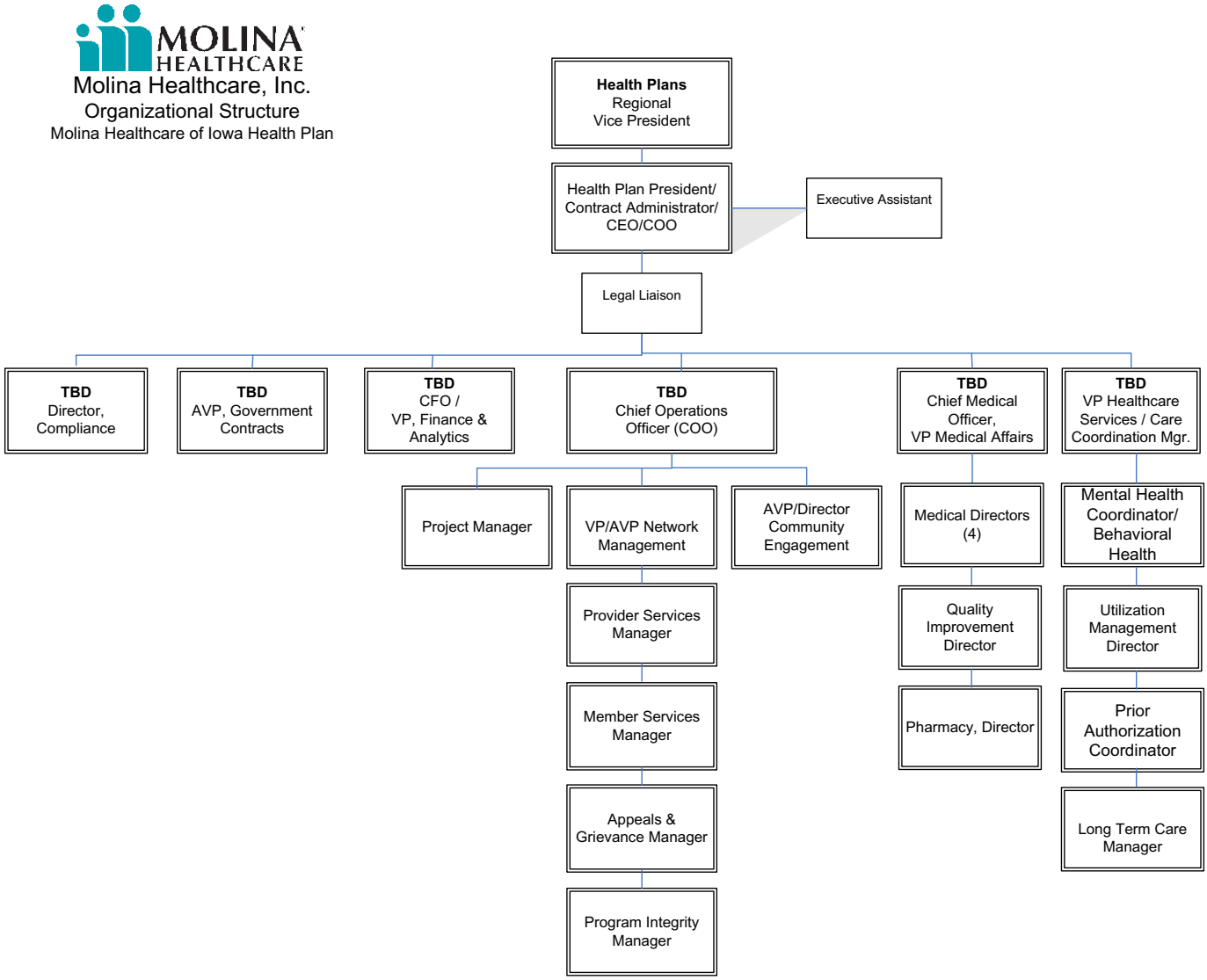
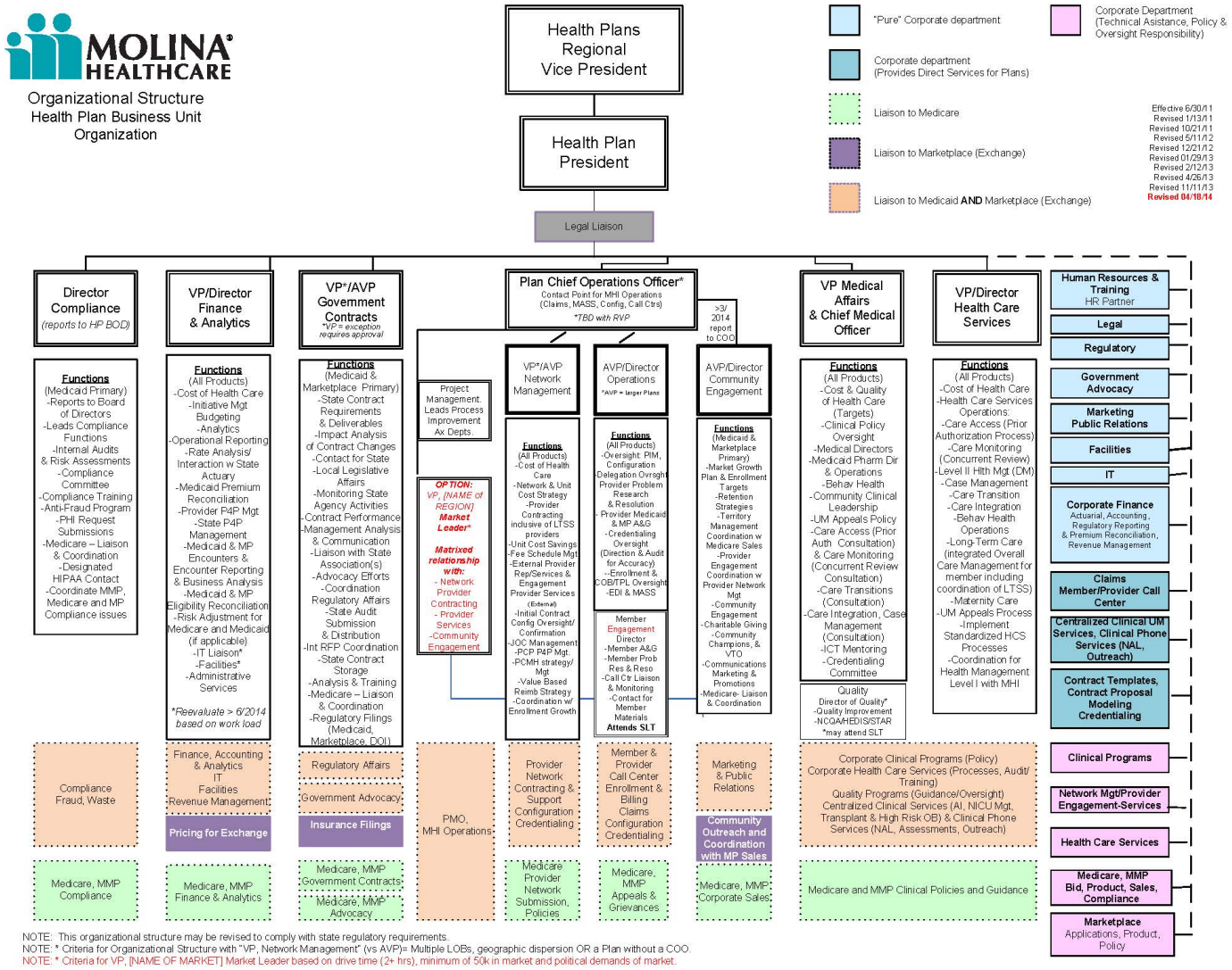


Exhibit 2.8.1-3 Molina Healthcare Inc.



NOTE: This organizational structure may be revised to comply with state regulatory requirements.
NOTE: * Criteria for Organizational Structure with "VP, Network Management" (vs AVP)= Multiple LOBs, geographic dispersion OR a Plan without a COO.
NOTE: * Criteria for VP, [NAME OF MARKET] Market Leader based on drive time (2+ hrs), minimum of 50k in market and political demands of market.

2. Describe how your administrative structure and practices will support the integration of the delivery of physical health, behavioral health and LTSS.

Molina's administrative structure supports the integration of delivery of physical, behavioral health and LTSS by collecting and integrating data across Molina's delivery system and internal functional units. Molina will have in place sufficient administrative and clinical staff and organizational components to achieve compliance with all Contract requirements and performance standards.

Molina will ensure coordination and continuity of care with providers, as effective coordination of a patient's health care services is a key component of high-quality and efficient care. Molina will promote integration and coordination of physical, behavioral health and LTSS providers through Molina's Integrated Care Management program and approach, as documented in written policies and procedures; transparency of information; and innovative programs and models.

Integrated Care Management Policies and Procedures – As required through written policies and procedures, providers are expected to coordinate care. For example, behavioral health providers will share treatment plans with a members PCPs who are expected to coordinate with specialists and long-term care providers. Hospitals will send discharge plans to PCPs within 48 hours of discharge. Case Managers will be available to support providers and ensure the appropriate sharing of information and alignment of care plans. Providers will also be expected to participate on Care Teams that facilitate coordination of services and sharing of information between providers of multiple disciplines, fully engaging the member to ensure all needs are being met.

Transparency of Information – Molina recognizes that member utilization and quality data must be transparent and informative to best enable practitioners to be successful in delivering comprehensive member care. Molina will provide access to this information through its secure Web Portal. The Web Portal will provide real-time access to information related to authorizations and referrals; care planning activities; claims; PCP assignments; encounter data; pharmacy data; HEDIS Alerts for missed services; and provider profiling scorecards. The Web Portal is a web-based tool accessible to any authorized provider or user in accordance with HIPAA privacy and security and other state laws.

Models and Programs to Support Integration – Molina's models and programs to increase the extent and effectiveness of care coordination include Patient-centered medical homes (PCMHs), Integrated Health Homes, Molina's Integrated Service Delivery Model, and Community Connectors. These models embrace a person-centered approach that is comprehensive, accessible, team-based, coordinated and culturally competent across all elements of the healthcare system and the community, and integrated with health information technology.

Patient-Centered Medical Homes (PCMH) – Molina's PCMH Module Program has incentivized core PCMH elements such as electronic medical records (EMR), e-prescribing, patient tracking and registries, access and communication, and performance reporting and improvement that are also keys to achieving National Committee for Quality Assurance (NCQA) recognition for PCMH.

Integrated Health Homes – Integrated Health Homes have been integral in the coordination of services and in addressing a member-centered comprehensive Care Plan. Successful ongoing collaboration with several core service agencies (CSAs) has contributed significantly to Molina's efforts to further integrate and coordinate member care. Current efforts have focused on a project to identify high-risk Molina adult members with severe persistent mental illness (SPMI), children and adolescents who are severely emotionally disturbed (SED), who have high emergency room and inpatient utilization, and have missed preventative health screenings, and refer these members for intervention by Molina's partner CSAs.

Integrated Service Delivery Model – For complex members being served outside of the PCMH or Health Home model, Molina has developed a fully integrated, person-centered, community-based Integrated Service Delivery Model aimed to improve service coordination, quality outcomes and

practitioner administrative efficiency. The model includes a comprehensive provider network for health and behavioral health needs, community resources, and supportive programs.

Molina's Integrated Service Delivery Model

Molina's model is person-centered, with services at all levels being coordinated with an identified lead provider. The treatment approach includes developing and implementing an Integrated Care Plan that integrates physical, behavioral and LTSS needs; conducting an initial assessment; conducting a review of medications, medical equipment and supplies; and supporting a Care Team to facilitate communication and determine appropriate physical, behavioral health and LTSS needs. Molina will contract with practices to provide care coordination, health promotion and referral responsibilities as appropriate based on practice competency. The provider will be the primary point of contact for program members and will work closely with all Care Team members, including physical and Behavioral Health, LTSS providers, and Molina Case Managers.

Community Connectors – As valuable members of Molina's Integrated Care Management team, Community Connector employees primarily coordinate physical and behavioral health services with a regular focus on recovery, resiliency and crisis management. Community Connectors also help members navigate the system and ensure the member's basic needs are met by connecting with housing, education and employment resources.

Implementation and Sustainability – Molina monitors and measures the success of its coordination and integration efforts through quarterly reporting. These reports are presented to the Quality Improvement Committee which oversees progress and develops new innovations or performance improvement plans. This information is also presented to high volume providers through regular provider visits to help improve performance. Performance measures include, but are not limited to: unnecessary inpatient admissions; Emergency Room visits; quality of Care Plans that include physical, behavioral, and long

term care interventions; documentation of appropriate member screenings; and member satisfaction. Case Managers are also accountable for ensuring successful implementation of coordination efforts and providing support and oversight to all members of the Care Team.

Molina will also design specific monitoring activities to measure performance of each integrated model and program. For example, to monitor the success of the PCMH model in improving coordination and health outcomes, Molina utilizes a Provider Performance Scorecard which is shared with PCMHs and used to measure PCMH performance. This same scorecard will be adapted to include behavioral health and long-term care specific metrics. Molina will continue to support the growth and sustainability of integrated models through innovative value-based reimbursement arrangements that support member-centered interventions and coordination of care and services.

2.9 Staffing

Molina understands, agrees and will comply with all Staff requirements as set forth in accordance with Section 2.9 Staffing, Attachment 1 – Scope of Work.

1. Describe in detail your staffing plan and expected staffing levels.

Molina's Staffing Plan

Molina's staffing plan is based on its experience successfully administering programs similar to the Iowa High Quality Healthcare Initiative in other states. Molina will maintain a level of staffing necessary to perform and carry out all of the functions, requirements, roles and duties of the Contract. Molina will at all times, employ sufficient staff to achieve compliance with contractual requirements and perform metrics. In addition to operational staffing, Molina's dedicated implementation team will assign project implementation resources to facilitate program initiation and member transition to Molina.

Molina executive staff will use their extensive experience in strategic planning, large complex project management, implementation and operations to lead a dedicated team committed to meeting DHS goals and serve Iowa High Quality Healthcare Initiative populations. The organizational structure will include the required key personnel and additional required staff tasked to achieve excellent operational performance to ensure responsiveness to member needs and fulfillment of Contract requirements. Molina will establish local Care Coordination, Member Services, Provider Services, Health Care Services and other key departments to facilitate the delivery of in-person services as appropriate that will generate up to 245 jobs in Iowa depending upon enrollment.

Molina Healthcare of Iowa's interim President (Contract Administrator), Paul Muench, is responsible for health plan operations and the management of general administration and implementation of the contract requirements. To ensure Molina can quickly respond to staffing demands, several key local management positions are currently being filled in healthcare services, provider contracting and government contracts. Upon award of the Contract, Molina will deliver the final staffing plan within ten (10) calendar days of the execution of the Contract, including a resume for each Key Personnel member.

In order to respond quickly to staffing demand, Molina has already begun recruiting for those positions. Molina has assigned existing resources and hired consultants to fill positions that are critical to pre-award activities. Molina will ensure that interim resources remain available to new staff throughout the implementation period.

Expected Staffing Levels

Below in Exhibit 2.9.1-1 are Molina's staff by position type, and staffing levels.

Exhibit 2.9.1-1 Expected Staffing Levels

Plan Organization	Estimated Staffing Level
Plan President and Administration	4
Compliance	3
Finance & Analytics	11
Government Contracts	3
Chief Operations Officer	1
Network Management*	20
Operations*	34
Community Engagement*	5
Medical Affairs & Chief Medical Officer	19
Health Care Services	147
Full Time Equivalents Total	247

*Reports to the Chief Operations Officer

Molina estimates it will hire 247 FTE's to provide services to approximately 200,000 Iowa Medicaid members.

2. For staffing positions proposed in your staffing plan, provide job descriptions that include the responsibilities and qualifications of the position, including the number of years of experience.

Molina will establish an administrative Molina Healthcare of Iowa office from which the majority of key staff personnel will perform administrative and operational functions that meets all requirements in the Iowa High Quality Healthcare Initiative RFP, section 2.9.2 Staffing requirements.

Some of Molina's current key personnel titles differ slightly from those indicated in the RFP and therefore, Exhibit 2.9.2-1 has been created to provide a cross-reference. Molina intends to fill the "to be hired" positions with individuals that have experience in Medicaid managed care in the Iowa market upon Contract award.

Exhibit 2.9.2-1 Key Personnel Cross-Reference Titles

RFP Reference	RFP Title	Molina Title	Key Personnel Name
2.9.3.1	Contract Administrator/CEO/COO	Interim President	Paul Muench
2.9.3.2	Medical Director	Interim Chief Medical Officer	Bery Engebretsen, M.D.
2.9.3.3	Chief Financial Officer	Vice President, Finance and Analytics	To be hired
2.9.3.4	Compliance Officer	Director, Compliance	To be hired
2.9.3.5	Pharmacy Director / Coordinator	Pharmacy Director	To be hired
2.9.3.6	Grievance & Appeals Manager	Manager, Provider Inquiry Research & Resolution	To be hired

RFP Reference	RFP Title	Molina Title	Key Personnel Name
2.9.3.7	Quality Management Manager	Director, Quality Improvement	To be hired
2.9.3.8	Utilization Management Manager	Utilization Management Manager	To be hired
2.9.3.9	Behavioral Health Manager	Behavioral Health Manager	To be hired
2.9.3.10	Member Services Manager	Director-Member Services	To be hired
2.9.3.11	Provider Services Manager	Provider Service Director/Associate Vice President Network Management	To be hired
2.9.3.12	Information Systems Manager	IT Director	Nitin Gotmare
2.9.3.13	Claims Administrator	Vice President, Claims	To be hired
3.3.1.14	Care Coordination Manager	Vice President, Health Care Services	To be hired
3.3.1.15	Program Integrity Manager	AVP, Special Investigation Unit	To be hired
3.3.1.16	Long Term Care Manager	Director of Long-Term Care	To be hired

Following are staffing positions in Molina's staffing plan, including attached job descriptions, responsibilities and qualifications, and number of years of experience.

Contract Administrator/CEO/COO

Refer to Attachment 2.9.2-1 Contract Administrator/CEO/COO Job Description that includes the responsibilities and qualifications of the position, including the number of years of experience. Paul Muench will be the interim President with clear authority over the general administration and implementation of the requirements detailed in the Contract. Mr. Muench, the Administrator/CEO/COO (President) is responsible for overseeing the entire operations of Molina and has full and final responsibility for contract compliance and will foster a success-oriented, accountable environment. This position provides the leadership, management and vision necessary to ensure that Molina has the proper administrative and reporting procedures and people systems in place to effectively support growth.

Medical Director (Chief Medical Officer)

Refer to Attachment 2.9.2-2 Chief Medical Officer Job Description that includes the responsibilities and qualifications of the position, including the number of years of experience. Bery Engebretsen, M.D. is the interim Medical Director (Chief Medical Officer) who is also an IPCA Medical Director, who is a licensed physician in the State of Iowa in good standing. The Medical Director (Chief Medical Officer) is responsible for oversight of all clinical functions including, but not limited to, disease management and care coordination programs, the development of clinical care guidelines and utilization management; also, responsible for the coordination and implementation of the Quality Management and Improvement Program. The Medical Director will attend and actively participate in any scheduled quality committee meetings as directed by DHS, and will direct Molina's internal utilization management committee.

Chief Financial Officer (CFO) (Vice President, Finance and Analytics)

Refer to Attachment 2.9.2-3 Chief Financial Officer Job Description that includes the responsibilities and

qualifications of the position, including the number of years of experience. The Vice President, Finance and Analytics is responsible for overseeing Molina's budget, accounting systems and financial reporting for the program.

Compliance Officer

Refer to Attachment 2.9.2-4 Compliance Officer Job Description that includes the responsibilities and qualifications of the position, including the number of years of experience. The Compliance Officer is accountable to Molina's executive leadership and dedicated full-time to the Contract. This individual will be the primary liaison with the State (or its designees) to facilitate communications between DHS, the State's contractors and the Contractor's executive leadership and staff. This individual will maintain a current knowledge of federal and state legislation, legislative initiatives and regulations that may impact the program. The Compliance Officer is responsible for complying with all HIPAA and privacy regulations as well as coordinate reporting to the State and to review the timeliness, accuracy and completeness of reports and data submissions to the State. The Compliance Officer, in close coordination with other Key Personnel, has primary responsibility for ensuring all Contractor functions are in compliance with the terms of the Contract.

Pharmacy Director

Refer to Attachment 2.9.2-5 Pharmacy Director Job Description that includes the responsibilities and qualifications of the position, including the number of years of experience. The Pharmacy Director is an Iowa licensed pharmacist who oversees the pharmacy benefits under the Contract. The Pharmacy Director has experience as a Medicaid Pharmacy Director or equivalent Medicaid pharmacy experience, inclusive of drug rebate and is responsible for oversight and coordination of all Contractor and Pharmacy Benefit Manager (PBM) pharmacy requirements including drug rebate. The Pharmacy Director will attend DHS Pharmaceutical & Therapeutics (P&T) Committee and Drug Utilization Review (DUR) Commission meetings.

Grievance and Appeals Manager

Refer to Attachment 2.9.2-6 Grievance and Appeals Manager Job Description that includes the responsibilities and qualifications of the position, including the number of years of experience. The Grievance and Appeals Manager manages Molina's grievance and appeals process, ensuring compliance with processing timelines and policy and procedure adherence.

Quality Management Manager

Refer to Attachment 2.9.2-7 Quality Management Manager Job Description that includes the responsibilities and qualifications of the position, including the number of years of experience. The Quality Manager is an Iowa licensed registered nurse, physician or physician's assistant or a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (HCQM) by the American Board of Quality Assurance and Utilization Review Physicians. The Quality Manager is responsible for overseeing Molina's Quality Management and Improvement program and ensuring compliance with quality management requirements and quality improvement initiatives.

Utilization Management Manager

Refer to Attachment 2.9.2-8 Utilization Management Manager Job Description that includes the responsibilities and qualifications of the position, including the number of years of experience. The Utilization Manager is an Iowa licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations. This position manages all elements of the Contractor's utilization management program and staff under the supervision of the Medical Director. This includes, but is not limited to functions related to prior authorization, medical necessity determinations, concurrent and retrospective reviews, and other clinical and medical management programs as described in Section 11.

Behavioral Health Manager

Refer to Attachment 2.9.2-9 Behavioral Health Manager Job Description that includes the responsibilities and qualifications of the position, including the number of years of experience. The Behavioral Health Manager is an Iowa licensed behavioral health professional such as a psychologist, psychiatrist, social worker, psychiatric nurse, marriage and family therapist or mental health counselor with experience in both mental health and substance use disorder services. The Behavioral Health Manager is responsible for ensuring that Molina's behavioral health operations, which include the operations of any behavioral health subcontractors, are in compliance with the terms of the Contract. The Behavioral Health Manager coordinates with all functional areas, including quality management, utilization management, network development and management, provider relations, member outreach and education, member services, contract compliance and reporting.

Member Services Manager

Refer to Attachment 2.9.2-10 Member Services Manager Job Description that includes the responsibilities and qualifications of the position, including the number of years of experience. The Member Services Manager is responsible for oversight of the member services functions of the Contract, including, but not limited to, member helpline telephone performance, member e-mail communications, member education, the member website, member outreach programs, development, approval and distribution of member materials. The Member Services Manager oversees the interface with the state or its subcontractors regarding such issues as member enrollment and disenrollment.

Provider Services Manager

Refer to Attachment 2.9.2-11 Provider Services Manager Job Description that includes the responsibilities and qualifications of the position, including the number of years of experience. The Provider Services Manager is responsible for the oversight of the provider services function of the Contract. This includes, but is not limited to, the provider services helpline, provider recruitment, contracting and credentialing, facilitating the provider claims dispute process, developing and distributing the provider manual and education materials and developing provider outreach programs. The Provider Services Manager, in close coordination with other Key Personnel, is responsible for ensuring that all of the Contractor's provider services operations are in compliance with the terms of the Contract.

Information Systems Manager

Refer to Attachment 2.9.2-12 Information Systems Manager Job Description that includes the responsibilities and qualifications of the position, including the number of years of experience. The Information Systems (IS) Manager serves as a liaison between Molina and DHS regarding encounter claims submissions, capitation payment, member eligibility, enrollment and other data transmission interface and management issues. The IS Manager, in close coordination with other Key Personnel, is responsible for ensuring all information system security and controls, program data transactions, data exchanges other information system requirements are in compliance with the terms of the Contract, and all data submissions required for federal reporting.

Claims Administrator

Refer to Attachment 2.9.2-13 Claims Administrator Job Description that includes the responsibilities and qualifications of the position, including the number of years of experience. The Claims Administrator is responsible for ensuring prompt and accurate provider claims processing in accordance with the terms of the Contract.

Care Coordination Manager

Refer to Attachment 2.9.2-14 Care Coordination Manager Job Description that includes the responsibilities and qualifications of the position, including the number of years of experience. The Care Coordination Manager is responsible for oversight care coordination and community-based case management programs. The Care Management Manager is a registered nurse or other medical

professional with extensive experience in providing care coordination to a variety of populations. The individual will be responsible for overseeing care coordination and community-based case management teams, care plan development and care plan implementation.

Program Integrity Manager

Refer to Attachment 2.9.2-15 Program Integrity Manager Job Description that includes the responsibilities and qualifications of the position, including the number of years of experience. The Program Integrity Manager is responsible for oversight of Molina's special investigations unit (SIU) activity. The Program Integrity Manager will serve as the liaison between the MCO and state agencies, law enforcement, and federal agencies. The Program Integrity Manager must be informed of current trends in fraud, waste, and abuse as well as mechanisms to detect such activity.

Long Term Care Manager

Refer to Attachment 2.9.2-16 Long Term Care Manager Job Description that includes the responsibilities and qualifications of the position, including the number of years of experience. The Long Term Care Manager is responsible for oversight of Molina's implantation of the state's community based and facility programs. The Long Term Care Manager has at least five years of experience in long term care policy and has a comprehensive understanding of CMS rules and regulations. The Long Term Care Manager is responsible for overseeing long-term care provider reviews, utilization reviews, member satisfaction surveys, and member health and welfare.

Associate Vice President, Government Contracts

Refer to Attachment 2.9.2-17 AVP Government Contracts Job Description that includes responsibilities and qualifications for the position, including the number of years of experience. The AVP Government Contracts will serve as the primary point of contact with DHS for delivery system reform activities, including managing a specific project plan and reporting on activity and progress towards identified goals. In matters related to healthcare delivery system transformation described in SIM, the AVP Government Contracts will also serve as the liaison between Molina and various state agencies, leaders from the healthcare delivery system, other payers, stakeholders, and federal agencies. The AVP Government Contracts will also be informed of current trends in delivery system reports and have the specific experience within the healthcare delivery system in Iowa.

Molina's Staff Plan also includes:

Prior Authorization & Concurrent Review Staff
Responsibilities: Authorize requests for services and conduct inpatient concurrent review.

Member Services Staff
Responsibilities: Respond to member inquiries via a member services helpline, as well as written and electronic correspondence. Member Services Representatives are responsible for ensuring members receive prompt resolution of their problems or inquiries, coordinating communications with members and other member services and acting as a member advocate.

Provider Services Staff
Responsibilities: Respond to provider inquiries and disputes and provide outreach on provider policies and procedures. Provider Service Representatives are responsible for Provider Relations, coordinating communications between Molina members and its providers.

Claims Processing Staff
Responsibilities: Ensure timely and accurate processing of claims.

Reporting and Analytics Staff
Responsibilities: Ensure timely and accurate reporting and analytics needed to meet the requirements of the Contract.

Quality Management Staff
Responsibilities: Perform quality management and improvement activities.

Marketing & Outreach Staff
Responsibilities: Manage marketing and outreach efforts.

Compliance Staff
Responsibilities: Support the Compliance Officer and ensure compliance with Laws and Regulations, internal policies and procedures, and terms of the Contract.

Community-Based Case Managers
Responsibilities: Ensure member needs are met, manages resources effectively, and ensure member's health, safety, and welfare are met. Assist the members in gaining access to appropriate resources. Recommend staff have bachelor's degree in social work or related field or commensurate experience.

3. Confirm that a final staffing plan, including a resume for each Key Personnel member, will be delivered within ten (10) calendar days after notice of award.

Molina confirms that upon award of the Contract, the final staffing plan will be delivered to DHS within ten (10) calendar days of the execution of the Contract. The staffing plan will also including a resume for each of the Key Personnel.

4. Describe your back up personnel plan, including a discussion of the staffing contingency plan for:

a. The process for replacement of personnel in the event of a loss of Key Personnel or others.

Back up Personnel Plan

Molina has polices in place to replace personnel in the event of a loss of Key Personnel or others. Molina will notify DHS, in writing, when changes to key staffing occur, including changes in the Key Personnel and other management and supervisory level staff at least five (5) business days prior to the last date the employee is employed to the extent possible. Molina will provide written notification to DHS at least thirty (30) calendar days in advance of any plans to change, hire, or re-assign designated Key Personnel. At that time, Molina will present an interim plan to cover the responsibilities created by the Key Personnel vacancy. Molina will also submit the name and resume of the candidate filling a Key Personnel vacancy within ten (10) business days after a candidate's acceptance to fill a Key Personnel position or ten (10) business days prior to the candidate's start date, whichever occurs first. Molina ensures that knowledge is transferred from an employee leaving a position to a new employee to the greatest extent possible. All Key Personnel positions will be filled within sixty (60) calendar days of departure, unless a different time frame is approved by the State.

b. Allocation of additional resources in the event of an inability to meet a performance standard.

Molina has polices in place to allocate additional resources to the Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (hawk-i) programs in the event of an inability to meet a performance standard. Molina's Director of Government Contracts will work directly with the DHS and has the authority to administer the day-to-day business activities of the Iowa High Quality Healthcare Initiative Contract, including revising processes or procedures and allocating additional resources as needed to maximize the efficiency and effectiveness of services required under the Contract and in the even of an inability to meet a performance standard.

The Associate Vice President (AVP) of Government Contracts will serve as the primary point of contact with DHS for delivery system reform activities, including managing a specific project plan and reporting on activity and progress towards identified goals. In matters related to healthcare delivery system

transformation described in SIM, The AVP of Government Contracts will also serve as the liaison between Molina and various state agencies, leaders from the healthcare delivery system, other payers, stakeholders, and federal agencies. The AVP of Government Contracts will also be informed of current trends in delivery system reports and have the specific experience within the healthcare delivery system in Iowa.

c. Replacement of staff with key qualifications and experience and new staff with similar qualifications and experience.

Molina has processes in place for replacement of personnel in the event of a loss of Key Personnel or others before or after signing the Contract. Molina will replace any of its staff with a person of equivalent experience, knowledge and talent.

Molina will notify DHS, in writing, when changes to key staffing of Molina occur, including changes in the Key Personnel and other management and supervisory level staff at least five (5) business days prior to the last date the employee is employed to the extent possible. Molina will provide written notification to DHS at least thirty (30) calendar days in advance of any plans to change, hire, or re-assign designated Key Personnel. At that time, Molina will present an interim plan to cover the responsibilities created by the Key Personnel vacancy. Molina will submit the name and resume of the candidate filling a Key Personnel vacancy within ten (10) business days after a candidate's acceptance to fill a Key Personnel position or ten (10) business days prior to the candidate's start date, whichever occurs first. Molina will ensure that knowledge is transferred from an employee leaving a position to a new employee to the extent possible. All Key Personnel positions will be filled within sixty (60) calendar days of departure, unless a different time frame is approved by DHS.

d. The time frame necessary for obtaining replacements.

Molina ensures that all Key Personnel positions will be filled within sixty (60) calendar days of departure, unless a different time frame is approved by DHS.

e. The method of bringing replacement or additions up to date regarding the Contract.

Molina's polices ensures that knowledge will be transferred from an employee leaving a position to a new employee to the extent possible, to bring new employees or additional staff up to date regarding the Contract.

5. Describe which staff will be located in Iowa, and where other staff will be located.

See Exhibit 2.9.5-1 below that describes which staff will be located in Iowa and where shared services staff will be located.

Exhibit 2.9.5-1 Staffing Location

Staff	Location
Prior Authorization & Concurrent Review Staff	Iowa
Member Services Staff	Iowa
Provider Services Staff	Iowa
Claims Processing Staff	California
Reporting and Analytics Staff	Iowa
Quality Management and Improvement Staff	California and Iowa

Staff	Location
Marketing and Outreach Staff	Iowa
Compliance Staff	Iowa
Community-Based Case Managers	Iowa

a. Describe how out-of-state staff will be supervised to ensure compliance with Contract requirements and how Iowa-based staff shall maintain a full understanding of the operations conducted out-of-state.

Molina ensures the location of any staff or operational functions outside of the State of Iowa does not compromise the delivery of integrated services and a seamless experience for members and providers. Out-of-state functions will be supervised by the AVP Government Contracts to ensure compliance with Contract requirements. Additionally, Molina ensures all staff functions conducted outside of the State of Iowa are readily reportable to DHS at all times to ensure such location does not hinder the State's ability to monitor Molina's performance and compliance with Contract requirements.

b. Indicate the location of the Iowa office from which key staff members will perform their duties and responsibilities.

Molina Healthcare of Iowa's business office where key staff member will perform their duties and responsibilities will be located at Hub Tower, 699 Walnut Street, 4th Floor Des Moines, Iowa, 50309, and will comply all requirements in the Scope of Work Section 2.9.5 Business Location.

6. Describe your process for ensuring all staff have the appropriate credentials, education, experience and orientation to fulfill the requirements of their position (including subcontractors' staff).

To ensure all staff, including subcontractors staff, have the appropriate credentials, education, experience and orientation to fulfill the requirements of each position, Molina has established procedures to ensure the hiring of qualified staff, and has an in-house professional recruiting team that supports Molina nationally. Recruiters focus on specific areas of specialty, and have expertise in developing job postings to attract qualified candidates. Candidates are pre-screened to ensure they meet the minimum standards as indicated in the job description and only the highest quality applicants are presented for an interview. There is a rigorous interview process that includes clinical and non-clinical experts to assess the knowledge, skills and abilities of all applicants.

Successful candidates receive an extensive back ground check and drug screening. After candidates are selected they are credentialed or re-credentialed, as appropriate for specific positions. In addition, Medical Directors and non-physician clinical staff receive monitored monthly.

Non-physician clinical professionals employed by Molina as either staff members or consultants must meet the license or certification requirements of their profession. All licensed professionals must have a current unrestricted license appropriate to their specific position. Molina verifies all licenses with the licensing board/agency upon employment and upon subsequent renewal dates. Molina's Human Resources and hiring managers are responsible for ensuring ongoing monitoring is conducted in accordance with state and federal requirements.

Molina employs sufficient numbers of qualified clinical and non-clinical staff to perform all required functions.

Molina provides initial and ongoing training and ensure all staff will be trained in the major components

of the Iowa High Quality Healthcare Initiative Contract. All Molina Healthcare of Iowa staff will be subject matter experts in their specific health care areas and will achieve excellent operational performance through execution of ongoing process improvements to enhance responsiveness to member needs and fulfillment of all Scope of Work requirements in Section 2.9.7 Staff Training and Qualifications.

7. Describe how you will ensure that all staff is knowledgeable in Iowa-specific policies and operations.

Molina conducts mandatory training and education to ensure all staff is knowledgeable in Iowa-specific policies, operations, processes and procedures; and the cultural nuances within its membership in order to best understand the different ways in which members approach their own health care decisions and care delivery. Molina staff will be provided robust training regarding vulnerable populations, coordinated, integrated patient-centered care components and requirements for delivery of services, including collaboration with medical, waiver and LTSS providers. Training will be provided to all new employees and as needed to existing staff to demonstrate competency.

Molina also provides intensive staff training on motivational interviewing and patient activation and cross-training on various disease states and health topics, e.g., medication adherence, psychiatric diagnoses, and functional status. Included in all training is an emphasis on empathy, self-care, and patient empowerment. Training methods include one-on-one mentoring, coaching, shadowing, on-site training, and classroom instruction.

8. Describe in detail your staff training plans (including subcontractors' staff) and ongoing policies and procedures for training all staff.

Molina's Staff Training Plan

Exhibit 2.9.8.1-1 below describes Molina's initial and ongoing staff training to ensure all staff is trained in components of the Iowa High Quality Healthcare Initiative Contract and in accordance with Section 2.9.7 Staff Training and Qualifications.

Molina's Policies and Procedures Manual is provided to the entire staff and will be incorporated into all training programs for staff responsible for providing services under the Iowa High Quality Healthcare Initiative Contract. Molina's training materials for the Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (hawk-i) programs will be updated on a regular basis to reflect any program changes. Molina maintains documentation to confirm staff training, curriculum, schedules and attendance. Molina will provide DHS its training documentation to review training materials and if necessary, implement additional staff training as required by DHS.

As part of the contract implementation process, subcontractors are also trained on their contractual requirements. Additional targeted training for subcontractors will be done on a case by case basis as areas of concern or inconsistency are identified. All subcontractor relationships are subject to a fully executed subcontractor agreement that clearly outlines each party's responsibilities.

Molina's training will include but not limited to: cultural competency, critical incident and abuse reporting, grievances, benefits (Medicaid and Medicare) model of care and confidentiality, as well as Demonstration specific services such as long term services and support and consumer direction. Staff training includes, but is not limited to the following.

Exhibit 2.9.8-1 Initial and Ongoing Staff Training Plan

Course Name	Staff	Completion Timeframe
Contract requirements and State and Federal requirements specific to job functions	All staff upon joining, and annually thereafter	60 days from start date
Advance Directives in accordance with 42 CFR 422.128	All staff upon joining	30 days from start date
Quality of Care	All staff upon joining	30 days from start date
Cultural Sensitivity	All staff upon joining	30 days from start date
Fraud and Abuse and the False Claims Act	All staff upon joining	30 days from start date
HIPAA (3 courses)	All staff upon joining	30 days from start date
Clinical Protocol	All clinical staff	30 days from start date
Utilization Management Guidelines	All Utilization Management staff, Health Care Services staff upon joining	30 days from start date and ongoing at least quarterly
LTSS Overview	All Health Care Services, Member Services and staff upon joining	30 days from start date
Assessment processes, person-centered planning and population specific training relevant to the enrolled populations for all Case Managers	All Health Care Services, Member Services, Provider Services and Appeals and Grievances staff upon joining	30 days from start date/Annual Training
Appeals and Grievance Process Training	All Health Care Services, Member Services, Provider services and Appeals and Grievances staff upon joining	30 days from start date/Annual Training
Understanding Abuse, neglect, exploitation and prevention including the detection, reporting, investigation and remediation procedures and requirements	Health Care Services Case Managers and Member Services staff upon joining	30 days from start date/Annual Training
Interdisciplinary Care Team (ICT) Members	Health Care Services Case Managers and Member Services staff upon joining	30 days from start date/Annual Training
New Hire Orientation Session	All staff upon joining	30 days from start date
Disability Sensitivity	All staff upon joining	30 days from start date
Critical Incident Process	All staff upon joining	30 days from start date
Overview of ADA	All staff upon joining	30 days from start date

The above high-level training content is complemented by function-specific, job-related training for each new employee. Completion of these courses is mandated with the Compliance unit, who is responsible for ensuring new employees adhere to this practice. Molina also offers live webinars that provide overviews of key applications used by Molina employees throughout the organization. Core operational functions

including: Member Services, Health Care Services, Provider Services, Grievance and Appeals and Claims have robust new employee training programs providing hands-on training both on the processes used by each job role as well as on the corresponding systems. These formal trainings are developed and facilitated by subject matter experts in each of these operational areas.

Molina's Ongoing Staff Education and Training Programs

Molina uses multiple methods to educate and train its employees on various policies and procedures. Training is revised annually to ensure the wide variety of topics covered is relevant and current. For employees' reference, core compliance documents, including the Molina Code of Conduct, Compliance Plan, Fraud and Abuse Plan, and Anti-Fraud and Deficit Reduction Act policy and procedure are all available to employees on Molina's Compliance intranet website.

Molina requires all employees, including board members, to successfully complete required online training programs through the Molina iLearn System. For example, the annual Molina fraud, waste and abuse training program reinforces and expands upon the fraud, waste and abuse training provided to new employees during employee orientation and includes information on the False Claims Act, as required by the Deficit Reduction Act. After taking the online course, all employees must complete an electronic post-test. For employees to receive credit for the training year, they must pass the post-test with a score of 100 percent. Employees who fail the post-test must continue to re-take the exam until achieving a passing grade. Molina's Compliance department maintains electronic logs of employee training and test results in order to track compliance with training requirements. Employee feedback is used to analyze course content and make improvements where necessary. Ongoing training is provided through web-based opportunities as well as onsite offerings supported by onsite subject matter experts, trainers, and corporate initiatives. Additional information on cultural competency and customer support training is provided in the following paragraphs.

The Molina Institute for Cultural Competency

Molina Healthcare, Inc. has always known the importance of cultural respect and understanding as a basis for health care. The Molina Institute for Cultural Competency was formed in 2006 to emphasize this principle. The Molina Institute for Cultural Competency is a unique resource with years of experience in the evaluation and practical application of cultural concepts and provides research, evaluation, consultation, training and support materials, policy and procedure review, and recommendations to improve cultural competency. Molina health plans undergo a periodic assessment by the Molina Institute for Cultural Competency to ensure that they have the tools and training necessary to provide high-quality care to members in a culturally competent way, and to design programs and policies that are culturally congruent with its membership.

Molina's Provider Services staff participates in mandatory company cultural diversity training and receives monthly communications which promote an understanding of various cultural beliefs and traditions. Staff is equipped to direct providers to resources that assist providers to meet the cultural and linguistic needs in caring for members in special population groups. To ensure members receive appropriate assistance, Member Services Representatives all participate in mandatory company cultural diversity training and can direct members to appropriate resources to address their cultural and linguistic needs. Molina provides initial and periodic training and education to its staff in culturally and linguistically appropriate service delivery. All Molina staff receives training about the significance of traditions and health practices of various cultural and ethnic groups, religious holidays and other cultural topics. Member Services staff who interact directly with members receive cultural competency and service excellence employee training upon hire and periodic refresher trainings. All Member Services Representatives participate in core concepts and resources training.

Cultural Competency Programs are offered to employees, providers and staff supporting providers as well, or anyone that may interact with a member. Cultural Competency Training programs may also be made available to Community Based Organizations. Individual consultation is also available with the

Molina Institute's medical anthropologist.

Customer Support Services Training

During the Implementation Phase, Molina will conduct Member Services functions and will train its Member Services Representatives (e.g., Customer Service staff) upon hire and on an ongoing basis to ensure in-depth knowledge of Iowa-specific benefits and services. New Member Services Representatives receive three days off-the-phone and two days on-the-phone training with an experienced staff member, in addition to 14 days in classroom training to ensure sufficient exposure to all Iowa-specific policies and operations. Supervisors periodically monitor calls to ensure optimum member services support is consistently provided. This is reinforced by periodic training sessions on an individual or group basis. Member Services Representatives participate in peer-to-peer training and support to ensure consistent performance among staff. Training curriculum includes:

- Operations, policies and procedures;
- Regulatory and contractual requirements;
- Fraud, Waste and Abuse;
- Role of the PCP and the Medical Home concept;
- Health care access and delivery;
- Disease management programs, care coordination, screening and preventive services and wellness promotion services;
- Guidelines to document and address member complaints and appeals;
- Use of oral interpreter services from local resources and Language Line Services (AT&T);
- How to change PCPs; enrollment and disenrollment from the plan;
- How to quickly identify, process, and resolve quality of care issues;
- Potential barriers to access;
- Definition of and appreciation of vulnerabilities during transitions in care;
- Claims and Coordination of Benefits (COB);
- Provider network practices and capacity (open or closed panels);
- Coordination with other state health and human services programs; and
- Services beyond those required by DHS.

Member Services Representatives all participate in mandatory company cultural diversity training and can direct members to appropriate resources to address their cultural and linguistic needs. Molina staff is trained on policies and procedures pertaining to the privacy and security of Protected Health Information (PHI) under HIPAA within 30 days of hire and additional training based upon job roles. All employees receive annual Fraud, Waste and Abuse training to make them aware of the detection, prevention, review, and reporting of illegal activity affecting the health plan and state.

2.11 Coordination with Other State Agencies and Program Contractors

1. Describe how you propose to work with other program contractors, subcontractors, state agencies and third-party representatives.

Molina agrees and will comply with Section 2.11 Coordination with Other State Agencies and Program Contractors. Molina will work with the other program contractors, subcontractors, state agencies and third-party representatives and to support community-based efforts as requested by DHS, including but not limited to:

- Program Contractors;
- Iowa Department of Public Health;
- Iowa Department of Education;
- DHS Division of Mental Health and Disability Services;
- DHS Division of Adult, Family and Children Services (ACFS);
- Ombudsman's Office;
- Community-Based Agencies; and
- Iowa Department of Inspections and Appeals.

2. Describe how you propose to work with IDPH related to IDPH-funded substance abuse services.

Molina will meet all program requirements of the Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (hawk-i) programs and will also provide services for individuals qualifying for Iowa Department of Public Health (IDPH) funded substance use disorder services.

Molina will work with IDPH and DHS in Iowa as well as other partners to ensure the services funded by IDPH are supported through augmenting covered services and access to care. Through the collaborative and integrated case management system at Molina, members will be assessed based on ASAM guidelines and tools within the Molina care management systems. The assessment tools will assist with referral to the appropriate level of care. When the level of care falls under IDPH funding, Molina Case Managers will work closely with the providers to ensure transitions of care to the next appropriate level is completed. Molina is also dedicated to providing access, coordination and reimbursement for preventative services. Molina has experience with this through our sister health plan in South Carolina with the identification of validated triggers and indicators of risk. Molina will work with the substance abuse providers and their current programming to establish best practices and criteria for the coverage and reimbursement of preventative services.

Molina also has experience in collaboration with community providers and coordinating and reimbursement for peer support programs. Molina will work with the State of Iowa certification board and provide collaboration for training and certification for peer support workers as well as work with providers for reimbursement schedules for these services.

2.13 Written Policies and Procedures

1. Describe your process for developing and maintaining written policies and procedures for each functional area.

Molina will develop and maintain written policies and procedures for each functional area. Written guidelines will be maintained for developing, reviewing and approving all policies and procedures. All policies and procedures must be reviewed at least annually by Molina to ensure they reflect current practice and will be updated as necessary. Reviewed policies will be signed and dated. All medical and quality management policies will be reviewed and approved by Molina's Medical Director. If DHS determines Molina's policy requires revision, Molina will work with DHS to revise within the timeframes specified. If DHS determines Molina lacks a policy or process required to fulfill the terms of the Contract, Molina will adopt a policy or procedure as directed by DHS.

2.14 Participation in Readiness Review

1. Submit a detailed implementation plan which identifies the elements for implementing the proposed services, including but not limited to:
a. Tasks;
b. Staff responsibilities;
c. Timelines; and
d. Processes that will be used to ensure contracted services begin upon the Contract effective date.

Refer to Attachment 2.14.1-1 Project Implementation Plan behind Tab 6, which identifies the elements for implementing the proposed services for the Iowa High Quality Healthcare Initiative, including but not limited to tasks, staff responsibilities, timelines, and processes that will be used to ensure contracted services begin upon the Contract effective date.

Please find a roll-up view of Molina's detailed implementation timeline below:

[redacted]

CONFIDENTIAL

Molina's approach to project management uses four interdependent sub-phases: Planning, Development and Testing, Readiness Review, Implementation and Post-Implementation.

Planning Phase

This Planning Phase will begin when the contract is awarded and will include a series of meetings with DHS to establish Molina's Implementation Plan. Activities include: defining project management and reporting standards; establishing contact with other DHS contractors; establishing a schedule for key activities and milestones; and clarifying expectations for the content and format of Contract Deliverables.

Development and Testing Phase

The majority of the tasks included in the Implementation Plan will occur in this phase including:

System Readiness and Data Transfer – During this Development and Testing Phase, Molina will update and develop deliverables required for operational and system readiness, create all system modifications necessary to accommodate external interfaces, and complete internal testing to demonstrate readiness and prepare for the Readiness Review phase. Molina will test all hardware, software, and telecommunications required to support the contract as well as produce data extracts and electronic data transfers and transmissions.

In addition to testing with the state and/or designated agents, Molina conducts full user acceptance testing prior to program start date to validate business processes and procedures, data interfaces, and reporting functions. This simulation of business activities includes but is not limited to importing and exporting data files, calling in to the test team to request authorizations, inputting and paying claims, and generating exports and reports, such as provider remittance and encounters. This approach ensures staff and systems are operating according as planned and helps proactively identify potential issues from the perspective of providers, members, and service partners.

Molina systems are in place with the hardware and software necessary to manage all functions required by DHS. Test plans will be developed according to subsystems and functional areas. Internal validation of tests will be performed in preparation for the Readiness Review Phase. The Transition Plan will provide a schedule of activities and materials to be developed during this phase.

Network Development/Network Adequacy – Upon contract award, Molina will assess the adequacy of its network. The assessment will utilize Geo-Access maps in comparison to DHS requirements. Additional efforts will be made to contract with all Significant Traditional Providers in each Service Area. Additional work will take place to ensure each provider's demographic information including address, specialty, and all required identifications numbers (TPI, NPI, DADS) is correctly entered into the QNXT system to ensure accurate claims payment.

Administration and Key Personnel – Molina will deliver the final staffing plan within ten (10) calendar days of the execution of the contract, including a resume for each Key Personnel member.

Material Subcontractor – Molina will conduct, at a minimum, one annual site visit to each Material Subcontractor per Contract Year to ensure compliance with the performance of all delegated functions. Molina will use a standard site visit tool. During the site visit Molina will review the policies, procedures, and applicable files and also interview Material Subcontractor staff. Molina will allow DHS to attend these meetings or review meeting minutes if desired. Molina will maintain a monitoring plan for each Material Subcontractor, which includes the following:

- The performance requirements for all delegated functions;
- Required reporting and interfaces;
- A review of the entity's solvency status, financial operation, and amounts paid for Covered Services (if applicable); and
- A review of the entity's contract compliance, logged complaints, and functional performance

measurements.

Organizational and Financial Readiness – Molina will update the organizational and financial information submitted in its proposal including providing DHS with updated Financial Statements, Corporate Background and Status, Corporate Experience, and Material Subcontractor Information.

Demonstration of Readiness Phase

Key milestones during the Readiness Review phase will include the following, as well as any changes identified during the Planning Phase: Organizational and Financial Readiness Review, System Testing, Systems Readiness Review, Demonstration and Assessment of System Readiness, Operations Readiness, and Assurance of System and Operational Readiness.

The Transition Plan will provide a schedule of test dates, based on input from DHS, to demonstrate the operational readiness of systems. All hardware and software necessary to support the contract will be tested. This will include receiving data files from DHS and material subcontractors, and producing data extracts. The plan will identify and describe the tests to be performed no later than 120 days prior to the operational start date that demonstrate adherence to contract specifications. The plan will define the activities, tests and demonstrations for the following operational and administrative subsystem functions:

- Enrollment/eligibility;
- Provider;
- Encounter/claims processing;
- Financial;
- Utilization/Quality Improvement;
- Reporting;
- Interface Subsystem; and
- TPR.

Molina will host a site visit based on an agenda provided by or co-developed with DHS. The goal of the site visit is to afford DHS or a designated agent the opportunity to meet the people who will be responsible for implementing and managing the contract, to learn more about Molina's policies and procedures, and to gain a better understanding of Molina's organizational structure, delegation and subcontracting arrangements, staffing, and preparedness for enrollment.

Implementation Phase

The Implementation Phase follows the DHS's Readiness Review approval and is comprised of activities that result in an operational program that accommodates the proposed program start date. Outputs from the Planning, Development, and Testing Phases are released to production, and Molina will begin processing production data including, but not limited to, member eligibility, provider, authorizations, claims, and encounters.

Post-Implementation Phase

This Post-Implementation Phase will be designed to identify issues that affect plan operations, and resolve them quickly. Molina program leadership will oversee program performance on a day to day basis. External questions and concerns from DHS, members, providers, advocacy groups, and other interested parties will go through existing processes used by Molina to administer the program today. Molina staff will leverage existing tracking and reporting tools to log, research and resolve such inquiries in a thorough, timely manner. Status and resolution will be communicated to the initiator and other relevant parties when applicable.

2. Confirm that you will revise the implementation plan and keep it updated throughout the

readiness review process.

Molina confirms that we will revise the implementation plan and keep it updated throughout the readiness review process. Molina's detailed Project Implementation Plan identifies the elements for implementing the Iowa High Quality Healthcare Initiative.

2.15 Confidentiality of Member Medical Records and Other Information

1. Describe your plans to ensure that health and enrollment information is used in accordance with the requirements set forth in the Health Insurance Portability and Accountability Act and other applicable federal and state privacy laws and regulations.

Molina has stringent measures in place to ensure all of its internal IT systems comply with Health Insurance Portability and Accountability Act (HIPAA) regulations, and that health and enrollment information pertaining to its members is used and disclosed in accordance with the requirements set for in HIPAA and all other applicable federal and state privacy laws and regulations regarding Protected Health Information (PHI).

Molina recognizes that it handles extremely sensitive information about its members and takes protecting member privacy and confidentiality very seriously. Molina has never experienced a broad spectrum security breach from an external source that has compromised the integrity of its members' personal data. Molina's comprehensive set of administrative, technical and physical safeguards ensures that PHI is appropriately stored and processed so that it is protected against unauthorized use or disclosure. The types of member information that Molina safeguards include, but are not limited to, the following:

- Member names and addresses;
- Medical services provided;
- Social and economic conditions or circumstances;
- Medical data, including diagnosis and past history of disease or disability; and
- Any information received, stored or processed in connection with Molina's program integrity operations.

Molina's policies and procedures generally limit the use and disclosure of a member's PHI to the following:

- For treatment, payment and health care operations;
- To the member or the member's personal representative (e.g., parent or legal guardian);
- To the Secretary of the U.S. Department of Health and Human Services; and
- As otherwise required or permitted by law, such as for public health purposes, legal proceedings, law enforcement or health care oversight activities.

For all other releases of a member's PHI, the member or their personal representative must sign a written authorization consenting to the release of the information. Molina's policy is to limit releases of PHI to the minimum necessary information to perform a transaction or process or to respond to a request for information. Molina staff must follow specified procedures to verify the identity and authority of the recipient prior to releasing PHI.

Molina requires that all of its employees complete HIPAA Privacy and Security Training within 30 days of their date of hire and annually thereafter, using online and classroom modules to effectively and efficiently deliver job-specific HIPAA training to its employees. Molina's online HIPAA training is used to address the core HIPAA training needs for all Molina employees and is supplemented by specialized

classroom training.

Molina's partner vendors are thoroughly vetted for HIPAA compliance, security, systems and processes before signing a Business Associate Agreement. Molina ensures that minimum necessary data in the form of extracts is transferred to its vendors. Patient Health Information is always protected and safeguarded unless as required to conduct business or provide health care services. All extracts/files sent to vendors are encrypted using industry-approved PGP encryption and compression software and transmitted on secure FTP sites. Molina expects and holds its vendors to the same exacting quality and security standards for any files or information it receives from them.

All PHI data is disposed of in accordance with Molina media reuse and disposal standards, including Department of Defense-level erasure and physical destruction.

2.16 Material Change to Operations

1. Describe how you will inform DHS in advance of any material changes, and how far in advance DHS will be informed.

Molina agrees, understands and will comply with Section 2.16, Material Change to Operations requirements.

Molina will provide written notice to DHS of any material changes in its business operations that affects more than five percent of its membership or provider network within the timeframe as required by the Contract or as contractually required. Molina will provide written member notice when there is a significant change that may impact member accessibility to services and benefits, in:

- Restrictions on the member's freedom of choice among network providers;
- Member rights and protections;
- Grievance and fair hearing procedures;
- Amount, duration and scope of benefits available;
- Procedures for obtaining benefits, including authorization requirements;
- The extent to which, and how, enrollees may obtain benefits from out-of-network providers;
- The extent to which and how after-hours and emergency coverage are provided;
- Policy on referrals for specialty care and for other benefits not furnished by the member's primary care provider; or
- Cost sharing.

2. Confirm that DHS may deny or require modification to proposed material changes if, in its sole discretion, it determines that such changes will adversely impact quality of care or access.

Molina confirms that DHS may deny or require modification to proposed material changes if, it is determined, at the sole discretion of DHS that such changes will adversely impact quality or access.

3. Describe your ability to communicate material changes to members or providers at least thirty (30) days prior to the effective date of the change.

Molina has various mechanisms in place to communicate material changes to members or providers at least 30 days prior to the effective date of the changes. These modes of communication includes but are not limited to, Molina Member Newsletter and website and portal, Provider Newsletter and website and portal, direct mail, and meetings, which are described in more detail below.

Molina policies and procedures also ensure all material changes in in its business operations that affect more than five percent of its membership or provider network will be communicated to members or providers at least thirty days prior to the effective date of the change.

Molina utilizes multiple communication avenues to communicate material changes to members and providers. The communication format depends upon the content, and communication modalities consist of the following approaches:

- **Member Newsletter –** Molina will publish and mail a Member Newsletter on a routine basis. The newsletter will note recent changes impacting members, general information regarding the plan, updates on quality, health promotion and wellness initiatives, and upcoming community events.
- **Molina's Website –** The Molina website is another venue for communicating with members. The Molina website will be used to communicate program changes and updates as well as to promote the Advisory Committee activities.
- **The Molina Interactive Website (Web Portal) –** The Molina Web Portal is a venue for communicating with members. The Web Portal will be used to communicate program changes and updates.
- **Provider Website** – Molina also utilizes the Web Portal provider website to communicate with providers when program changes or laws and regulations take effect. Molina posts program changes on the website to alert providers of changes that impact services or requirements; these postings will also include copies of recently distributed documents.
- **Direct Mail Communications -** Molina will mail notifications to providers to inform them of regulatory, subcontract or program changes as in advance of changes taking effect.
- **Provider Newsletters** – Molina will publish and mail a Provider Newsletter on a routine basis. The newsletter will note recent changes impacting providers, general information regarding the plan and updates on quality and compliance initiatives.
- **Provider Meetings** – Molina will update providers on the latest changes that affect the provider network during Molina provider meetings. During these routine training sessions Molina will include reminders to providers to access the Molina Web Portal on a regular basis for access to current information.

ADDENDUM A
MEDICARE PROGRAM REQUIREMENTS--DELEGATED SERVICES

This Addendum A sets forth Medicare program requirements applicable to the performance of any services delegated by Health Plan to MHI. MHI agrees to perform such delegated services in compliance with the requirements outlined in this Addendum. The Agreement and this Addendum shall be automatically modified to conform to subsequent amendments to Medicare program requirements by statute, regulation, or the instructions, guidelines, policies, and procedures of the Centers for Medicare and Medicaid Services ("CMS"). In the event of any inconsistency between the terms of this Addendum and the Agreement, the terms of this Addendum shall control, except if there is a conflict between Addendum A and Addendum B, the terms of Addendum B shall control for Medicare Part D program requirements.

1. Downstream Compliance.
MHI agrees to require all of its downstream, related entity(s), and transferees that provide any services benefiting Health Plan's Medicare members to agree in writing to all of the terms provided herein.

2. Medicare Compliance.
MHI shall comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v)).

3. Confidentiality.
MHI shall comply with the confidentiality and enrollee record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13)).

4. Right to Audit.
The United States Department of Health and Human Services "HHS", the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. MHI agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 422.504(e)(3), 422.504(e)(4), and 422.504(i)(2)(ii)).

5. Responsibilities and Reporting Arrangements.
The Agreement specifies the delegated activities and reporting responsibilities. To the extent applicable, MHI shall support Health Plan in complying with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 310 by providing relevant data. (42 CFR 504(a)(8)).

6. Revocation of Delegated Activities.
In the event CMS or Health Plan determines, in its sole discretion, that MHI has not performed the delegated activities or functions satisfactorily, the delegated activities shall be revoked upon not less than five (5) days prior written notice. (42 CFR 422.504(i)(4)(ii)).

7. Accountability.
Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement shall be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(1), and 422.504(i)(3)(iii)).

8. Credentialing.
If MHI is delegated credentialing activities, MHI's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, MHI agrees that its

credentialing process will comply with all applicable NCQA standards. Health Plan retains the right to approve, suspend, or terminate any credentialing delegation arrangement. (422.504(i)(4), and 422.504(i)(5)).

9. Monitoring.

Notwithstanding any relationship(s) MHI or Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement shall be consistent and comply with the Health Plan's contractual obligations. Health Plan shall monitor the performance of first tier, downstream, and related entities. (42 CFR 422.504(i)(1), and 422.504(i)(4)).

10. Further Requirements.

Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement shall be consistent and comply with Health Plan's contractual obligations. If MHI delegates selection of the providers, contractors or subcontractors to another organization, Health Plan retains the right to approve, suspend, or terminate any such arrangement. (42 CFR 422.504(i)(3)(iii), 42 CFR 422.504(i)(4), and 42 CFR 422.504(i)(5)).

ADDENDUM B
MEDICARE PART D PROGRAM REQUIREMENTS—DELEGATED SERVICES

This Addendum B sets forth the provisions CMS requires Health Plans offering Part D benefits to include in contracts with providers of administrative services. The Services Agreement and this Addendum shall be automatically modified to conform to subsequent amendments to the Medicare Part D program requirements stated herein. In the event of any inconsistency between the terms of this Addendum and the terms of the Services Agreement or any other Addendum to the Services Agreement, the terms of this Addendum shall control for Medicare Part D program Requirements.

1. Party to a Contract

MHI agrees that any contract in which Health Plan is not a party, that Health Plan will be identified as an entity that will benefit from the services described in the contract.

2. Responsibilities and Reporting Arrangements

The Agreement specifies the delegated activities and reporting responsibilities. To the extent applicable, MHI shall support Health Plan in complying with the reporting requirements. 42 CFR §423.505(i)(4)(i).

3. Participation in Medicare Prescription Drug Benefit Program

MHI shall participate in Health Plan's Medicare Prescription Benefit Program.

4. Compliance with Contractual Obligations

MHI's activities shall be consistent and comply with Health Plan's contractual obligations as the Medicare-Medicaid plan sponsor. 42 CFR §423.505(i)(3)(iii).

5. Medicare Compliance

MHI shall comply with all applicable Federal laws and regulations and CMS instructions. 42 CFR §423.505(i)(4)(iv).

6. Privacy and Security

MHI shall abide by State and Federal privacy and security requirements, including the confidentiality and security provisions stated in the regulations for the program at 42 CFR §423.136.

7. Right to Audit

The United States Department of Health and Human Services "HHS", the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation involving transactions related to CMS's contract with the Medicare-Medicaid plan sponsor. MHI agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records related to its Medicare-Medicaid enrollees, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later. 42 CFR 423.505(e)(2), 42 CFR 423.505(i)(2), and 42 CFR §423.505.

8. Member Hold Harmless

MHI shall ensure that Members are not held liable for fees that are the responsibility of Health Plan. 42 CFR §423.505(i)(3)(i).

9. Revocation of Delegated Activities

In the event CMS or Health Plan determines, in its sole discretion, that MHI has not performed the delegated activities or functions satisfactorily, the delegated activities shall be revoked. 42 CFR §423.505(i)(4)(ii).

10. Monitoring

Health Plan will monitor the performance of MHI on an ongoing basis. 42 CFR §423.505(i)(4)(iii).

11. Approve, Suspend or Terminate any Arrangement

Health Plan retains the right to approve, suspend, or terminate any arrangement with a pharmacy if MHI will establish the pharmacy network or select pharmacies to be included in the network. 42 CFR §423.505(i)(5).

12. Payment to Pharmacies

If MHI will establish the pharmacy network or select pharmacies to be included in the network, payment to such pharmacies (excluding long term case and mail order) shall be issued, mailed, or otherwise transmitted with respect to all clean claims submitted by or on behalf of pharmacies within 14 days for electronic claims and within 30 days for claims submitted otherwise. 42 CFR §423.505(i)(3)(vi).

13. Prescription Drug Pricing standard of Reimbursement

If MHI will establish the pharmacy network or select pharmacies to be included in the network and a prescription drug pricing standard is used for reimbursement, the source used by Health Plan for the prescription drug pricing standard of reimbursement will be identified. 42 CFR §423.505(i)(3)(viii)(B).

14. Updates to Prescription Drug Pricing Standard of Reimbursement

If MHI will establish the pharmacy network or select pharmacies to be included in the network and a prescription drug pricing standard is used for reimbursement, updates to such a standard will occur not less frequently than once every 7 days beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the drug. 42 CFR §423.505(i)(3)(viii)(A).

15. Submitting Claims

If MHI will establish the pharmacy network or select pharmacies to be included in the network, network pharmacies must submit claims to Health Plan or MHI whenever the membership ID card is presented or on file at the pharmacy unless the enrollee expressly requests that a particular claim not be submitted. 42 CFR §423.120(c)(3).

16. Reporting Requirements

If MHI will adjudicate and process claims at the point of sale and/or negotiate with prescription drug manufacturers and others for rebates, discounts, or other price concessions on prescription drugs, MHI will comply with the reporting requirements established in 42 CFR 423.514(d) and (e).

ADDENDUM C

MISCELLANEOUS REQUIREMENTS – IOWA

Health Plan intends to participate in the Iowa Medicaid program and other Iowa government sponsored health care programs ("Iowa Programs"). Accordingly, this Addendum C applies to the services provided by MHI under the Agreement with respect to Iowa Programs. To the extent a term of this Addendum C is in conflict with a term of the Agreement, the term of this Addendum C shall control.

In this Addendum C, the Iowa Insurance Division shall be referred to as the "Division".

1. The parties acknowledge that the contract that relates to Health Plan's participation in the Iowa Programs between the Iowa Department of Human Services and Health Plan is still being negotiated and that upon such execution of the contract directly related to Health Plan's participation in the Iowa Programs, this Addendum C will immediately be amended to conform to any requirements as set forth therein.

2. In the event Health Plan utilizes MHI to manage Health Plan's cash or assets, MHI agrees that it will comply in all respects with all applicable statutes and regulations, including, but not limited to, Iowa Admin. Code § 191-40.15.

SERVICES AGREEMENT

This Services Agreement (this "Agreement") is entered into as of _____ __, 2015 (the "Effective Date"), by and between Molina Healthcare of Iowa, Inc., an Iowa corporation ("Health Plan"), and Molina Healthcare, Inc., a Delaware corporation ("MHI") (collectively, the "Parties").

RECITALS

A. Health Plan is licensed as a health maintenance organization under the laws of the State of Iowa, which makes available health services pursuant to the Iowa Code chapter 514B.

B. MHI is corporation with significant experience in the fields of managed care and government funded health programs. MHI routinely provides to health plans consultation and assistance with respect to substantially all areas of health plan operations, regulation, finance, marketing, and administration, as it pertains to government funded health programs. MHI maintains staff and resources for that purpose.

C. Health Plan desires to delegate certain services to MHI and further desires to obtain certain consulting, administrative and other support services which are intended to enhance Health Plan's organizational and administrative capacity, and to augment its operations, all as set forth in this Agreement;

NOW, THEREFORE, it is agreed as follows:

AGREEMENT

SECTION 1. DEFINITIONS.

1.1 The following definitions apply to this Agreement and any exhibits, addendums or attachments attached hereto unless specifically stated therein:

1.1.1 "Medicaid Product(s)" means any and all products that may be offered by Health Plan under Title XIX of the Social Security Act, as may be amended from time to time.

1.1.2 "CHIP Product(s)" means any and all products that may be offered by Health Plan under Title XXI of the Social Security Act, as may be amended from time to time.

1.1.3 "Medicare Product(s)" means any and all products that may be offered by Health Plan under Title XVIII of the Social Security Act, as may be amended from time to time.

1.1.4 "Duals Product(s)" means any and all products that may be offered by Health Plan pursuant to 1115A of the Social Security Act and subject to a three way contract between Centers for Medicare & Medicaid Services ("CMS"), Health Plan and the state Medicaid agency, also known as the Capitated Financial Alignment Model Demonstration, as may be amended from time to time.

1.1.5 "Commercial Product(s)" means any and all products that may be offered by Health Plan that are considered commercial in nature, including but not limited to products offered on the insurance marketplace, also known as the insurance exchange, in accordance with the Affordable Care Act.

1.1.6 "Enrollee(s)" means Health Plan's eligible subscribers and enrollees in any of Health Plan's products.

1.1.7 "Subcontract" means any agreement between MHI and a third party to provide services identified in Sections 3, 4, and 5 of this Agreement and/or services incidental to those services identified in Sections 3, 4, and 5 of this Agreement.

SECTION 2. HEALTH PLAN RESPONSIBILITIES.

2.1 The Parties agree that nothing in this Agreement alters or in any way reduces the Board of Directors of Health Plan's (the "Board of Health Plan") ultimate control over the assets and operations of Health Plan. The Parties further agree that this Agreement and the services to be performed by MHI hereunder shall at no time serve to interfere with the ability of the Board of Health Plan and the employees of Health Plan to carry out their duties, obligations and responsibilities under any other contract or applicable law.

2.2 The Parties agree that nothing in this Agreement relieves Health Plan of its obligation to maintain the organizational and administrative capacity required to carry out its operations.

SECTION 3. DELEGATED SERVICES.

3.1 At Health Plan's election, MHI hereby agrees to perform the following services on behalf of Health Plan for all of the products Health Plan offers as of the date of this Agreement and those products Health Plan may offer in the future except as otherwise agreed upon by the Parties in the attached Addendums to this Agreement. MHI agrees that it will perform these services subject to Health Plan's oversight and monitoring and further agrees to perform these services pursuant to policies, procedures and work flows approved by Health Plan. Further, MHI understand and agrees that it will fully cooperate with any audit by the Health Plan or other governmental agency in conjunction with the services provided and will comply with any corrective action plan put forth by Health Plan.

3.1.1 Accounting and Finance Services. MHI agrees to perform general accounting and finance services including but not limited to tax returns for Health Plan.

3.1.2 Actuarial and Underwriting Services. MHI agrees to provide actuarial and underwriting services on behalf of Health Plan including actuarial and data analysis, and the development of underwriting standards, rates for health plan services and bid proposals.

3.1.3 Analytical Support and Report Generation Services. MHI agrees to perform analytical support and report generation services for Health Plan.

3.1.4 Claims Processing and Administration. MHI agrees to provide claims processing services for Health Plan and perform all necessary administrative services in connection with claims processing. MHI agrees to implement and maintain such systems and procedures as may be necessary for the appropriate adjudication and timely payment of provider claims as well as Enrollee claims for payment. MHI agrees to follow any applicable Health Plan policies, procedures and data to determine the appropriateness of the billing, coding and payment.

3.1.5 Contract Development and Negotiations. MHI agrees to draft and negotiate vendor, health care services, provider and various other agreements on behalf of Health Plan as Health Plan may request from time to time.

3.1.6 Enrollee and Provider Call Centers. MHI agrees to operate Enrollee and provider call centers offering telephonic assistance to providers and Enrollees.

3.1.7 Enrollee Materials. MHI agrees to distribute various enrollment materials including, without limitation, membership cards and evidence of coverage to Enrollees. MHI further agrees to distribute, at the request of Enrollees, printed materials such as Enrollee handbooks, provider directories and other informational materials.

3.1.8 Enrollment Services. MHI agrees to provide enrollment related services, including without limitation assisting Enrollees in selecting or changing primary care physicians, agreeing to respond to Enrollees' questions regarding benefits and coverage and coordination thereof, and other general enrollment services.

3.1.9 Facilities and Facilities Management. MHI agrees, on behalf of Health Plan, to negotiate leases, subleases or other occupancy agreements and facilities management agreements with respect to Health Plan facilities as Health Plan may request from time to time.

3.1.10 General Assistance. MHI agrees to perform additional services on behalf of Health Plan as Health Plan may request from time to time.

3.1.11 Health Care Services. MHI agrees to perform initial telephonic health assessments of Enrollees and low level care management services, also known as population based health management services, on behalf of Health Plan. MHI further agrees to perform case management services for high risk obstetrics, sick newborns and other populations at Health Plan's discretion.

3.1.12 Health Plan Employee Benefits and Payroll. MHI agrees to obtain, maintain and/or manage Health Plan employee benefits and payroll on behalf of the Health Plan including but not limited to 401(k) and other retirement benefits, stock programs, and medical, dental and vision insurance.

3.1.13 Human Resource Functions. MHI agrees to provide general human resource functions for Health Plan including without limitations recruiting Health Plan employee candidates, new employee orientations, and crafting and implementing personnel policies and procedures.

3.1.14 Information Technology Systems and Infrastructure. MHI agrees to provide information technology services and infrastructure to Health Plan including security as necessary. MHI agrees to develop, design, operate and support Health Plan's information and communication systems. The Parties agree that such services include maintenance services related to systems software, hardware, data networks, telephonic networks and upgrades thereof.

3.1.15 Insurance. MHI agrees to obtain and maintain for the benefit of Health Plan professional liability insurance, directors' and officers' liability insurance, general liability insurance and such other forms of coverage typically carried by like businesses and as required by state law or contract. MHI agrees to ensure that insurance policies secured under this Section provide separate coverage limits for Health Plan equal to or in excess of limits required under applicable laws.

3.1.16 Legal Services. MHI agrees to provide legal services to Health Plan with regard to analysis and interpretation of applicable and proposed laws, threatened or asserted claims, corporate structuring and maintenance, and matters of a general legal nature.

3.1.17 Nurse Advice Line. MHI agrees to operate a nurse advice line offering specialized services involving telephonic nursing consulting and advice services to Enrollees.

3.1.18 Pharmacy. MHI agrees to obtain and maintain pharmacy benefits on behalf of Health Plan. The Parties agree that such services may include administering, negotiating, maintaining, entering into and managing prescription benefit service agreements on behalf of Health Plan.

3.1.19 Premium Collection. MHI agrees to provide billing and premium collection services as needed by Health Plan.

3.1.20 Print and Fulfillment. MHI agrees to provide print and fulfillment services as needed by Health Plan.

3.1.21 Utilization Review. MHI agrees to perform utilization review relating to advanced imaging, neonatal intensive care and/or transplant services provided by Health Plan as may be requested by Health Plan. Health Plan understands and agrees that it remains responsible for provider and Enrollee grievances and appeals related to any utilization review decisions made by MHI under this Section.

3.1.22 Website Design and Maintenance. MHI agrees to develop, design, operate and support a website relating to Health Plan's business. MHI understands and agrees that any website relating to Health Plan's business must be compliant with applicable state laws and regulations relating to advertising and solicitation.

SECTION 4. CONSULTING AND ADVISORY SERVICES.

4.1 MHI hereby agrees to provide consultation and assistance to Health Plan in connection with the following services for all of the products Health Plan offers as of the date of this Agreement and those products Health Plan may offer in the future except as otherwise agreed upon by the Parties in the attached Addendums to this Agreement. The

Parties agree that the services provided under this Section are intended to assist with Health Plan's administration, operation and/or management of those services.

4.1.1 Accounting and Finance. To the extent services are not performed on behalf of Health Plan pursuant to Section 3.1.1 above, MHI agrees to provide consultation and assistance with accounting advisory services. MHI further agrees to provide consultation and assistance to Health Plan in conducting analyses of the financial condition of Health Plan, including projections, financial review and analysis of health care costs incurred by Health Plan.

4.1.2 Analytical Support and Report Generation Services. To the extent services are not performed on behalf of Health Plan pursuant to Section 3.1.3 above, MHI agrees to provide consultation and assistance with analytical support and report generation services for Health Plan.

4.1.3 Annual Budget. MHI agrees to provide consultation and assistance to Health Plan in the preparation of Health Plan's annual budget, which includes setting forth Health Plan's major operating objectives, anticipating revenues, expenses, cash flow and capital expenditures.

4.1.4 Capital Access. MHI, in its discretion, agrees to provide Health Plan with periodic access to capital funding. Such funding may be provided from MHI's operating cash flows, available cash on hand, equity or debt offering proceeds, or draws under MHI's credit facility.

4.1.5 Compliance. MHI agrees to provide consultation and assistance to Health Plan in connection with Health Plan compliance-related activities, including but not limited to compliance audits, annual anti-fraud training, and compliance trainings. Health Plan understands and agrees that it remains responsible for implementing and enforcing its own compliance plan.

4.1.6 Contract Development and Negotiations. To the extent services are not performed on behalf of Health Plan pursuant to Section 3.1.5 above, MHI agrees to provide consultation and assistance to Health Plan in negotiating vendor, health care services, provider and various other agreements. MHI further agrees to provide consultation and assistance in analyzing and preparing applications for contracts with government agencies administering government funded health care programs.

4.1.7 Enrollee Materials. MHI agrees to provide consultation and assistance to Health Plan in connection with the development of enrollment, disclosure and educational materials for Enrollees, any employer groups contracting with Health Plan and others as needed.

4.1.8 Facilities and Facilities Management. To the extent services are not performed on behalf of Health Plan pursuant to Section 3.1.9 above, MHI agrees to provide consultation and assistance to Health Plan in the negotiation of leases, subleases and other occupancy agreements and facilities management agreements with respect to Health Plan facilities.

4.1.9 General Assistance. MHI agrees to furnish Health Plan with such consultation, recommendations, administrative services, materials and supplies as Health Plan may request from time to time.

4.1.10 Governmental Relations. MHI agrees to provide consultation and assistance to Health Plan in connection with governmental relations and legislative/regulatory activities affecting Health Plan and the health care field generally.

4.1.11 Health Care Services. To the extent services are not performed on behalf of Health Plan pursuant to Section 3.1.11 above, MHI agrees to provide consultation and assistance to Health Plan relating to Health Plan's health care service programs including but not limited to case management and other care management activities.

4.1.12 Maintenance of Corporate Documents. MHI agrees to provide Health Plan consultation and assistance with the maintenance and filing of various corporate documents as needed by Health Plan.

4.1.13 Marketing. MHI agrees to provide consultation and assistance to Health Plan in connection with marketing and community outreach efforts of Health Plan. This includes recommending advertising agencies to Health Plan and

assisting Health Plan in the conduct of surveys to assess the satisfaction of subscriber groups and Enrollees of Health Plan. MHI further agrees to assist in the development and creation of marketing materials for use by Health Plan.

4.1.14 Medical Affairs. MHI agrees to provide consultation and assistance to Health Plan with medical operations.

4.1.15 Pharmacy. To the extent services are not performed on behalf of Health Plan pursuant to Section 3.1.18 above, MHI agrees to provide consultation and assistance to Health Plan in connection with obtaining and maintaining pharmacy benefits.

4.1.16 Planning. MHI agrees to provide consultation and assistance to Health Plan and its executives in reviewing the short, medium and long-range objectives of Health Plan and in formulating recommendations with respect thereto.

4.1.17 Privacy and Confidentiality. MHI agrees to provide consultation and assistance to Health Plan in connection with Health Plan's efforts to protect the confidentiality of the records of Health Plan, including Enrollee identities and Enrollee medical information, and ensuring compliance with all applicable federal, state and local laws relating to such records.

4.1.18 Provider Contract Development. MHI agrees to provide consultation and assistance to Health Plan in designing and drafting contracts with Health Plan's participating providers.

4.1.19 Provider Credentialing. MHI agrees to provide consultation and assistance to Health Plan with respect to credentialing providers. Such services may include preparing provider credentialing files for review by Health Plan and assisting Health Plan's Provider Credentialing Peer Review Committee with obtaining necessary information regarding providers' credentials.

4.1.20 Quality Assurance. MHI agrees to provide consultation and assistance to Health Plan in the conduct of Health Plan's quality assurance program. Health Plan understands and agrees that it will maintain responsibility for adopting, implementing and enforcing quality assurance standards.

4.1.21 Report Generation. MHI agrees to provide consultation and assistance to Health Plan in the development and production of reports required by applicable law, program requirements and/or contract.

4.1.22 Strategic Plan and Product Offerings. MHI agrees to provide consultation and assistance to Health Plan in conducting analyses of the marketplace in which Health Plan operates and in developing an appropriate strategic plan for Health Plan, including recommendations concerning the products and services to be offered by Health Plan, the service areas in which Health Plan should operate and/or expand its activities, and other services that should be offered by Health Plan.

4.1.23 Training and Development. MHI agrees to provide consultation and assistance to Health Plan with identifying training needs as well as developing and delivering or coordinating training programs on various topics and systems.

4.1.24 Utilization Review. To the extent services are not performed on behalf of Health Plan pursuant to Section 3.1.21 above, MHI agrees to provide consultation and assistance to Health Plan relating to Health Plan's utilization review program. Health Plan understands and agrees that it will maintain responsibility for adopting, implementing and enforcing utilization review standards.

SECTION 5. INCIDENTAL SERVICES.

5.1 Incidental Services. MHI agrees to provide any services that are incidental to the services set forth in Sections 3 and 4, as may be needed from time to time.

SECTION 6. PRODUCT SPECIFIC REQUIREMENTS.

6.1 Product Specific Requirements. MHI agrees that any and all services provided by MHI with respect to Health Plan's Medicaid Product(s), CHIP Product(s), Duals Product(s), Medicare Product(s) and/or Commercial Product(s) are to

be provided in accordance with any and all rules, regulations and contract provisions applicable to that specific product. In addition, MHI agrees to follow these product specific requirements as applicable:

6.1.1 Medicare Product Requirements. In addition to providing services for Health Plan's Medicare Products(s) in accordance with all applicable Medicare Product rules, regulations and contract provisions between Health Plan and CMS, MHI agrees that any and all services to be provided by MHI with respect to Health Plan's Medicare Product(s) are to be provided in accordance with the terms of Addendum A (Medicare Product Requirements – Delegated Services) and Addendum B (Medicare Part D Program Requirements – Delegated Services).

6.1.2 Duals Product Requirements. Services for Health Plan's Duals Products(s) shall be provided in accordance with all applicable rules, regulations and contract provisions between Health Plan, CMS and the state Medicaid agency. MHI also agrees that any services to be provided by MHI with respect to Health Plan's Duals Product(s) are to be provided in accordance with the terms of Addendum A (Medicare Product Requirements – Delegated Services) and Addendum B (Medicare Part D Program Requirements – Delegated Services), setting forth certain provisions required by federal statutes and regulations which apply to Enrollees who receive Medicare benefits under the Duals Product(s).

6.1.3 Miscellaneous State Specific Requirements. In addition to providing services for all of Health Plan's products in accordance with all applicable product specific rules, regulation and contract provisions, MHI agrees that services are to be provided in accordance with the terms of Addendum C (Miscellaneous Requirements – Iowa).

SECTION 7. HEALTH PLAN PROVIDED SERVICES.

7.1 Health Plan Services. Health Plan agrees to provide services for MHI that may benefit MHI's affiliates and subsidiaries as requested by MHI from time to time. MHI understands and agrees that Health Plan may decline to provide a requested service if providing the service negatively impacts Health Plan's operations.

SECTION 8. LICENSE OF MHI MARKS AND CORPORATE NAMES.

8.1 License Grant. MHI hereby grants to Health Plan a non-exclusive, non-transferrable license to use the corporate names "Molina" and "Molina Healthcare" and MHI owned marks and designs including but not limited to "Molina," Molina Healthcare," "Molina Advantage," and the distinctive three "block and circle design," distinctive lettering, and color schematics (all of MHI's marks and designs collectively referred to as the "Molina Marks") (the "License"). Notwithstanding anything herein to the contrary, the License shall be: (i) for the purposes of conducting Health Plan's business; (ii) limited to usage within all jurisdictions within the United States of America; (iii) subject to governing law; and (iv) limited to the extent necessary to ensure that any such rights do not violate or infringe upon the intellectual property rights of others.

8.2 Past Acts. MHI hereby approves of any past reproduction and use by Health Plan of the Molina Marks and corporate names. Health Plan may continue to use member enrollment or promotional materials, stationery, and all other forms of recorded communications, whether written, electronic, visual or audio (collectively, "Materials"), existing as of the Effective Date containing the Molina Marks or corporate names (collectively, "Permitted Materials") during the term of this Agreement and shall have the right to reproduce the Permitted Materials during the term of this Agreement.

8.3 Quality Control. Health Plan agrees to meet and maintain such quality, appearance and other standards with respect to use of the Molina Marks and corporate names as MHI may from time to time prescribe. Furthermore, Health Plan shall not use, and shall take commercially reasonable measures to prevent their respective directors, officers, employees, agents and brokers from using, the Molina Marks and corporate names in any manner that might reasonably be anticipated to subject MHI to adverse publicity, violate any law or regulation, or subject MHI to liability.

SECTION 9. SERVICE FEES.

9.1 Amount. Health Plan agrees to pay to MHI on a monthly basis an amount reflecting the value of the consultation, assistance, services, materials, supplies, capital access, and License referenced under Sections 3, 4, 5, and 8 above. The invoice charges or fees for services performed must be fair and reasonable and expenses incurred and payment received must be allocated to Health Plan in conformity with customary statutory accounting practices consistently applied. Health

Plan agrees to pay such amount no later than thirty (30) days after receipt of invoices from MHI. Such amount may be adjusted periodically by mutual consent of MHI and Health Plan. At the request of Health Plan, MHI agrees to provide Health Plan with documentation and other substantiation of the costs and expenses incurred by MHI hereunder.

9.2 Suspension of Payment. Notwithstanding any other provision of this Agreement, the Parties agree that the obligation of Health Plan to compensate MHI hereunder may be suspended to the extent that the amounts payable by Health Plan cause the capital and surplus of Health Plan, calculated pursuant to applicable law, to fall below the minimum level required by applicable law; provided, however, that at such time as the payment thereof can permissibly be made consistent with applicable law requirements, amounts suspended under this Section may be re-billed by MHI, and upon re-billing, Health Plan agrees to pay such amounts. The Parties further agree that suspension of any amounts otherwise payable by Health Plan under this Section does not relieve MHI of its obligations under this Agreement.

9.3 Enrollee Responsibility for Obligations of Health Plan. MHI agrees that under no circumstances will MHI look to Enrollees for payment of obligations of Health Plan to MHI hereunder, regardless of the insolvency of Health Plan or the inability of Health Plan to pay.

SECTION 10. ADDITIONAL MHI RESPONSIBILITIES.

Notwithstanding any other provision of this Agreement to the contrary:

10.1 Compliance. MHI agrees the services provided pursuant to this Agreement will comply with all applicable regulatory and accreditation requirements, including requirements of the National Committee for Quality Assurance (NCQA), CMS, applicable product specific state and federal law and contract requirements, state insurance requirements, and any other requirements that may apply.

10.2 Availability of Resources. MHI agrees to maintain at all times sufficient resources, personnel, expertise and contacts to furnish to the services under this Agreement.

10.3 Availability of MHI Records. MHI agrees to make all of its books and records pertaining to the goods and services furnished under the terms of this Agreement available to Health Plan, state and federal regulatory agencies or their designees and any other regulatory body as required by contract, state or federal law.

10.4 Additional Reports. The Parties agree that Health Plan has the right to require MHI to assist Health Plan in the development of such reports and disclosures as may be required by applicable rules, regulations, and state regulators.

10.5 Subcontracts. MHI agrees to ensure that any Subcontracts between MHI and third parties performing portions of MHI's obligations hereunder contain provisions to the following effect:

(a) That the third party shall make all applicable books and records available for inspection, examination and copying by Health Plan, state and federal regulatory agencies or their designees and any other regulatory body as required by contract, state or federal law; and

(b) That the third party shall retain such books and records for a reasonable period of time following the termination of the Subcontract.

(c) Any other provisions or addendums as required by contract, state or federal law.

10.6 Confidentiality and Business Associate Addendum. MHI agrees to maintain the confidentiality of Enrollees' enrollment information and medical records as required by all applicable federal, state and local laws. MHI acknowledges that it will have access to "protected health information" (as defined in the Business Associate Addendum). Each party agrees that the terms and conditions of the Business Associate Addendum attached hereto as Addendum D shall apply to "protected health information" (as defined therein) at all times during the term of this Agreement.

10.7 Grievance and Appeals Procedures and Other Policies and Procedures. MHI agrees to assist Health Plan in complying with the grievance and appeals procedures and other policies and procedures applicable to Health Plan.

10.8 Books and Records of Health Plan. MHI agrees that any books and records of Health Plan that come into the possession or stewardship of MHI are to be maintained by MHI in a manner consistent with applicable laws and applicable contracts.

SECTION 11. MISCELLANEOUS.

11.1 Term. The term of this Agreement will commence on the Effective Date and shall remain in effect thereafter for a period of one (1) year. The Parties agree that this Agreement will thereafter be automatically renewed for successive periods of one (1) year each, unless either party terminates this Agreement by written notice giving at least sixty (60) days prior to the end of any such one (1) year term or at any other time if the parties mutually agree in writing.

11.2 Assignment. MHI agrees and understands that it does not have the right to assign this Agreement other than to a wholly-owned or majority-owned subsidiary of MHI, or to a corporation under common control with MHI. Without in any way limiting the above, all of the terms of this Agreement shall be binding upon, inure to the benefit of and be enforceable by the heirs, personal representatives, successors and permitted assigns of the parties.

11.3 Notices. The Parties agree that any notice or other communication required by this Agreement by either party to the other shall be in writing and shall be deemed given on the date of receipt if personally delivered, sent by electronic mail or facsimile to the party to whom the same is directed or on the third day after mailing if mailed to such party, by registered or certified mail, postage prepaid, addressed to the following addresses:

(a) Molina Healthcare of Iowa, Inc.
Attn: Jeff Barlow
General Counsel, Secretary
300 University Avenue, Suite 100
Sacramento, California 95825
Facsimile: (916) 646-4572
E-mail: Jeff.Barlow@MolinaHealthcare.com

(b) Molina Healthcare, Inc.
Attn: John C. Molina
Chief Financial Officer
200 Oceangate, Suite 100
Long Beach, California 90802
Facsimile: (562) 495-7770
E-mail: John.Molina@MolinaHealthcare.com

or to such other address, and to the attention of such other person or officer, as either party may designate in writing.

11.4 Amendments. The Parties recognize that it may be desirable to alter the terms of this Agreement to take into account such events or conditions as may from time to time occur. The Parties agree that any amendments to this Agreement must be in writing and executed by both parties.

11.5 Headings. The headings contained herein are for convenience of reference only and are not intended to define, limit or describe the scope or intent of any provision of this Agreement.

11.6 No Waiver. The Parties agree that neither the failure by the aggrieved party to insist upon strict performance of any covenant, agreement, term or condition of this Agreement or to exercise any remedy upon a breach thereof, nor the acceptance of full or partial performance during the continuance of any breach by the other party, constitutes a waiver of any such breach or of such covenant, agreement, term or condition.

11.7 Further Instructions or Action. Each party agrees that it will execute and deliver such further instruments and will take such other action as may be reasonably necessary in order to effectively discharge, perform or carry out any of the respective obligations and agreements hereunder.

11.8 Governing Law. The Parties agree that the validity and construction of this Agreement is governed by the laws of the State of Iowa, without reference to its conflict of laws provisions.

11.9 Severability. If any part of this Agreement is declared invalid for any reason, such part shall not affect the validity of the rest of this Agreement. The other parts of this Agreement shall remain in effect as if this Agreement had been executed without the invalid part. The Parties declare that they intend and desire that the remaining parts of this Agreement continue to be effective without any part or parts that have been declared invalid.

11.10 Entire Agreement. This Agreement together with all addendums, exhibits and attachments hereto constitutes the entire agreement and understanding between the Parties in respect of the subject matter of this Agreement and supersedes all prior agreements and understandings with respect to such subject matter, whether oral or written.

11.11 Counterparts. This Agreement may be executed in one or more counterparts, each of which is deemed an original, but all of which together shall constitute one and the same instrument. Facsimile or photocopy signatures shall be deemed as legally enforceable as the original signatures.

Remainder of this page intentionally left blank

IN WITNESS WHEREOF, the parties have executed this Amended and Restated Services Agreement as of the date first mentioned above.

MOLINA HEALTHCARE OF IOWA, INC.

By:_____

Name: _____

Title: _____

MOLINA HEALTHCARE, INC.

By:_____

Name: _____

Title: _____

INDEPENDENT CONTRACTOR AGREEMENT

This Independent Contractor Agreement ("Agreement") is entered into as of _____ __, 20__ ("Effective Date") between Molina Healthcare, Inc., and its subsidiaries and affiliates, ("Client") and _____ ("Contractor") and shall be based upon the following terms and conditions:

I. CONTRACTOR RESPONSIBILITIES

1. Job Assignment/Services. During the term of this Agreement, Contractor shall provide the Services set forth in Attachment A – Statement of Work ("SOW"), which is appended hereto and incorporated herein by this reference. Any additional Services agreed to by the parties will be identified in subsequent attachments, exhibits or addenda to this Agreement, which when signed and dated by both parties, shall be made a part of this Agreement. In the event of any contradiction between the terms and conditions of any SOW and this Master Agreement, the terms and conditions of the Master Agreement shall prevail.

Unless otherwise agreed to in writing, Contractor shall perform the Services specified, commencing and completing the Services on the date specified in Attachment A or any applicable attachment, exhibit or schedule, unless terminated or extended in writing.

2. Offshore Resources. Contractor or its agents or subcontractors shall not perform any work outside the United States of America without the prior written consent of Client. In the event that Contractor or its agents or subcontractors seek to perform any work outside the United States of America or uses off-shore resources (as defined in Attachment D), Contractor shall complete the form attached to this Agreement as "Attachment D, Offshore Resources". If during the term of this Agreement, or at any time after the Effective Date of this Agreement, it is determined that Contractor is in breach of this Section or Attachment D, Client shall have, in its sole discretion, the right to terminate this Agreement.

Contractor acknowledges and agrees that Client, at any time, may require all services to be brought back onshore to the United States of America due to changes in laws, regulations, or state contractual requirements.

3. Schedule of Services. Contractor shall provide Services at such times as are requested and agreeable to Client. Client shall set forth a mutually agreeable timetable for completion of deliverables and reviews.

4. Business Reports. Contractor shall provide Client written status reports upon request.

5. Change of Services. Client may request that modifications be made to the SOW. Should Client and Consultant agree to modify the provisions set forth in the SOW, a Change Order will be prepared and signed by both parties. The Change Order shall contain or incorporate by reference any and all modifications to the SOW. The provisions set forth in the Change Order shall prevail over those set forth in the SOW and those set forth in all prior and related Change Orders. A copy of the Change Order shall be attached hereto.

6. Conflict of Interest. Contractor represents and warrants that neither the execution of this Agreement nor the performance of the Contractor's obligations under this Agreement will result in a violation or breach of any other agreement by which the Contractor is bound. Client represents that this Agreement has been duly authorized and executed and is a valid and legally binding obligation of Client, to the best of its knowledge, subject to no conflicting agreements.

7. Independent Contractor. Contractor shall act as an independent contractor having responsibility for and control over the means and details of performing the Services, and shall not act as an agent or employee of Client. Accordingly, Contractor shall have no claim under this Agreement for vacation or sick leave, retirement benefits, Social Security, Workers' Compensation benefits, disability or unemployment insurance benefits, or employee benefits of any kind. Client shall be interested only in the results obtained. The parties shall not make any commitments or incur any charges or expenses for or in the name of one another and shall, to the greatest extent possible, perform this Agreement in a manner consistent with Contractor's status as an independent contractor.

8. Quality and Acceptance of Service. Contractor represents to Client that the Services will be performed in a professional and workmanlike manner in compliance in all material respects with any specifications set forth in the applicable SOW. Deliverables defined in each SOW shall be subject to Client's acceptance. The parties will determine and agree on appropriate acceptance criteria and testing procedures (if testing is applicable) consistent with the requirements of this Agreement. Client shall determine in its sole and reasonable opinion whether or not a deliverable meets applicable acceptance criteria.

Acceptance of a deliverable will occur upon the earlier of: (i) the date Client notifies Contractor of acceptance; or (ii) ten (10) days after Client's completion of acceptance evaluation or testing if Client has not notified Contractor of a rejection of a deliverable ("Acceptance"). A deliverable rejection shall contain specific reasons for the failure of a deliverable to meet acceptance criteria.

In the event a deliverable is rejected by Client: within two (2) business days following notice of rejection of the deliverable, Contractor shall submit to Client a plan to resolve the deliverable failures. The plan shall outline specific steps for resolving the deliverable failures and a time for resolution and/or re-submission ("Resolution Date"). In the event that either the resolution plan or the Resolution Date is unacceptable to Client, Client shall have the option to: (1) insist that a new resolution plan be created, and/or a new Resolution Date be established; or (2) terminate the Services as they relate to the particular deliverable, or (3) terminate the entire Agreement for convenience and receive a refund for any monies paid.

9. Subcontractors. Contractor will not utilize the services of any subcontractors in providing the services required hereunder without Client's prior written approval (which consent Client may grant or withhold in Client's sole and absolute discretion) and the execution of an addendum to this Agreement or within a Statement of Work setting forth the terms and conditions under which Client shall consent to the use of such subcontractors. Contractor shall be responsible for the conduct and performance of each approved subcontractor as if Contractor had performed all of the subcontracted Services. All references to Contractor in this Agreement in the context of providing Services, where applicable, will also include Contractor's employees and approved subcontractors.

10. Business Conduct. While on Client's premises, Contractor and Contractor's employees will abide by Client's reasonable security guidelines, and will comply with Client's professional business standards both in terms of appearance and conduct.

11. Indemnification. Contractor agrees to defend, indemnify and hold harmless Client and its directors, officers, employees, subcontractors and agents from and against all damages, costs (including reasonable attorneys' fees), judgments and other expenses arising out of or on account of (A) any liability for personal injury or physical damage caused to persons or real, intangible or tangible personal property at Client's site by the negligent or intentional acts or omissions of Contractor, its employees or agents during the performance of this Agreement, or (B) any third party claim: (i) alleging that the Services, deliverables, works or retained components, in the form delivered to Client by Contractor, infringe or misappropriate the U.S. patent, copyright, trademark or other proprietary or intellectual property rights of such third party; (ii) arising out of Contractor's failure to comply with applicable laws and regulations in the performance of the Services, including but not limited to violation of data protection laws, or misuse or wrongful disclosure of personal or consumer information contained in Client databases; or (iii) relating to any payments or benefits due to or claimed by an Contractor employee or contractor (including liability for any withholding, statutory or benefit payment). Client agrees to indemnify and hold harmless Contractor from and against any losses, damages, expenses or other liabilities, including reasonable attorney's fees, incurred to the extent arising out of the Client's gross negligence or willful misconduct occurring within the course and scope of this Agreement.

The indemnified party shall: (i) provide prompt notice to the indemnifying party of any claim subject to indemnification, (ii) allow the indemnifying party to control the response to and defense of any related claim; and (iii) reasonably cooperate with the indemnifying party in the defense of same.

12. No Consequential Damages. IN NO EVENT WILL EITHER PARTY BE LIABLE TO THE OTHER FOR LOST PROFITS, SPECIAL, INCIDENTAL, PUNITIVE, CONSEQUENTIAL OR INDIRECT DAMAGES OF ANY

KIND (INCLUDING, WITHOUT LIMITATION, COSTS OF COVER, LOST PROFITS OR LOSS OR DAMAGE TO DATA ARISING OUT OF THE USE, PARTIAL USE OR INABILITY TO USE THE RESULTS OF THE SERVICES) ARISING UNDER THIS AGREEMENT, AN SOW, OR IN THE COURSE OF CONTRACTOR PROVIDING ANY SERVICES TO THE CLIENT, WHETHER BASED IN CONTRACT, TORT (INCLUDING NEGLIGENCE), INTENDED CONDUCT OR OTHERWISE, EVEN IF THAT PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

13. Limitation of Liability. The aggregate liability of the indemnifying party , its affiliates and its employees, actuaries, directors, agents, and brokers (collectively the "Indemnifying Parties"), whether arising in contract, tort (including negligence), or otherwise, in connection with any of the Services provided under this Agreement, whether or not documented in an SOW, shall not exceed the amounts paid or payable to Contractor under any applicable SOW to which the liability relates and for the twelve (12) month period preceding the liability causing event. NOTWITHSTANDING THE FOREGOING, THE LIMITATIONS SET FORTH IN THIS SECTION SHALL NOT APPLY TO CLAIMS ARISING OUT OF CONTRACTOR'S INDEMNIFICATION AND CONFIDENTIALITY OBLIGATIONS UNDER THIS AGREEMENT OR CLAIMS ARISING OUT OF CONTRACTOR'S GROSS NEGLIGENCE OR WILLFUL MISCONDUCT.

This section shall not be applicable to any security incidents or breaches under HIPAA. Such breaches or incidents shall be governed by the Business Associate Addendum to this Agreement.

14. Insurance Requirements. Contractor shall maintain, throughout the performance of its obligations under this Agreement a policy or policies of worker's compensation insurance with such limits as may be required by law, and a policy or policies of general liability insurance insuring against liability to and death of persons and damage to and destruction of property arising out of or based upon any act or omission of Contractor or its respective officers, directors, employees, or agents. Client shall require Contractor and its approved Subcontractors to obtain and maintain in force, the following insurance:

(a) Workers Compensation Insurance in compliance with applicable Federal and State laws and Employer's Liability coverage with a minimum $1,000,000 limit of liability.

(b) Commercial General Liability Insurance, including contractual liability, with $1,000,000 bodily injury and property damage combined single limit of coverage.

(c) Automobile bodily injury and property damage liability insurance covering owned, non-owned and hired automobiles, the limits of which shall not be less than $500,000 combined single limit per occurrence.

(d) Professional Liability insurance covering acts, errors, mistakes, omissions arising out of the work or services performed by Vendor Name, or any subcontractor, agent or person employed by the Contractor, with a limit of not less than $1,000,000 per claim.

Upon Client's request, Contractor shall provide Client with a certificate of insurance completed by its insurance carrier certifying that minimum insurance coverage as required above are in effect. Additionally, If Contractor is to perform work while on the premises of Client, all liability insurance shall name Client and such other parties as Client may identify as an additional insured with respect to the Services being performed and provide that such insurance is primary to any liability insurance carried by Client. All insurance policies carried by Contractor whether specified herein or otherwise shall contain endorsements waiving the insurer's rights of subrogation against Client. Client shall be given not less than thirty (30) days written notice prior to any cancellation or material change to any policy.

IF APPLICABLE- ADDITIONAL INSUREDS: Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802

Please fax or email a copy of the certificate of insurance to Miguel Torres - fax: 562-951-1580 email: procurementservices@molinahealthcare.com. Otherwise, send a hard copy certificate to:

Molina Healthcare, Inc.
Attn: Procurement Services
200 Oceangate, Suite 100
Long Beach, CA 90802

15. Drug Free Policy. Contractor agrees to notify its employees who perform services under this Agreement ("Contractor Employee(s)") of the Client's policy concerning drug and alcohol use that prohibits (a) the use, possession, distribution, purchasing or selling drugs or alcohol on Client's premises or while engaged in Client's business and (b) reporting to and/or performing work for Client while under the influence of same (except for authorized amounts of prescribed drugs required for health reasons).

II. CLIENT RESPONSIBILITIES

Client shall inform appropriate Client personnel of Contractor's engagement so as to facilitate their cooperation with and prompt response to requests for information from Contractor and shall provide Contractor with necessary relevant information when requested and appropriate.

III. REIMBURSEMENT

16. Fees. Client agrees to compensate Contractor on the fee basis set forth in Attachment A. Total Not to Exceed $_____ plus any approved and acceptable expenses. Client shall pro-rate Contractor's monthly rate of compensation in the event this Agreement is terminated prior to the end of the month. Otherwise, Client agrees to be responsible for all fees and expenses incurred for the project up to and including the final day of work.

17. Billing and Payment. Contractor shall submit a detailed invoice reflecting service(s) provided and applicable fees. Client shall pay approved invoices within 30 days after Client's receipt of invoice. Fees for travel and related expenses shall be governed by Attachment C, Molina Healthcare, Inc. Corporate Travel Policy, appended hereto and incorporated herein by this reference.

IV. TERM OF AGREEMENT

This Agreement will become effective on the Effective Date as noted on the first page of this Agreement and will terminate upon the Contractor's completion of deliverables detailed in Attachment A, unless terminated earlier as provided in Section V. The parties may extend the expiration period of this Agreement by mutually executing applicable Amendments or adding deliverables to Attachment A, as required.

Upon termination both parties will determine in consultation with each other the portion of any fees or retainer earned to date. For any Services performed on an hourly basis, Client agrees agree to pay Contractor for all hourly time charges for Services performed up to the effective date of termination.

V. TERMINATION OF AGREEMENT

18. For Convenience. Client may terminate this Agreement for its convenience at any time by giving thirty (30) days prior written notice to the Contractor. If applicable, upon termination of this Agreement both parties shall consults with each other to determine the portion of any fees or retainer earned up to the effective date of termination. For Services performed on an hourly basis, Client agrees agree to pay Contractor for all hourly time charges for Services performed up to the effective date of termination.

19. For Cause. Either party hereto may terminate this Agreement by providing the other party with a minimum of ten (10) business days prior written notice in the event the other party commits a material breach of any provision of this Agreement. Said notice must specify the nature of said material breach. The breaching party shall have seven (7) business days from the date of the breaching party's receipt of the foregoing notice to cure said material breach. In the

event the breaching party fails to cure the material breach within said seven (7) business days period, this Agreement shall automatically terminate upon expiration of the ten (10) business days notice period.

20. Return of Information. Upon request of Client, Contractor shall immediately return to Client any and all information acquired by Contractor during this Agreement. Upon the cessation of this Agreement, Contractor shall immediately return to Client all information acquired by Contractor during the course of the Agreement.

21. Return of Property. All Company property in the possession or control of Contractor including, but not limited to specifications, documentation, source code, magnetic media, and building/parking entry keys and cards, as well as all material developed or derived by Contractor in performing its duties under this Agreement will be returned by Contractor to Company on demand, or at the termination of this Agreement whichever shall come first.

VI. CONFIDENTIALITY, PROTECTED HEALTH INFORMATION, INJUCTIVE RELIEF

22. Confidentiality. Neither Client nor Contractor shall disclose, directly or indirectly, without the prior approval of the other, (i) the terms of this Agreement and/or any Services provided; or (ii) any other non-public information about the other party's business or activities that is proprietary and confidential, which information will include any and all business, all strategic and development plans, results of the Services, business plans, information about parent, subsidiaries or sister companies, co-developer identities, data, business records, customer lists, policy information, personally identifiable information, personal financial information or personal health information (as those terms are defined by governing law), product designs, test data, project records, market reports, investor information, know-how, discoveries, ideas, concepts, specifications, models, diagrams, methodologies, research, technical and statistical data, drawings, models, flow charts, work-flow, marketing, pricing, selling, distribution, database descriptions, software code, source code, object code, Intellectual Property, and any and all other tangible or intangible information, other than trade secrets, encompassed in any medium, which may be disclosed, whether or not in writing, whether or not marked as "Confidential" or "Proprietary" by the disclosing party or to which the receiving party may be provided access to by disclosing party in accordance with this Agreement, or which is generated or learned as a result of or in connection with the Services and is not generally available to the public. "Confidential Information" also includes proprietary or confidential information of any third party that may disclose such information to either party in the course of that party's relationship with a party.

The above obligations shall not apply to Confidential Information which is already known to the to either party at the time it is disclosed, or which before being divided either (a) has become publicly known through no wrongful act of the parties; (b) has been rightfully received from a third party without restriction on disclosure and without breach of this Agreement; (c) has been approved for release by written authorization of Client; (d) has been disclosed pursuant to a requirement of a governmental agency or of law.

23. HIPAA Language. If Contractor, in performing its obligations under this Agreement, will have access to "protected health information" ("PHI") about individuals as defined under the Health Insurance Portability and Accountability Act ("HIPAA") of 1996 and the privacy and security rules promulgated there under, as amended from time to time then the parties agree to abide by the terms and conditions set forth in Attachment B – Business Associate Addendum, appended hereto and incorporated herein by this reference.

24. Enforcement and Injunctive Relief. Contractor and Client agree that if any party to this Agreement violates any of the provisions of this Agreement, that the aggrieved party shall be entitled to any and all applicable remedies at law and/or equity to prevent further breach of this Agreement, including injunctive relief, without posting bond. Contractor acknowledges that any unauthorized use or disclosure of Confidential Information would result in damage to Client that may be intangible but nonetheless real, and that is incapable of complete remedy by an award of damages. Accordingly, any such violation shall give Client the right to a court-ordered injunction or other appropriate order to specifically enforce the provisions of this Agreement. Contractor agrees to pay to Client any reasonable expenses, including but not limited to attorneys' fees, incurred in obtaining and collecting any remedies, relief or damages.

VII. CLIENT'S INTELLECTUAL PROPERTY

25. Contractor acknowledges Client, and/or its affiliates' ownership of, and full and exclusive rights in and to, any of Client's trademarks, service marks, trade names, works protected by copyright, or other designations or property rights (the "Existing Intellectual Property") which Contractor uses or produces in connection with its performance under this Agreement. Contractor agrees to use the Existing Intellectual Property only in the manner and form approved by Client and agrees that all use of the Existing Intellectual Property will inure to the benefit of Client. Nothing in this Agreement shall be construed or deemed to give Contractor any property, right or interest in any of the Existing Intellectual Property.

26. Client, and/or its affiliates, shall retain all ownership rights it may have in all materials delivered to Contractor by or on behalf of Client. Contractor shall use its reasonable efforts to protect such materials against any loss, theft, damage or destruction. Contractor shall return all originals and copies of such materials to Client upon Client's request, and in any event, immediately upon termination of this Agreement. After expiration or termination of this Agreement, Contractor will immediately cease all use of the Existing Intellectual Property, and shall not permit others to make any such use.

27. Contractor hereby acknowledges that any and all software, documentation and Services, as well as any other data that Contractor may prepare, deliver or has prepared or delivered (in whole or in part) during its engagement with Client which: (i) relate in any way to Client's business, or (ii) result in any way from the use of Client's premises, property, facilities, or time whether or not done during normal working hours, are made for hire and that Client owns all rights thereto, including any copyright in all or any portion thereof, and Contractor hereby irrevocably assigns any rights Contractor might have in any such materials or items to Client. Contractor shall execute or record (or cause to be executed or recorded) such further documents, instruments or agreements to evidence or reflect such assignment. Contractor hereby irrevocably appoints Client, as its attorney-in-fact to execute or record such documents, instrument or agreements, in the event that Contractor does not timely execute or record such documents, instruments or agreements as determined by Client.

VIII. MISCELLANEOUS

28. Notices. Any notices required under this Agreement shall be made in writing and given to the other party by personal delivery or certified mail at the following addresses:

If to Contractor:

Insert Contractor mailing address here

If to Client:

All Contract or Legal Notices: Molina Healthcare, Inc. **Chief Legal Officer** 300 University Avenue, Suite 100 Sacramento, CA 95825	All Invoices Should be Directed to: Molina Healthcare, Inc. P.O. Box 22813 Long Beach, CA 90801 Attn: Accounts Payable – RE

29. Arbitration. Any claim or controversy arising out of or in connection with this Agreement shall be resolved, to the extent possible, within forty-five (45) days through informal meetings and discussions between appropriate representatives of the parties. Any remaining claim or controversy shall be resolved through binding arbitration conducted by a single arbitrator in accordance with the AAA Commercial Arbitration Rules, then in effect, in Long Beach. CA. If possible, the arbitrator shall have at least five (5) years' experience in managed health care. The parties shall conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator shall have no authority to award damages or provide a remedy that would not be available to such prevailing party in a court of law or

award punitive damages. Each party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator's and administrative fees. The parties agree to accept any decision by the arbitrator as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. Arbitration must be initiated within one (1) year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise it shall be deemed waived. The use of binding arbitration shall not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

30. Debarment or Exclusion. Each party represents and warrants that to the best of its knowledge neither it nor any of its officers, directors or employees (including any personnel) will ever have been listed by a federal or state agency (www.epls.gov) as debarred, excluded or otherwise ineligible for participation in any federal or state program. Each party promptly will notify the other party in the event it is debarred or disqualified from participating in any state or federal program or it obtains knowledge that any officer, director or employee (including any personnel) is listed by a federal or state agency as debarred, excluded or otherwise ineligible for participation in any federal or state program. In the event that either party is excluded from participation in any federally funded health care program during the term of this Agreement, or if at any time after the Effective Date of this Agreement it is determined that the excluded party is in breach of this Section, this Agreement shall, as of the effective date of such exclusion or breach, automatically terminate.

31. Assignment. Neither party may sell, assign, transfer, or otherwise convey any of its rights or delegate any of its duties under this Agreement without the prior written consent of the other party; provided, however, that either party may without the prior consent of the other party assign all of its rights under this Agreement to: (a) its Affiliate; (b) a purchaser of all or substantially all of its stock or assets; or (c) a third party participating in a merger or other corporate reorganization in which the assigning party is a constituent corporation. A written notice of such assignment shall be provided to the non-assigning party. This Agreement will be binding upon and inure to the benefit of the parties and their respective successors and permitted assigns. Under such assignment, the terms and condition of this Agreement shall remain in full effect and cannot be replaced by any new assignee. Any attempted assignment of this Agreement not in accordance with this section shall be null and void.

32. Publicity. Neither party shall use the name, logo, trademark, trade name, or other marks of the other party or its affiliates without such party's prior written consent, which may be withheld in either party's sole discretion.

33. Severability. If any clause, sentence, provision, or other portion of this Agreement is or becomes illegal, null, void or unenforceable for any reason, or is so held by any court of competent jurisdiction, the remaining portions shall remain in force and effect.

34. Waiver. No assent or waiver, express or implied, of any breach of any one or more of the covenants, conditions or provisions hereof shall be deemed or taken to be a waiver of any other covenant, conditions or provision hereof, or a waiver of any subsequent breach of the same covenant, condition or provision hereof.

35. Affirmative Action. During the performance of this Agreement Contractor agrees to comply with all Federal, state and local laws respecting discrimination in employment and non-segregation of facilities including, but not limited to, requirements set out at 41 CFR 60-1.4, 60-300.5, and 60-741.5, which equal opportunity clauses and reporting requirement are hereby incorporated by reference.

36. Governing Law. This Agreement shall, in all respects, be interpreted, construed, enforced and given effect according to the laws of the State of California, excluding its principles of conflicts of laws.

37. Immigration Compliance. Contractor warrants, represents and agrees that it will not assign any of its employees or other individual to perform work under this Agreement who is an unauthorized alien under the immigration and reform and control act of 1986 (as the same has been or may be amended) or its implementing regulations.

38. Export Regulations. Contractor acknowledges its obligations to control access to technical data under the U.S. Export Laws and Regulations and agrees to adhere to such laws and regulations with regard to any technical data received under this Agreement.

39. Inspection and Access. Client shall at all times have access to the Contractor's work product developed under this Agreement whenever in preparation, and Contractor shall facilitate such access and inspection thereof; inspection or lack of inspection by Client shall not be deemed to be a waiver of any of its rights under Contractor's guarantees or its right to subsequently reject defective Services.

40. Contractor Personnel.

A) Contractor may not, without prior written notice to Client, substitute the designated Contractor personnel identified in any Attachment A for other Contractor personnel or reassign or modify the duties of Contractor personnel during the term of the Agreement to other functions if so doing would require the alteration or reduction of such Contractor personnel's contribution or involvement with delivery of the Services hereunder. Under no circumstances shall any substitution of designated personnel result in an increase in any compensation due to Contractor under this Agreement, or a decrease in the quantity or quality of Services, as determined in Client's sole discretion.

B) In the event Contractor personnel is reassigned or becomes incapacitated for any reason and therefore becomes unable to perform the functions or responsibilities assigned to him or her, Contractor shall promptly temporarily replace such person with another person or persons (in the event additional resources shall be required in order to meet the project schedule and deliverable dates) properly qualified to perform the functions of such replaced person, and promptly thereafter permanently replace such replaced person with another person or persons approved by Client and properly qualified to perform the functions of such replaced person. Contractor shall bear all costs associated with the knowledge transfer to bring the replacement Contractor personnel up to speed on the Services and deliverables. In any event, Contractor shall not be relieved of any delivery dates nor shall it be entitled to charge additional fees for additional Contractor personnel required to perform the Services in a timely manner.

C) If at any time Client is dissatisfied with the performance of the Contractor personnel, Client may at its sole discretion report such dissatisfaction to Contractor and request a replacement, which Contractor shall promptly replace with a Contractor personnel that possesses equivalent or higher experience and skills.

41. Captions and Construction. The captions used as headings of the various Sections hereof are for convenience only, and the parties agree that such captions are not to be construed to the part of this Agreement or to be used in determining or construing the intent or context of this Agreement.

42. Counterparts; Faxes. This Agreement may be executed in counterparts, each of which so executed will be deemed to be an original and such counterparts together will constitute one and the same agreement. The Parties may execute this Agreement by exchange of faxed or scanned signatures, which both Parties agree shall be an acceptable delivery method of a manually executed counterpart of this Agreement.

43. Electronic Signatures. In the event that an electronic signature is used, both Parties represent and warrant that the electronic or digital signature is an official signature of the Parties authorized representative.

44. Entire Agreement. This Agreement shall consist of the terms and conditions set out in the main body of this Agreement together with those provisions set out in any Schedule, Exhibit, Attachment and/or Addenda ("Documents") relating to this Agreement and signed by the parties to this Agreement. This Agreement shall constitute the entire, integrated agreement and understanding between the parties and supersedes all prior agreements, representations and understandings between the parties, whether written or oral. This Agreement may not be amended or modified except by an instrument in writing executed by the parties hereto.

IN WITNESS WHEREOF, the parties have duly executed this Agreement by their authorized representatives as of the Effective Date.

CONTRACTOR NAME	**MOLINA HEALTHCARE, INC.**
By:_____	By:_____
Printed:_____	Printed:_____
Title:_____	Title:_____
Date:_____	Date:_____

PO #: _____
The purchase order number provided must appear on all related correspondence, receipts and invoices.

Attachment A

Insert Scope of Services, Statement of Work or Schedule Services here
Include list of deliverables and schedules, items out of scope, schedule/type of fees/expenses, contact list data including subcontractors, resumes,

ATTACHMENT B
BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum ("Addendum") to the [*insert title of underlying agreement*] dated [*insert date of underlying agreement*] ("Agreement"), is entered into by and between [*insert name of Molina entity, e.g., Molina Healthcare, Inc.; Molina Healthcare of Utah, Inc., etc.*] ("Molina Healthcare") and _____ ("Business Associate") and shall be effective as of [*insert effective date of Addendum*].

RECITALS

WHEREAS, Business Associate may create, receive, maintain, or transmit protected health information on behalf of Molina Healthcare in conjunction with the services described in the Agreement;

WHEREAS, such protected health information may be used or disclosed only in accordance with the Privacy Rule issued by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

WHEREAS, Business Associate must safeguard any electronic protected health information that it creates, receives, maintains, or transmits on behalf of Molina Healthcare as required by the Security Rule issued by the U.S. Department of Health and Human Services under HIPAA; and

WHEREAS, Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") provisions in the American Recovery and Reinvestment Act of 2009 ("ARRA") amended HIPAA and its implementing regulations.

NOW THEREFORE, the parties agree as follows:

1. DEFINITIONS

Unless otherwise provided for in this Addendum, terms used in this Addendum shall have the same meanings as set forth in HIPAA, ARRA, the Privacy Rule and the Security Rule.

"ARRA" means Subtitle D of the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, 42 U.S.C. §§17921-17954, and any and all references in this Addendum to sections of ARRA shall be deemed to include all associated existing and future implementing regulations, when and as each is effective.

"Availability" means the property that data or information is accessible and useable upon demand by an authorized person.

"Breach" shall mean the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule that compromises the security or privacy of the PHI as defined, and subject to the exceptions set forth, in 45 C.F.R. 164.402.

"Business Associate" means an entity or a person that performs a function on behalf of, or provides a service to, Molina Healthcare that involves the creation, receipt, use or disclosure of PHI.

"Compliance Date" shall mean, in each case, the date by which compliance is required under the referenced provision of ARRA and/or its implementing regulations, as applicable; provided that, in any case for which that date occurs prior to the effective date of this Addendum, the Compliance Date shall mean the effective date of this Addendum.

"Confidentiality" means the property that data or information is not made available or disclosed to unauthorized persons or processes.

"Electronic Protected Health Information" ("Electronic PHI") means Protected Health Information that is transmitted by, or maintained in, electronic media.

"Integrity" means the property that data or information have not been altered or destroyed in an unauthorized manner.

"Protected Health Information" ("PHI") means individually identifiable information, transmitted or maintained in any form or medium, relating to the past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual, as more fully defined in 45 CFR § 160.103, and any amendments thereto.

"Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

"Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

"Security Rule" means the Security Standards for the Protection of Electronic Protected Health Information, set forth at 45 CFR Parts 160 and 164.

"Services" shall mean, to the extent and only to the extent they involve the creation, use or disclosure of PHI, the services provided by Business Associate to Molina Healthcare under the Agreement, including those set forth in this Addendum, as amended by written agreement of the parties from time to time.

"Unsecured PHI" means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of Health and Human Services (HHS) in guidance issued pursuant to ARRA.

2. GENERAL PROVISIONS

2.1 Effect. This Addendum supersedes any agreements between the parties involving the disclosure of PHI by Molina Healthcare to Business Associate. To the extent any conflict or inconsistency between this Addendum and the terms and conditions of any agreement exists, the terms of this Addendum shall prevail.

2.2 Amendment. The parties agree to amend this Addendum as necessary to comply with the Privacy Rule, the Security Rule, and such other regulations promulgated by the Secretary of Health and Human Services pursuant to HIPAA.

3. SCOPE OF USE AND DISCLOSURE

3.1 Business Associate may use or disclose PHI as required to provide Services and satisfy its obligations under the Agreement, if such use or disclosure of PHI would not violate the Privacy Rule. Unless otherwise limited herein, Business Associate may use or disclose PHI:

a. for Business Associate's proper management and administrative services;

b. to carry out the legal responsibilities of Business Associate; and

c. to provide data aggregation services relating to the health care operations of Molina Healthcare if required under the Agreement.

3.2 Business Associate shall not request, use or release more than the minimum amount of PHI necessary to accomplish the purpose of the use or disclosure and shall comply with 42 U.S.C. § 17935(b) as of its Compliance Date. Business Associate hereby acknowledges that all PHI created or received from, or on behalf of, Molina Healthcare is the sole property of Molina Healthcare.

3.3 Business Associate or its agents or subcontractors shall not perform any work outside the United States of America that involves access to, or the disclosure of, PHI without the prior written consent of Molina Healthcare.

3.4 As of the Compliance Date, Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI as prohibited by 42 U.S.C. § 17935(d) as of its Compliance Date.

3.5 As of the Compliance Date, Business Associate shall not make or cause to be made any communication about a product or service that is prohibited by 42 U.S.C. § 17936(a) as of its Compliance Date.

3.6 As of the Compliance Date, Business Associate shall not make or cause to be made any written fundraising communication that is prohibited by 42 U.S.C. § 17936(b) as of its Compliance Date.

4. OBLIGATIONS OF BUSINESS ASSOCIATE

Business Associate shall:

4.1 Use or disclose PHI only as permitted or required by this Addendum or as required by law.

4.2 Establish and use appropriate safeguards to prevent unauthorized use or disclosure of PHI.

4.3 Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of Molina Healthcare. Business Associate shall, as of the Compliance Date of 42 U.S.C. § 17931, comply with the Security Rule requirements set forth in 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316.

4.4 Promptly report to Molina Healthcare any unauthorized use or disclosure of PHI, or security incident, within no more than three (3) days after Business Associate becomes aware of the unauthorized use or disclosure of PHI or Security Incident. Business Associate shall take all reasonable steps to mitigate any harmful effects of such breach or security incident. Business Associate shall indemnify Molina Healthcare against any losses, damages, expenses or other liabilities including reasonable attorney's fees incurred as a result of Business Associate's or its agent's or subcontractor's unauthorized use or disclosure of PHI or Breach of Unsecured PHI including, but not limited to, the costs of notifying individuals affected by a Breach of Unsecured PHI.

4.5 Business Associate shall, following discovery of a Breach of Unsecured PHI that is caused by Business Associate or its agents or subcontractors, notify Molina Healthcare of such Breach, without unreasonably delay, and in no event more than thirty (30) days after the discovery of the Breach. The notification by the Business Associate to Molina Healthcare shall include: (1) the identification of each individual whose Unsecured PHI was accessed, acquired, used or disclosed during the Breach; and (2) any other available information that Molina Healthcare is required to include in its notification to individuals affected by the Breach including, but not limited to, the following:

a. a brief description of what happened, including the date of the Breach and the date of the discovery of the Breach;

b. a description of the types of Unsecured PHI that were involved in the Breach;

c. a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches.

4.6 Ensure that all of its subcontractors and agents are bound by the same restrictions and obligations contained herein, whenever PHI is made accessible to such subcontractors or agents.

4.7 Within ten (10) days of receiving a request, make all PHI and related information in its possession available as follows:

a. To the individual or Molina Healthcare to the extent necessary to permit Molina Healthcare to respond to an individual's request for access to their PHI for inspection and copying in accordance with 45 CFR § 164.524, to the extent the PHI is maintained in a Designated Record Set;

b. To the individual or Molina Healthcare to the extent necessary to permit Molina Healthcare to make an accounting of disclosures of PHI about the individual, in accordance with 45 CFR § 164.528. At a minimum, Business Associate shall provide Molina Healthcare with the following information: (i) the date of the disclosure, (ii) the name of the entity or person who received the PHI, and if known, the address of such entity or person, (iii) a brief description of the PHI disclosed, and (iv) a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure;

c. In the event that Business Associate in connection with the Services uses or maintains an Electronic Health Record of PHI of or about an individual, then Business Associate shall provide an accounting of disclosures of PHI, within ten (10) days, to Molina Healthcare, or when and as directed by Molina Healthcare, directly to an individual in accordance with the requirements for accounting for disclosures made through an Electronic Health Record in 42 U.S.C. 17935(c), as of its Compliance Date.

4.8 Within fifteen (15) days of receiving a request from Molina Healthcare, incorporate any amendment or correction to the PHI in accordance with the Privacy Rule, to the extent the PHI is maintained in a Designated Record Set.

4.9 Make its internal practices, books and records relating to the use or disclosure of PHI received from or on behalf of Molina Healthcare available to Molina Healthcare or the U. S. Secretary of Health and Human Services for purposes of determining compliance with the Privacy Rule.

4.10 Upon termination of the Agreement, Business Associate shall, at the option of Molina Healthcare, return or destroy all PHI created or received from, or on behalf of, Molina Healthcare. Business Associate shall not retain any copies of PHI except as required by law. If PHI is destroyed, Business Associate agrees to provide Molina Healthcare with certification of such destruction. If return or destruction of all PHI, and all copies of PHI, is not feasible, Business Associate shall extend the protections of this Addendum to such information for as long as it is maintained. Termination of the Agreement attached hereto shall not affect any of its provisions that, by wording or nature, are intended to remain effective and to continue in operation.

4.11 Standard Transactions. To the extent Business Associate conducts Standard Transaction(s) on behalf of Molina Healthcare, Business Associate shall comply with the HIPAA Regulations, "Administrative Requirements," 45 C.F.R. § 162.100 et seq., by the applicable compliance date(s) and shall not: (a) Change the definition, data condition or use of a data element or segment in a standard; (b) Add any data elements or segments to the maximum defined data set; (c) Use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s); or (d) Change the meaning or intent of the standard's implementation specifications.

5. INDEMNIFICATION

Each party will indemnify and defend the other party from and against any and all claims, losses, damages, expenses or other liabilities, including reasonable attorney's fees, incurred as a result of any breach by such party of any representation, warranty, covenant, agreement or other obligation contained herein by such party, its employees, agents, subcontractors or other representatives.

6. TERMINATION OF AGREEMENT

Notwithstanding any other provision of this Addendum or the Agreement, Molina Healthcare may terminate this Addendum and the Agreement upon five (5) days written notice to Business Associate if Molina Healthcare determines, in its sole discretion, that Business Associate has violated a material term of this Addendum and such breach is not cured within such five (5) day period.

INTENDING TO BE LEGALLY BOUND, the parties hereto have caused this Addendum to be executed by their duly authorized representatives.

BUSINESS ASSOCIATE	**MOLINA HEALTHCARE, INC.**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date:_____	Date:_____

ATTACHMENT C
MOLINA HEALTHCARE, INC. CORPORATE TRAVEL POLICY

I. TRAVEL ARRANGEMENTS: All travel arrangements must be arranged using the following requirements:

A. Air Travel. The Company will reimburse all business air travel as long as such travel is at the lowest cost available, short of endangering the reason for the trip or the business needs dictated by a customer. The guidelines surrounding our travel policy are as follows:

The lowest available airfare, regardless of penalties or restriction, must be utilized by anyone traveling at the expense of Molina. Any tickets being requested within seven (7) days of travel require Molina management (contact) approval before the ticket can be issued.

The traveler will confirm the lowest airfare available on the requested routing. The traveler will check all flights one-and-a-half hours before and one-and-a-half hours after the originally requested arrival, for the lowest available airfare and book lowest fare options.

B. Lodging. The Company will pay only actual room rental costs supported by the hotel bill for each day that lodging away from home is required for business reasons. Molina travelers will be required to stay at hotels with a Molina Healthcare rate contract if such a hotel has rooms available and is within seven miles of the traveler's destination. All lodging shall be booked through the Molina's authorized travel agency. See contact information at the bottom of attachment.

C. Car Rentals. The Company will reimburse car rentals only when other means of transportation are unavailable, more costly, or impractical. The use of a rental car must be justified as a business need and not as a matter of personal convenience. The use of intermediate or full-size cars is acceptable only when two or more contractors are traveling together and sharing the rental car, or when it is necessary to have a larger vehicle for carrying clients or equipment.

D. Other Transportation.

Personal Car. The Company prefers travel through use of public transportation, but a contractor's automobile should be used when other transportation is unavailable or economy can be realized. The Company will reimburse the contractor at the rate of $0.55 (as amended by the IRS from time to time) per mile over and above the normal commute, plus parking and tolls, for authorized business use of personal cars. The normal commute includes a contractor's drive to his/her office if located in the same city in which the contractor resides.

Taxi and Other Out-of-Town Transportation. The cost of a taxi to and from places of business, hotels, or airports in connection with business activities is reimbursable. Use of taxis is authorized only when more economical services (hotel vans, shuttles, etc.) are not available. Contractors are encouraged to utilize public transportation whenever feasible. Receipts are required for all transportation expenses.

II. MEALS

Molina may determine standard per diem for meals and incidental expenses when traveling (overnight away from home), and in any case, will be limited to no more than $65.00 (tax and tip included). Detail receipts are required for all meals. "Business Meals" shall be reasonable and appropriate to Molina business undertaken. If applicable, document attendees, position, and business purpose.

Contact for Travel agency

Robert Montgomery
Corporate Sales Executive
Montrose Travel – Corporate Division
2355 Honolulu Ave, Montrose CA 91020
T: 818-553-3349 or 800-766-4687 ext 549 F: 818-550-6682
E: rmontgomery@montrosetravel.com
www.MontroseCorporateTravel.com

Attachment D

Offshore Resources

[Contractor Name]
[Contractor Address]
[Address line 2]
[City, State, Zip]

[Contractor Contact Name]
[Contractor Contact Phone]

This Attachment D is an attachment to the ICA and incorporated therein by reference.

Offshore Resources include any human resources or technological resourced located outside of the U.S. used to perform the Services under the Agreement or used to transmit, disclose, display, maintain, or access PHI outside of the U.S. The following details the Offshore Resources utilized by [Contractor Name]:

[Contractor shall provide, here in Attachment D, specific information on where the work will be done, what services will be performed offshore, the volume of work being performed offshore, and the date Contractor will begin performing work offshore.

If a subcontractor is performing the work, please provide, in addition to the aforementioned specifications, name of the subcontractor, and an acknowledgement on whether or not the subcontractor has entered into a confidentiality agreement with Contractor that is at least as strict as the confidentiality agreement that Contractor has entered into with Molina.

In the event that PHI is sent to a location offshore or accessed from a location offshore, please provide the following in addition to the aforementioned specifications: the precise offshore location where such PHI has been sent or is being accessed from, the volume of PHI sent offshore or accessed from offshore; and the specific technical/physical/administrative safeguards used to protect PHI sent offshore and accessed from offshore. Additionally, please state whether or not any data proposed to be sent offshore or accessed from offshore contains any PHI of Molina Healthcare's Medicare members.]

Please note that Molina Healthcare PHI must never be sent offshore without express written approval by an authorized Molina Healthcare representative.

The information provided above is current as of the Effective Date of the Master Agreement. Contractor acknowledges and agrees that this Attachment D must be amended and accepted in writing by Molina Healthcare prior to any change of location, change of subcontractor receiving or accessing PHI offshore, any material change in safeguards for the protection of PHI, any material increase in work being performed offshore, or any material change in the volume of PHI being sent offshore or accessed from offshore. Molina Healthcare's approval of changes to Attachment D will not be unreasonably withheld.

Contractor acknowledges and agrees that Client, at any time, may require all services to be brought back onshore to the United States of America due to changes in laws, regulations, or state contractual requirements.

Accepted by:

VENDOR NAME	**MOLINA HEALTHCARE, INC.**
Signature:_____	Signature:_____
Name:_____	Name:_____
Title:_____	Title:_____
Date:_____	Date:_____

Molina Healthcare, Inc.
MASTER SERVICES AGREEMENT (MSA)

This Master Services Agreement (the "Agreement") is entered into as of _____ __, 2015 ("Effective Date") between Molina Healthcare, Inc., a Delaware corporation and its subsidiaries and affiliates, ("Client") and _*enter supplier's legal name*_____, a enter *enter where supplier is incorporated* corporation (enter where supplier is incorporated) ("Contractor") and shall be based upon the following terms and conditions:

I. CONTRACTOR RESPONSIBILITIES

1. Job Assignment/Services. During the term of this Agreement, Contractor shall provide the Services set forth in Attachment A – Statement of Work ("SOW"), which is appended hereto and incorporated herein by this reference. Any additional Services agreed to by the parties will be identified in subsequent attachments (as Attachment A-2, A-3, etc.), exhibits or addenda to this Agreement, which when signed and dated by both parties, shall be made a part of this Agreement. In the event of any contradiction between the terms and conditions of any SOW and this Master Agreement, the terms and conditions of the Master Agreement shall prevail.

Unless otherwise agreed to in writing, Contractor shall perform the Services specified, commencing and completing the Services on the date specified in Attachment A or any applicable attachment, exhibit or schedule, unless terminated or extended in writing.

2. Offshore Resources. Contractor or its agents or subcontractors shall not perform any work outside the United States of America without the prior written consent of Client. In the event that Contractor or its agents or subcontractors seek to perform any work outside the United States of America or uses off-shore resources (as defined in Attachment D), Contractor shall complete the form attached to this Agreement as "Attachment D, Offshore Resources". If during the term of this Agreement, or at any time after the Effective Date of this Agreement, it is determined that Contractor is in breach of this Section or Attachment D, Client shall have, in its sole discretion, the right to terminate this Agreement.

Contractor acknowledges and agrees that Client, at any time, may require all services to be brought back onshore to the United States of America due to changes in laws, regulations, or state contractual requirements.

3. Schedule of Services. Contractor shall provide Services at such times as are requested and agreeable to Client. Client shall set forth a mutually agreeable timetable for completion of deliverables and reviews.

4. Business Reports. Contractor shall provide Client written status reports upon request.

5. Change of Services. Client may request that modifications be made to the SOW. Should Client and Contractor agree to modify the provisions set forth in the SOW, a Change Order will be prepared and signed by both parties. The Change Order shall contain or incorporate by reference any and all modifications to the SOW. The provisions set forth in the Change Order shall prevail over those set forth in the SOW and those set forth in all prior and related Change Orders. A copy of the Change Order shall be attached hereto.

6. Conflict of Interest. Contractor represents and warrants that neither the execution of this Agreement nor the performance of the Contractor's obligations under this Agreement will result in a violation or breach of any other agreement by which the Contractor is bound. Client represents that this Agreement has been duly authorized and executed and is a valid and legally binding obligation of Client, to the best of its knowledge, subject to no conflicting agreements.

7. Independent Contractor. Contractor shall act as an independent contractor having responsibility for and control over the means and details of performing the Services, and shall not act as an agent or employee of Client. Accordingly, Contractor shall have no claim under this Agreement for vacation or sick leave, retirement benefits, Social Security, Workers' Compensation benefits, disability or unemployment insurance benefits, or employee benefits of any kind. Client shall be interested only in the results obtained. The parties shall not make any commitments or incur any charges or

expenses for or in the name of one another and shall, to the greatest extent possible, perform this Agreement in a manner consistent with Contractor's status as an independent contractor.

A. Background Checks.

Contractor shall conduct background checks of Subcontractor/Contract Worker personnel assigned to Molina to perform the Work/Services. Contractor shall be responsible for all costs related to the background check, and shall utilize Client's preferred employee screening, identified below (see 7B), for all such background checks If the performance of the Work/Services necessitates the requirement for Subcontractor/Contract Worker personnel to obtain an appropriate level security clearance, the Contractor agrees to fully cooperate with Molina and the issuing agency in obtaining such security clearance.

Contractor when conducting criminal background checks for Subcontractor/Contract Worker personnel shall comply with the Fair Credit Reporting Act and all other applicable laws. Contractor hereby certifies that there is nothing revealed by such background checks that would create a reasonable doubt about the utilization of Subcontractor personnel for the Services in a safe manner and with proper regard for the security of Molina and its employees, customers, Contractors and other third parties. Subcontractor personnel whose background checks indicate the following convictions shall not be assigned to Molina: any felony conviction, any conviction resulting in time spent in jail, more than one misdemeanor of any kind (excluding traffic violations), any sex offense, any offense involving a weapon , any offense involving violence, any crime against a previous employer, and any crime involving fraud, theft, deception, etc.

B. Client's Background Check Contractor

STERLING INFOSYSTEMS
Global Background Checks
Mike Bailey | Assistant Vice President of Sales - West Region
Direct: 916.251.5785 | Mobile: 916.838.9726 | Fax: 866.652.4159
www.sterlinginfosystems.com

C. Types of Background Checks available from Client's Background Check Contractor are listed on Attachment E. Contractor shall cooperate with Client Business Unit and Client's Background check Contractor in selecting and shall be responsible for ordering the appropriate type of background check in sufficient time to allow project(s) to commence on schedule. Time is of the essence.

8. Quality and Acceptance of Service. Contractor represents to Client that the Services will be performed in a professional and workmanlike manner in compliance in all material respects with any specifications set forth in the applicable SOW. Deliverables defined in each SOW shall be subject to Client's acceptance. The parties will determine and agree on appropriate acceptance criteria and testing procedures (if testing is applicable) consistent with the requirements of this Agreement. Client shall determine in its sole and reasonable opinion whether or not a deliverable meets applicable acceptance criteria.

Acceptance of a deliverable will occur upon the earlier of: (i) the date Client notifies Contractor of acceptance; or (ii) thirty (30) days after Client's receipt of such deliverable completion of acceptance evaluation or testing if Client has not notified Contractor of a rejection of a deliverable ("Acceptance"). A deliverable rejection shall contain specific reasons for the failure of a deliverable to meet acceptance criteria.

In the event a deliverable is rejected by Client: within five (5) business days following notice of rejection of the deliverable, Contractor shall submit to Client a plan to resolve the deliverable failures. The plan shall outline specific steps for resolving the deliverable failures and a time for resolution and/or re-submission ("Resolution Date"). In the event that either the resolution plan or the Resolution Date is unacceptable to Client, Client shall have the option to: (1) insist that a new resolution plan be created, and/or a new Resolution Date be established; or (2) terminate the Services as they relate to the particular deliverable, or (3) terminate the entire Agreement for convenience and receive a refund for any monies paid, with respect to the particular deliverable

9. Subcontractors. Contractor will not utilize the services of any subcontractors in providing the services required hereunder without Client's prior written approval (which consent Client may grant or withhold in Client's sole and absolute discretion) and the execution of an addendum to this Agreement or within a Statement of Work setting forth the terms and conditions under which Client shall consent to the use of such subcontractors. Contractor shall be responsible for the conduct and performance of each approved subcontractor as if Contractor had performed all of the subcontracted Services. All references to Contractor in this Agreement in the context of providing Services, where applicable, will also include Contractor's employees and approved subcontractors.

10. Contractor Personnel.

A) Contractor may not, without prior written notice to Client, substitute the designated Contractor personnel identified in any Attachment A for other Contractor personnel or reassign or modify the duties of Contractor personnel during the term of the Agreement to other functions if so doing would require the alteration or reduction of such Contractor personnel's contribution or involvement with delivery of the Services hereunder. Under no circumstances shall any substitution of designated personnel result in an increase in any compensation due to Contractor under this Agreement, or a decrease in the quantity or quality of Services, as determined in Client's sole discretion.

B) In the event Contractor personnel is reassigned or becomes incapacitated for any reason and therefore becomes unable to perform the functions or responsibilities assigned to him or her, Contractor shall promptly temporarily replace such person with another person or persons (in the event additional resources shall be required in order to meet the project schedule and deliverable dates) properly qualified to perform the functions of such replaced person, and promptly thereafter permanently replace such replaced person with another person or persons approved by Client and properly qualified to perform the functions of such replaced person. Contractor shall bear all costs associated with the knowledge transfer to bring the replacement Contractor personnel up to speed on the Services and deliverables, but in no event more than five (5) working days for the replacement. In any event, Contractor shall not be relieved of any delivery dates nor shall it be entitled to charge additional fees for additional Contractor personnel required to perform the Services in a timely manner.

C) If at any time Client is dissatisfied with the performance of the Contractor personnel, Client may at its sole discretion report such dissatisfaction to Contractor and request a replacement, which Contractor shall promptly replace with a Contractor personnel that possesses equivalent or higher experience and skills.

11. Requests for Accommodation.

A) Contractor agrees to handle all requests for accommodations, received directly from its personnel or its Contract Worker. Client agrees to timely provide notice of any accommodation request received by Client Contractor's personnel/Contract Worker, and Contractor agrees to handle all such requests for accommodation.

B) Contractor agrees to notify Client of any requests for accommodation approved pursuant to the Americans with Disabilities Act and the details of the granted accommodation. Client agrees to timely response to Contractor as to whether or not that accommodation can be provided to the Contractor's personnel/Contract Worker at Client and agrees that such determination by Client shall be made consistent with the requirements of the Americans with Disabilities Act. Contractor agrees to incur the cost of any such accommodation. Client agrees to assist in providing the granted accommodation to the Contractor's personnel/Contract Worker. If Contractor denies the accommodation it agrees to notify Client that the request has been denied to and to provide Client with the reason for the denial. Client agrees that if Contractor approves an accommodation and Client cannot provide such accommodation, Client will provide the reason why it cannot provide that accommodation. Both Client and Contractor agree to engage in the interactive process. Client agrees that it will make parties necessary to evaluating any such requests available to Contractor for the purpose of providing requisite information. Contractor and Client agree that they will only exchange confidential information related to a request for an accommodation, to the extent necessary, and Contractor and Client agree to keep any such information confidential pursuant to applicable laws.

12. Business Conduct. While on Client's premises, Contractor and Contractor's employees, subcontractors/Contract Workers will abide by Client's reasonable security guidelines, and will comply with Client's professional business standards both in terms of appearance and conduct.

II. CLIENT RESPONSIBILITIES

Client shall inform appropriate Client personnel of Contractor's engagement so as to facilitate their cooperation with and prompt response to requests for information from Contractor and shall provide Contractor with necessary relevant information when requested and appropriate.

III. INDEMNIFICATION, LIMITATION OF LIABILITY AND INSURANCE

Indemnification. Contractor agrees to defend, indemnify and hold harmless Client and its directors, officers, employees, subcontractors and agents from and against all damages, costs (including reasonable attorneys' fees), judgments and other expenses arising out of or on account of:

(A) any liability for personal injury or physical damage caused to persons or real, intangible or tangible personal property at Client's site by the negligent or intentional acts or omissions of Contractor, its employees or agents during the performance of this Agreement, or

(B) any third party claim:

(i) alleging that the Services, deliverables, works or retained components, in the form delivered to Client by Contractor, infringe or misappropriate the U.S. patent, copyright, trademark or other proprietary or intellectual property rights of such third party.

Notwithstanding anything to the contrary, to the extent that any Services, deliverables, works or retained components are subject to an infringement of U.S. patent, copyright, or trademark or other proprietary or intellectual property rights of such third party claim, Contractor, at its own expense, shall
(a) obtain a license for Client's continued use of such infringing Services, deliverables, works or retained components, or (b) shall modify such Services, deliverables, works or retained components so that they are no longer infringing, without loss of material functionality. If Contractor is unable to provide one of the remedies in (a) nor (b) within thirty (30) days of notice of the claim (unless such period is extended by Client), Client shall have the right to terminate this Agreement or applicable Statement of Work (SOW) and Contractor shall within thirty (30) days of such termination refund to Client any amounts paid to Contractor by Client with respect to such Services, deliverables, works or retained components, which shall be Client' sole remedy with respect to such infringement claim; or

(ii) or arising out of Contractor's failure to comply with applicable laws and regulations in the performance of the Services, including but not limited to violation of data protection laws, or misuse or wrongful disclosure of personal or consumer information contained in Client databases; or

(iii) relating to any payments or benefits due to or claimed by an Contractor employee or contractor (including liability for any withholding, statutory or benefit payment).

Client agrees to indemnify and hold harmless Contractor from and against any losses, damages, expenses or other liabilities, including reasonable attorney's fees, incurred to the extent arising out of the Client's gross negligence or willful misconduct occurring within the course and scope of this Agreement.

The indemnified party shall: (i) provide prompt notice to the indemnifying party of any claim subject to indemnification, (ii) allow the indemnifying party to control the response to and defense of any related claim; and (iii) reasonably cooperate with the indemnifying party in the defense of same.

1. No Consequential Damages. IN NO EVENT WILL EITHER PARTY BE LIABLE TO THE OTHER FOR LOST PROFITS, SPECIAL, INCIDENTAL, PUNITIVE, CONSEQUENTIAL OR INDIRECT DAMAGES OF ANY KIND (INCLUDING, WITHOUT LIMITATION, COSTS OF COVER, LOST PROFITS OR LOSS OR DAMAGE TO DATA ARISING OUT OF THE USE, PARTIAL USE OR INABILITY TO USE THE RESULTS OF THE SERVICES) ARISING UNDER THIS AGREEMENT, AN SOW, OR IN THE COURSE OF CONTRACTOR PROVIDING ANY SERVICES TO THE CLIENT, WHETHER BASED IN CONTRACT, TORT (INCLUDING NEGLIGENCE), INTENDED CONDUCT OR OTHERWISE, EVEN IF THAT PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

2. Limitation of Liability. The aggregate liability of the indemnifying party , its affiliates and its employees, actuaries, directors, agents, and brokers (collectively the "Indemnifying Parties"), whether arising in contract, tort (including negligence), or otherwise, in connection with any of the Services provided under this Agreement, whether or not documented in an SOW, shall not exceed the amounts paid or payable to Contractor under any applicable SOW to which the liability relates and for the twelve (12) month period preceding the liability causing event.
NOTWITHSTANDING THE FOREGOING, THE LIMITATIONS SET FORTH IN THIS SECTION SHALL NOT APPLY TO CLAIMS ARISING OUT OF CONTRACTOR'S INDEMNIFICATION AND CONFIDENTIALITY

OBLIGATIONS UNDER THIS AGREEMENT OR CLAIMS ARISING OUT OF CONTRACTOR'S GROSS NEGLIGENCE OR WILLFUL MISCONDUCT.

This section shall not be applicable to any security incidents or breaches under HIPAA. Such breaches or incidents shall be governed by the Business Associate Addendum to this Agreement.

3. Insurance Requirements. Contractor shall maintain, throughout the performance of its obligations under this Agreement a policy or policies of worker's compensation insurance with such limits as may be required by law, and a policy or policies of general liability insurance insuring against liability to and death of persons and damage to and destruction of property arising out of or based upon any act or omission of Contractor or its respective officers, directors, employees, or agents. Client shall require Contractor and its approved Subcontractors to obtain and maintain in force, the following insurance:

(a) Workers Compensation Insurance in compliance with applicable Federal and State laws and Employer's Liability coverage with a minimum $1,000,000 limit of liability,

(b) Commercial General Liability Insurance with $3,000,000 bodily injury and property damage combined single limit of coverage, and

(c) Automobile bodily injury and property damage liability insurance covering owned, non-owned and hired automobiles, the limits of which shall not be less than $500,000 combined single limit per occurrence.

(d) Professional Liability insurance covering acts, errors, mistakes, omissions arising out of the work or services performed by Contractor Name, or any subcontractor, agent or person employed by the Contractor, with a limit of not less than $1,000,000 per claim.

Upon Client's request, Contractor shall provide Client with a certificate of insurance completed by its insurance carrier certifying that minimum insurance coverage as required above are in effect. Additionally, If Contractor is to perform work while on the premises of Client, all liability insurance shall name Client and such other parties as Client may identify as an additional insured with respect to the Services being performed and provide that such insurance is primary to any liability insurance carried by Client. All insurance policies carried by Contractor whether specified herein or otherwise shall contain endorsements waiving the insurer's rights of subrogation against Client. Client shall be given not less than thirty (30) days written notice prior to any cancellation or material change to any policy.

IF APPLICABLE- ADDITIONAL INSUREDS: Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802

Please fax or email a copy of the certificate of insurance to Miguel Torres - fax: 562-951-1580 email: procurementservices@molinahealthcare.com. Otherwise, send a hard copy certificate to:

Molina Healthcare, Inc.
Attn: Procurement Services
200 Oceangate, Suite 100
Long Beach, CA 90802

4. Drug Free Policy. Contractor agrees to notify its employees who perform services under this Agreement ("Contractor Employee(s)") of the Client's policy concerning drug and alcohol use that prohibits (a) the use, possession, distribution, purchasing or selling drugs or alcohol on Client's premises or while engaged in Client's business and (b) reporting to and/or performing work for Client while under the influence of same (except for authorized amounts of prescribed drugs required for health reasons).

IV. REIMBURSEMENT

1. Fees. Client agrees to compensate Contractor on the fee basis set forth in Attachment A. Client shall pro-rate Contractor's monthly rate of compensation in the event this Agreement is terminated prior to the end of the month. Otherwise, Client agrees to be responsible for all fees and expenses incurred for the project up to and including the final day of work.

2. Billing and Payment. Contractor shall submit a detailed invoice reflecting service(s) provided and applicable fees. Client shall pay approved invoices within 30 days after Client's receipt of invoice. Fees for travel and related

expenses shall be governed by Attachment C, Molina Healthcare, Inc. Corporate Travel Policy, appended hereto and incorporated herein by this reference.

V. TERM OF AGREEMENT

This Agreement will become effective on the Effective Date as noted on the first page of this Agreement and will continue until termination as provided in Section VI.

Upon termination both parties will determine in consultation with each other the portion of any fees or retainer earned to date. For any Services performed on an hourly basis, Client agrees agree to pay Contractor for all hourly time charges for Services performed up to the effective date of termination.

VI. TERMINATION OF AGREEMENT

3. For Convenience. Either party may terminate this Agreement for its convenience at any time by giving thirty (30) days prior written notice to the non-terminating party. If applicable, upon termination of this Agreement both parties shall consult with each other to determine the portion of any fees or retainer earned up to the effective date of termination. For Services performed on an hourly basis, Client agrees agree to pay Contractor for all hourly time charges for Services performed up to the effective date of termination.

4. For Cause. Either party hereto may terminate this Agreement by providing the other party with a minimum of ten (10) business days prior written notice in the event the other party commits a material breach of any provision of this Agreement. Said notice must specify the nature of said material breach. The breaching party shall have seven (7) business days from the date of the breaching party's receipt of the foregoing notice to cure said material breach. In the event the breaching party fails to cure the material breach within said seven (7) business days period, this Agreement shall automatically terminate upon expiration of the ten (10) business days notice period.

5. Return of Information. Upon request of Client, Contractor shall immediately return to Client any and all information acquired by Contractor during this Agreement. Upon the cessation of this Agreement, Contractor shall immediately return to Client all information acquired by Contractor during the course of the Agreement.

6. Return of Property. All Company property in the possession or control of Contractor including, but not limited to specifications, documentation, source code, magnetic media, and building/parking entry keys and cards, as well as all material developed or derived by Contractor in performing its duties under this Agreement will be returned by Contractor to Company on demand, or at the termination of this Agreement whichever shall come first.

VII. CONFIDENTIALITY, PROTECTED HEALTH INFORMATION, INJUCTIVE RELIEF

1. Confidentiality. Neither Client nor Contractor shall disclose, directly or indirectly, without the prior approval of the other, (i) the terms of this Agreement and/or any Services provided; or (ii) any other non-public information about the other party's business or activities that is proprietary and confidential, which information will include any and all business, all strategic and development plans, results of the Services, business plans, information about parent, subsidiaries or sister companies, co-developer identities, data, business records, customer lists, policy information, personally identifiable information, personal financial information or personal health information (as those terms are defined by governing law), product designs, test data, project records, market reports, investor information, know-how, discoveries, ideas, concepts, specifications, models, diagrams, methodologies, research, technical and statistical data, drawings, models, flow charts, work-flow, marketing, pricing, selling, distribution, database descriptions, software code, source code, object code, Intellectual Property, and any and all other tangible or intangible information, other than trade secrets, encompassed in any medium, which may be disclosed, whether or not in writing, whether or not marked as "Confidential" or "Proprietary" by the disclosing party or to which the receiving party may be provided access to by disclosing party in accordance with this Agreement, or which is generated or learned as a result of or in connection with the Services and is not generally available to the public. "Confidential Information" also includes proprietary or confidential information of any third party that may disclose such information to either party in the course of that party's relationship with a party.

The above obligations shall not apply to Confidential Information which is already known to the to either party at the time it is disclosed, or which before being divided either (a) has become publicly known through no wrongful act of the parties; (b) has been rightfully received from a third party without restriction on disclosure and without breach of this Agreement; (c) has been approved for release by written authorization of Client; (d) has been disclosed pursuant to a requirement of a governmental agency or of law.

2. HIPAA Language. If Contractor, in performing its obligations under this Agreement, will have access to "protected health information" ("PHI") about individuals as defined under the Health Insurance Portability and Accountability Act ("HIPAA") of 1996 and the privacy and security rules promulgated there under, as amended from time to time then the parties agree to abide by the terms and conditions set forth in Attachment B – Business Associate Agreement, appended hereto and incorporated herein by this reference.

3. Enforcement and Injunctive Relief. Contractor and Client agree that if any party to this Agreement violates any of the provisions of this Agreement, that the aggrieved party shall be entitled to any and all applicable remedies at law and/or equity to prevent further breach of this Agreement, including injunctive relief, without posting bond. Contractor acknowledges that any unauthorized use or disclosure of Confidential Information would result in damage to Client that may be intangible but nonetheless real, and that is incapable of complete remedy by an award of damages. Accordingly, any such violation shall give Client the right to a court-ordered injunction or other appropriate order to specifically enforce the provisions of this Agreement. Contractor agrees to pay to Client any reasonable expenses, including but not limited to attorneys' fees, incurred in obtaining and collecting any remedies, relief or damages.

VIII. CLIENT'S INTELLECTUAL PROPERTY

1. Contractor acknowledges Client, and/or its affiliates' ownership of, and full and exclusive rights in and to, any of Client's trademarks, service marks, trade names, works protected by copyright, or other designations or property rights (the "Existing Intellectual Property") which Contractor uses or produces in connection with its performance under this Agreement. Contractor agrees to use the Existing Intellectual Property only in the manner and form approved by Client and agrees that all use of the Existing Intellectual Property will inure to the benefit of Client. Nothing in this Agreement shall be construed or deemed to give Contractor any property, right or interest in any of the Existing Intellectual Property.

2. Client, and/or its affiliates, shall retain all ownership rights it may have in all materials delivered to Contractor by or on behalf of Client. Contractor shall use its reasonable efforts to protect such materials against any loss, theft, damage or destruction. Contractor shall return all originals and copies of such materials to Client upon Client's request, and in any event,

immediately upon termination of this Agreement. After expiration or termination of this Agreement, Contractor will immediately cease all use of the Existing Intellectual Property, and shall not permit others to make any such use.

3. Contractor hereby acknowledges that any and all software, documentation and Services, as well as any other data that Contractor may prepare, deliver or has prepared or delivered (in whole or in part) during its engagement with Client and pursuant to this Agreement which: (i) relate in any way to Client's business, or (ii) result in any way from the use of Client's premises, property, facilities, or time whether or not done during normal working hours, are made for hire and that Client owns all rights thereto, including any copyright in all or any portion thereof, and Contractor hereby irrevocably assigns any rights Contractor might have in any such materials or items to Client. Contractor shall execute or record (or cause to be executed or recorded) such further documents, instruments or agreements to evidence or reflect such assignment. Contractor hereby irrevocably appoints Client, as its attorney-in-fact to execute or record such documents, instrument or agreements, in the event that Contractor does not timely execute or record such documents, instruments or agreements as determined by Client.

IX. NOTICES

Notices. Any notices required under this Agreement, shall be made in writing and given to the other party by personal delivery or certified mail at the following addresses:

If to Contractor:

Insert Vendor contact/notice info here

If to Client:

All Contract or Legal Notices: Molina Healthcare, Inc. **General Counsel** 300 University Avenue, Suite 100 Sacramento, CA 95825	All Invoices Should be Directed to: Molina Healthcare, Inc. P.O. Box 22813 Long Beach, CA 90801 Attn: Accounts Payable Or emailed to: MHIinvoicehelp@Molinahealthcare.com

X. Arbitration.

Any claim or controversy arising out of or in connection with this Agreement shall be resolved, to the extent possible, within forty-five (45) days through informal meetings and discussions between appropriate representatives of the parties. Any remaining claim or controversy shall be resolved through binding arbitration conducted by a single arbitrator in accordance with the AAA Commercial Arbitration Rules, then in effect, in Long Beach. CA. If possible, the arbitrator shall have at least five (5) years' experience in managed health care. The parties shall conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator shall have no authority to award damages or provide a remedy that would not be available to such prevailing party in a court of law or award punitive damages. Each party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator's and administrative fees. The parties agree to accept any decision by the arbitrator as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. Arbitration must be initiated within one (1) year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise it shall be deemed waived. The use of binding arbitration shall not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

XI. General Terms and Conditions

1. Debarment or Exclusion. Each party represents and warrants that to the best of its knowledge neither it nor any of its officers, directors or employees (including any personnel) will ever have been listed by a federal or state agency as debarred, excluded or otherwise ineligible for participation in any federal or state program. Each party will promptly notify the other party in the event it is debarred or disqualified from participating in any state or federal program or it obtains knowledge that any officer, director or employee (including any personnel) is listed by a federal or state agency as debarred, excluded or otherwise ineligible for participation in any federal or state program. In the event that either party is excluded from participation in any federally funded health care program during the term of this Agreement, or if at any time after the Effective Date of this Agreement it is determined that the excluded party is in breach of this Section, this Agreement shall, as of the effective date of such exclusion or breach, automatically terminate.

2. Assignment. Neither party may sell, assign, transfer, or otherwise convey any of its rights or delegate any of its duties under this Agreement without the prior written consent of the other party; provided, however, that either party may without the prior consent of the other party assign all of its rights under this Agreement to: (a) its Affiliate; (b) a purchaser of all or substantially all of its stock or assets; or (c) a third party participating in a merger or other corporate reorganization in which the assigning party is a constituent corporation. A written notice of such assignment shall be provided to the non-assigning party. This Agreement will be binding upon and inure to the benefit of the parties and their respective successors and permitted assigns. Under such assignment, the terms and condition of this Agreement shall remain in full effect and cannot be replaced by any new assignee. Any attempted assignment of this Agreement not in accordance with this section shall be null and void.

3. Publicity. Neither party shall use the name, logo, trademark, trade name, or other marks of the other party or its affiliates without such party's prior written consent, which may be withheld in either party's sole discretion.

4. Severability. If any clause, sentence, provision, or other portion of this Agreement is or becomes illegal, null, void or unenforceable for any reason, or is so held by any court of competent jurisdiction, the remaining portions shall remain in force and effect.

5. Waiver. No assent or waiver, express or implied, of any breach of any one or more of the covenants, conditions or provisions hereof shall be deemed or taken to be a waiver of any other covenant, conditions or provision hereof, or a waiver of any subsequent breach of the same covenant, condition or provision hereof.

6. Affirmative Action. During the performance of this Agreement, Contractor agrees to comply with all Federal, state and local laws respecting discrimination in employment and non-segregation of facilities including, but not limited to, requirements set out at 41 CFR 60-1.4, 60-300.5, and 60-741.5, which equal opportunity clauses and reporting requirements are hereby incorporated by reference.

7. Governing Law. This Agreement shall, in all respects, be interpreted, construed, enforced and given effect according to the laws of the State of California, excluding its principles of conflicts of laws.

8. Immigration Compliance. Contractor warrants, represents and agrees that it will not assign any of its employees or other individual to perform work under this Agreement who is an unauthorized alien under the immigration and reform and control act of 1986 (as the same has been or may be amended) or its implementing regulations.

9. Export Regulations. Contractor acknowledges its obligations to control access to technical data under the U.S. Export Laws and Regulations and agrees to adhere to such laws and regulations with regard to any technical data received under this Agreement.

10. Inspection and Access. Client shall at all times have access to the Contractor's work product developed under this Agreement whenever in preparation, and Contractor shall facilitate such access and inspection thereof; inspection or lack of inspection by Client shall not be deemed to be a waiver of any of its rights under Contractor's guarantees or its right to subsequently reject defective Services.

11. Captions and Construction. The captions used as headings of the various Sections hereof are for convenience only, and the parties agree that such captions are not to be construed to the part of this Agreement or to be used in determining or construing the intent or context of this Agreement.

12. Counterparts; Faxes. This Agreement may be executed in counterparts, each of which so executed will be deemed to be an original and such counterparts together will constitute one and the same agreement. The Parties may execute this Agreement by exchange of faxed or scanned signatures, which both Parties agree shall be an acceptable delivery method of a manually executed counterpart of this Agreement.

13. Electronic Signatures. In the event that an electronic signature is used, both Parties represent and warrant that the electronic or digital signature is an official signature of the Parties authorized representative.

14. Entire Agreement. This Agreement shall consist of the terms and conditions set out in the main body of this Agreement together with those provisions set out in any Schedule, Exhibit, Attachment and/or Addenda ("Documents") relating to this Agreement and signed by the parties to this Agreement. This Agreement shall constitute the entire, integrated agreement and understanding between the parties and supersedes all prior agreements, representations and understandings between the parties, whether written or oral. This Agreement may not be amended or modified except by an instrument in writing executed by the parties hereto.

IN WITNESS WHEREOF, the parties have duly executed this Agreement by their authorized representatives as of the Effective Date.

Vendor Name	**MOLINA HEALTHCARE, INC.**
By: _____	By: _____
Printed: _____	Printed: _____

Title: _____

Date: _____

Title: _____

Date: _____

Attachment A-1

Insert Scope of Services, Statement of Work or Schedule of Services here

Services/SOW's should include:

list and description of deliverables and schedules,
definitions of any key or special words, systems, etc.
items out of scope (exclusions),
schedule/type of fees/expenses,
contact list data including subcontractors, resumes.
Subsequent SOW's will become Attachment A-2, A-3 A-4, etc.

Sample SOW format

Attachment A-1
STATEMENT OF WORK ("SOW")

REFERENCE NUMBER: _____ (Supplier's internal number)

Molina Healthcare, Inc., and its subsidiaries and affiliates (the "Client")
Contractor Name [insert office address] (the "Contractor").

This Work Order, is issued pursuant to and incorporates and is governed by the Master Services Agreement [the "AGREEMENT" or "MSA"] between the parties dated [ ], and sets forth the specific terms and conditions relating to the provision of Services referred to in this SOW. The combination of the terms of the MSA and the provisions of this SOW shall together constitute the contract between the parties in respect of the Services ("the AGREEMENT"). To the extent that there is a conflict between the SOW and the AGREEMENT, the AGREEMENT shall prevail.

NOW THEREFORE IT IS HEREBY AGREED as follows:

Contractor agrees to provide the Services as set out in this SOW.

I Services to be provided

i. Definition of Services

ii. Scope of Services

iii. Location of Services

iv. Deliverables

v. Contractor Intellectual Property *(Please specify if any Contractor proprietary IP is being used.)*

vi. Third Party Software/Materials *(Please specify third party software being used.)*

vii. ***Milestones*** *[if applicable – indicate Critical Milestones as "Critical"*

viii. Acceptance Criteria *[For Fixed Price Development projects]*

ix. Acceptance Procedure *[For Fixed Price Development projects]*

x. Dependencies

xi. Assumptions

II Contacts

Project Executives

The following Project Executives shall assume operational responsibility for this SOW.

Client Project Executive:

Telephone	
Fax	
E-Mail	

Contractor Project Executive :

Telephone	
Fax	
E-Mail	

Other Contacts

Telephone	
Fax	
E-Mail	

III Reporting & Meetings

IV RESERVED

V Term

The Services under this SOW shall commence on: _____and be completed/expire on _____ unless terminated as provided in the AGREEMENT.

VI Charges/Fees

[Specify Rates if not specified]

All rates specified are exclusive of taxes.

[Choose Appropriate Option for Payment]

Payment Schedule for Fixed Charges (option 1)

	Deliverable	Due Date	Payment	% of Total
1				
2				

Time and materials Charges (option 2)

Role	Grade	Base	No of	Daily	Currency

		Location	Days	rate	

(Time and Material Rates Are Valid For a Period of Two Years from Date of Execution of the Work Order)

Invoicing Instructions
Invoices should be emailed to: MHIinvoiceHelp@MolinaHealthcare.com

Or mailed to:

Molina Healthcare, Inc.
P.O. Box 22813
Long Beach, CA 90801

All undisputed invoices shall be paid within 30 days of Customer's receipt of invoice.

Execution:

Contractor Name.	**Molina Healthcare, Inc.**
_____	_____
Authorized Signatory	Authorized Signatory
_____	_____
Name	Name
_____	_____
Title	Title
Date:	**Date:**

Sample SOW format

Exhibit B
(Hourly Rate Card for Time & Material Based Services)

Change/Add titles to fit Project, these are just sample IT titles)

Lead Architect	**$XXX.00**
Senior Consultant	**$XXX.00**
Infrastructure Consultant	**$XXX.00**
Microsoft Technology Consultant	**$XXX.00**
Storage Consultant	**$XXX.00**
Project Management	**$XXX.00**
Project Coordinator	**$XXX.00**
System Administration and Support	**$XX.00**
Programmer	**$XXX.00**

Offshore Titles/rates

Attachment B

BAA

Would be inserted here if required if access/use of PHI required

ATTACHMENT C
MOLINA HEALTHCARE, INC. CORPORATE TRAVEL POLICY

I. TRAVEL ARRANGEMENTS: All travel arrangements must be arranged using the following requirements:

A. Air Travel. The Company will reimburse all business air travel as long as such travel is at the lowest cost available, short of endangering the reason for the trip or the business needs dictated by a customer. The guidelines surrounding our travel policy are as follows:

The lowest available airfare, regardless of penalties or restriction, must be utilized by anyone traveling at the expense of Molina. Any tickets being requested within seven (7) days of travel require Molina management (contact) approval before the ticket can be issued.

The traveler will confirm the lowest airfare available on the requested routing. The traveler will check all flights one-and-a-half hours before and one-and-a-half hours after the originally requested arrival, for the lowest available airfare and book lowest fare options.

B. Lodging. The Company will pay only actual room rental costs supported by the hotel bill for each day that lodging away from home is required for business reasons. Molina travelers will be required to stay at hotels with a Molina Healthcare rate contract if such a hotel has rooms available and is within seven miles of the traveler's destination. All lodging shall be booked through the Molina's authorized travel agency. See contact information at the bottom of attachment.

C. Car Rentals. The Company will reimburse car rentals only when other means of transportation are unavailable, more costly, or impractical. The use of a rental car must be justified as a business need and not as a matter of personal convenience. The use of intermediate or full-size cars is acceptable only when two or more contractors are traveling together and sharing the rental car, or when it is necessary to have a larger vehicle for carrying clients or equipment.

D. Other Transportation.

Personal Car. The Company prefers travel through use of public transportation, but a contractor's automobile should be used when other transportation is unavailable or economy can be realized. The Company will reimburse the contractor at the rate of $0.55 (as amended by the IRS from time to time) per mile over and above the normal commute, plus parking and tolls, for authorized business use of personal cars. The normal commute includes a contractor's drive to his/her office if located in the same city in which the contractor resides.

Taxi and Other Out-of-Town Transportation. The cost of a taxi to and from places of business, hotels, or airports in connection with business activities is reimbursable. Use of taxis is authorized only when more economical services (hotel vans, shuttles, etc.) are not available. Contractors are encouraged to utilize public transportation whenever feasible. Receipts are required for all transportation expenses.

II. MEALS

Molina may determine standard per diem for meals and incidental expenses when traveling (overnight away from home), and in any case, will be limited to no more than $75.00 (tax and tip included). Detail receipts are required for all meals. "Business Meals" shall be reasonable and appropriate to Molina business undertaken. If applicable, document attendees, position, and business purpose.

Contact for Travel agency

Dave Green
Corporate Sales Executive
Montrose Travel – Corporate Division
2355 Honolulu Ave, Montrose CA 91020
T: 818-553-3349 or 800-766-4687 ext 549 F: 818-550-6682
E: egreen@montrosetravel.com
www.MontroseCorporateTravel.com

Attachment D

Offshore Resources

[Contractor Name]
[Contractor Address]
[Address line 2]
[City, State, Zip]

[Contractor Contact Name]
[Contractor Contact Phone]

This Attachment D is an attachment to the MSA and incorporated therein by reference.

Offshore Resources include any human resources or technological resourced located outside of the U.S. used to perform the Services under the Agreement or used to transmit, disclose, display, maintain, or access PHI outside of the U.S. The following details the Offshore Resources utilized by [Contractor Name]:

[Contractor shall provide, here in Attachment D, specific information on where the work will be done, what services will be performed offshore, the volume of work being performed offshore, and the date Contractor will begin performing work offshore.

If a subcontractor is performing the work, please provide, in addition to the aforementioned specifications, name of the subcontractor, and an acknowledgement on whether or not the subcontractor has entered into a confidentiality agreement with Contractor that is at least as strict as the confidentiality agreement that Contractor has entered into with Molina.

In the event that PHI is sent to a location offshore or accessed from a location offshore, please provide the following in addition to the aforementioned specifications: the precise offshore location where such PHI has been sent or is being accessed from, the volume of PHI sent offshore or accessed from offshore; and the specific technical/physical/administrative safeguards used to protect PHI sent offshore and accessed from offshore. Additionally, please state whether or not any data proposed to be sent offshore or accessed from offshore contains any PHI of Molina Healthcare's Medicare members.]

Please note that Molina Healthcare PHI must never be sent offshore without express written approval by an authorized Molina Healthcare representative.

The information provided above is current as of the Effective Date of the Master Agreement. Contractor acknowledges and agrees that this Attachment D must be amended and accepted in writing by Molina Healthcare prior to any change of location, change of subcontractor receiving or accessing PHI offshore, any material change in safeguards for the protection of PHI, any material increase in work being performed offshore, or any material change in the volume of PHI being sent offshore or accessed from offshore. Molina Healthcare's approval of changes to Attachment D will not be unreasonably withheld.

Contractor acknowledges and agrees that Client, at any time, may require all services to be brought back onshore to the United States of America due to changes in laws, regulations, or state contractual requirements.

Accepted by:

CONTRACTOR NAME	**MOLINA HEALTHCARE, INC.**
Signature: _____	Signature: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Molina Healthcare of Iowa, Inc.
Hospital Services Agreement

SIGNATURE AUTHORIZATION

In consideration of the promises, covenants, and warranties stated, the parties agree as set forth herein. The Authorized Representative for each party executes this Agreement with the intent to bind the parties in accordance with applicable Laws. The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and proper authorization to act on behalf of Hospital. The Authorized Representative further acknowledges he/she received and reviewed the entirety of this Agreement.

Hospital Signature

Hospital's Legal Name ("Hospital") – as listed on applicable tax form (i.e. Tax Form W-9) and any doing business as name		
Authorized Representative's Signature	Title	Signature Date
Authorized Representative's Name – Printed	Hospital Telephone Number	

Hospital Information

Mailing Address – Official Correspondence	Billing / Payment Address – if different than Mailing Address
Fax Number – Official Correspondence	Tax ID Number – as listed on applicable tax form
E-mail Address – Official Correspondence	NPI Number – that corresponds to the listed Tax ID Number

Health Plan Signature and Information

Molina Healthcare of Iowa, Inc., a Iowa Corporation ("Health Plan")		
Authorized Representative's Signature	Title	Countersignature Date
Authorized Representative's Name – Printed	Mailing Address – Official Correspondence	
E-mail Address – Official Correspondence		

HOSPITAL SERVICES AGREEMENT

This Agreement is entered into between Health Plan and Hospital as set forth and made effective as of the date of Health Plan's countersignature ("Effective Date").

RECITALS

A. Health Plan arranges for the provision of certain health care services to Members pursuant to contracts with various government sponsored health products/programs ("Government Programs") and other products/programs, as applicable. Health Plan intends to participate in additional Government Programs and offer other health products/programs as the opportunities become available.

B. Health Plan is a domiciled corporation that has been issued a certificate of authority by the appropriate state licensing agency to provide health care services to Members. Health Plan also is certified, licensed and/or approved by all other required agencies to provide health care services to eligible recipients.

C. Health Plan arranges for the provision of certain health care services to Members by entering into provider service agreements with individual physicians, groups of physicians, individual practice associations, hospitals, clinics, ancillary health providers, and other health providers.

D. Hospital is licensed to render certain health care services and desires to provide such services to Health Plan's Members in connection with Health Plan's contractual obligations to provide and/or arrange for health care services for Health Plan's Members.

Now, therefore, in consideration of the promises, covenants and warranties stated herein, Health Plan and Hospital agree as follows:

ARTICLE ONE – DEFINITIONS

1.1 Capitalized words or phrases in this Agreement have the meaning set forth in Attachment A.

ARTICLE TWO – PROVIDER OBLIGATIONS

2.1 **Provision of Hospital Services.** Hospital agrees to provide Hospital Services to Members within the scope of Hospital's business, practice and license, and in accordance with applicable Law and the terms of this Agreement including, but not limited to, the Provider Manual, Health Plan's QI and UM Programs and applicable Accreditation Organization standards.

2.2 **Hospital Standards.**

a. **Standard of Care.** Hospital will provide Hospital Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and standards of professional conduct, and any controlling governmental licensing requirements.

b. **Facilities, Equipment, and Personnel.** Hospital's facilities, equipment, personnel and administrative services will be at a level and quality as necessary to perform Hospital's duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.

c. **Prior Authorization.** Prior to admitting any Member as an inpatient or outpatient, Hospital will obtain the prior authorization of Health Plan in accordance with Provider Manual unless the situation is one involving the delivery of Emergency Services. For Emergency Services that result in an admission, Hospital will notify Health Plan or its agent within twenty-four (24) hours of admission and will request authorization from Health Plan prior to the provision of any post-stabilization care. For non-emergent services, regardless of whether prior authorization was received, Hospital will cooperate and participate in Health Plan's notification procedures described in Provider Manual for all inpatient (acute, rehabilitation, mental health and SNF) and outpatient admission on the same day of admission or at a maximum within twenty-four (24) hours of admission. Failure to receive prior authorization from Health Plan may result in Claim denial.

d. **Use of Participating Providers.** Except in the case of Emergency Services or where Hospital obtains the prior authorization of Health Plan, Hospital will utilize Health Plan's Participating Providers to provide Hospital Services to Members. Should Health Plan have no Participating Provider to render Medically Necessary Hospital Services, Health Plan will use reasonable efforts to coordinate an out of network agreement with an appropriate provider.

e. **Member Eligibility Verification.** Hospital will verify eligibility of Members prior to rendering services unless the situation is one involving the delivery of Emergency Services.

f. **Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Hospital will abide by Health Plan's drug formularies and prescription policies, including those regarding the

prescription of generic or lowest cost alternative brand name pharmaceuticals. Hospital will obtain prior authorization from Health Plan if Hospital believes a generic equivalent or formulary drug should not be dispensed. Hospital acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Hospital.

g. **Availability of Services.** Hospital will make Hospital Services available twenty-four (24) hours a day, seven (7) days a week. Hospital will meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

h. **Treatment Alternatives.** Health Plan encourages open Hospital-Member communication regarding appropriate treatment alternatives. Health Plan promotes open discussion between Hospital and Members regarding Medically Necessary or appropriate patient care, regardless of limitations on Covered Services. Hospital is free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Health Plan's decision to terminate or refuse to contract with a Hospital will not be based in whole or in part on the fact that the Hospital discussed medical treatment options with a Member.

2.3 **Standards for Hospital Providers.**

a. **Hospital Providers.** Hospital will have a sufficient number of Hospital Providers to provide Hospital Services and meet the needs of Health Plan and its Members as determined by Health Plan's Quality Improvement Program and in accordance with the Law. Hospital will be responsible for the Hospital Services provided by Hospital Providers.

b. **Contract with Hospital Providers.** Hospital's contract with its Hospital Providers will be in writing and will bind Hospital Providers to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance and billing of Members for Hospital Services.

c. **Hospital Provider Information.** Upon request, Hospital will provide Health Plan with a complete list of its Hospital Providers, together with the provider specific information required by Health Plan for credentialing and for administration of its health programs.

d. **Restriction, Suspension or Termination of Hospital Provider(s).** Hospital will immediately restrict, suspend or terminate Hospital Providers(s) from providing Hospital Services to Members in the following circumstances: (i) the Hospital Provider(s) ceases to meet the licensing/certification requirements or other professional standards as specified in this Article; or (ii) Health Plan or Hospital reasonably determine that there are serious deficiencies in the quality of care of the applicable Hospital Provider(s) which affects or could adversely affect the health or safety of Members. Hospital will immediately notify Health Plan of such action(s).

e. **Staffing Privileges.** Hospital agrees to use its best efforts to arrange staff privileges or other appropriate access for Health Plan's Participating Providers, Health Plan's medical directors and hospitalist providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standard of practice and credentialing standards established by Hospital's medical staff and the bylaws, rules and regulations of Hospital.

f. **Notification.** Hospital will notify Health Plan within five (5) business days should any disciplinary or other action of any kind be initiated against any Health Plan or Hospital Provider which could result in any suspension, reduction or modification of Hospital Provider's hospital privileges. Hospital's notification to Health Plan will state Hospital's actions taken against the Hospital Provider or Health Plan provider. If Hospital fails to act as required by this Article with respect to any of its Hospital Provider(s) or Health Plan reasonably determines and provides documentation to Hospital that there are serious deficiencies in the professional competence, conduct, or quality of care of the Hospital Provider which could adversely affect the health and safety of Members, Health Plan will have the right to prohibit such Hospital Provider(s) from continuing to provide Hospital Services to Members.

2.4 **Rights of Members.** Hospital will observe, protect and promote the rights of Members.

2.5 **Corrective Action.** Health Plan and certain state and federal regulators routinely monitor the level, manner, and quality of Covered Services provided pursuant to this Agreement as well Hospital's compliance with the terms of this Agreement. In the event a deficiency is identified, Health Plan or regulator, in their sole discretion, may choose to issue a corrective action plan, and Hospital will be required to accept and implement such a corrective action plan. A corrective action plan is not required to be given to Hospital before issuing a Termination with Cause or an Immediate Termination.

2.6 **Promotional Activities.** At the request of Health Plan, Hospital will: (i) display Health Plan promotional materials in its offices and facilities as practical; and (ii) cooperate with and participate in all reasonable Health Plan marketing efforts so long as it does not violate applicable Law. Hospital will not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan.

2.7 **Nondiscrimination.**

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

b. Employment. Hospital will not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual's ability to perform the duties of the particular job or position.

2.8 **Recordkeeping.**

a. **Maintaining Member Medical Record.** Hospital will maintain a medical and billing record for each Member to whom Hospital renders health care services. Hospital will open each Member's medical record upon the Member's first Encounter with Hospital. The Member's medical record will contain all information required by Law, generally accepted and prevailing professional practice, applicable Government Programs, and all Health Plan policies and procedures. Hospital will retain all such records for as long as required by applicable Law and/or Government Contracts. This section will survive the termination of this Agreement or an individual product/program.

b. **Confidentiality of Member Health Information.** Hospital will comply with all applicable Law, Health Plan's policies and procedures, Government Program requirements regarding privacy and confidentiality of Members' health information and medical records, including mental health records. Hospital will not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision will not affect or limit Hospital's obligation to make available medical records, Encounter Data and information concerning Member care to Health Plan, any authorized state or federal agency, or other providers of health care upon authorized referral.

c. **HIPAA.** Hospital will comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act and any regulations promulgated thereunder (collectively the "HIPAA Rules").

d. **Delivery of Patient Care Information.** Hospital will promptly deliver to Health Plan, upon request and/or as may be required by Law, Health Plan's policies and procedures, applicable Government Programs, Health Plan's contracts with the government agencies, or third party payors, any information, statistical data, Encounter Data, or patient treatment information pertaining to Members served by Hospital, including but not limited to, any and all information requested by Health Plan in conjunction with Health Plan's UM Program, grievances, peer review, Healthcare Effectiveness Data and Information Set ("HEDIS") studies, Health Plan's QI Program, Consumer Assessment of Healthcare Providers and Systems ("CAHPS"), Medicare and/or Medicaid risk adjustment, or Claims payment. The party producing the records will be responsible for any fees associated with producing such records. Hospital will further provide direct access to said patient care information as requested by Health Plan and/or as required by any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan. Health Plan will have the right to withhold compensation from Hospital in the event that Hospital fails or refuses to promptly provide any such information to Health Plan. This section will survive the termination of this Agreement or an individual product/program.

e. **Member Access to Health Information.** Hospital will give Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with applicable Law, applicable Government Programs, and Health Plan's policies and procedures. This section will survive the termination of this Agreement or an individual product/program.

2.9 **Program Participation.**

a. **Participation in Grievance Program.** Hospital will participate in Health Plan's Grievance Program and will cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.

b. **Participation in Quality Improvement Program.** Hospital will participate in Health Plan's Quality Improvement Program and will cooperate with Health Plan in conducting peer review and audits of care rendered by Hospital.

c. **Participation in Utilization Review and Management Program.** Hospital will participate in and comply with Health Plan's Utilization Review and Management Program, including all policies and procedures regarding prior

authorizations, and will cooperate with Health Plan in audits to identify, confirm, and/or assess utilization levels of Hospital Services.

d. **Participation in Credentialing.** Hospital will cooperate with, participate in and satisfy all credentialing and re-credentialing criteria established by Health Plan prior to the Effective Date and provision of Covered Services set forth in and in accordance with and throughout the term of this Agreement. Hospital will immediately notify Health Plan in writing of any change in the information submitted or relied upon by Hospital in order to achieve or maintain credentialed status. All Participating Providers must be credentialed in accordance with Health Plan's policies and procedures, by Health Plan or its designee, prior to treating Members.

e. **Provider Manual.** Hospital will comply with and render Covered Services in accordance with the contents, instructions and procedures set forth in the Provider Manual, which is incorporated herein by reference and which may be unilaterally amended from time to time by Health Plan. Health Plan's Provider Manual is made available to Hospital at Health Plan's website.

f. **Supplemental Materials.** In addition to the contents, instructions, and procedures set forth in the Provider Manual, Health Plan may periodically promulgate bulletins or other written materials that may or may not be used to supplement the Provider Manual or may be used to provide additional instruction, guidance or information to Hospital ("Supplemental Materials"). Health Plan may issue such Supplemental Materials in an electronic format. Hospital can obtain paper copies upon request. Revisions to the Supplemental Materials shall become binding upon Hospital as of the effective date indicated on the Supplemental Materials. If applicable, such effective date shall be determined in accordance with the terms of this Agreement.

g. **Health Plan's Electronic Processes and Initiatives.** Hospital will participate in and comply with Health Plan's electronic processes and initiatives, including but not limited to, electronic submission of prior authorization, Health Plan access to electronic medical records, electronic claims filing, electronic data interchange ("EDI"), electronic remittance advice and electronic funds transfers, registration and use of Health Plan's interactive web portal. Such programs, registration, and use are contained and described in the Provider Manual or Supplemental Materials.

h. **Government Contracts.** Hospital acknowledges that Health Plan has entered into contracts with state and federal agencies for the arrangement of health care services for Members through Government Programs. Hospital will comply with any term or condition of those Government Contracts that are applicable to the Hospital Services to be performed under this Agreement. Health Plan will give Hospital a copy of any applicable Government Contract(s), upon request by Hospital.

i. **Health Education/Training.** Hospital will participate in and cooperate with Health Plan's provider education and training efforts as well as Member education and related efforts. Hospital will also comply with all Health Plan health education, Health Plan's Cultural Competency Plan, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Hospital will ensure prompt delivery to any constituent providers all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Hospital Services to Members.

2.10 **Hospital Information.** Hospital will deliver to Health Plan a complete list of its healthcare providers, facilities, and business/practice locations that it uses to provide Covered Services, together with specific information required for credentialing and administration in a format acceptable to Health Plan. Hospital will deliver such information prior to the execution of this agreement and every six (6) months thereafter or promptly provide notice when there is any change to such information. Health Plan also reserves the right to request such information at any time.

2.11 **Licensure and Standing.**

a. **Licensure.** Hospital warrants and represents that it is appropriately licensed to render health care services within the scope of Hospital's practice, including having and maintaining a current narcotics number, where appropriate, issued by all proper authorities. Hospital will provide evidence of licensure to Health Plan upon request. Hospital will maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Hospital will immediately notify Health Plan of any change in Hospital's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Hospital.

b. **Unrestricted Status.** Hospital warrants and represents that it has not been and is not currently excluded from, and will immediately notify Health Plan in the event it becomes excluded from, participation in Medicare and/or state health care programs pursuant to Section 1128 of the Social Security Act (42 U.S.C. 1320a-7) ("Section 1128") for any of the following: (i) conviction of a crime; (ii) assessment of a civil penalty; (iii) entered into a contractual relationship with an entity convicted of a crime; and/or (iv) taken any other action that would prohibit it from participation in Medicare and/or state health care programs, all as set forth under Section 1128.

c. **Malpractice and Other Actions.** Hospital will give immediate notice to Health Plan of: (i) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Hospital in settlement or compromise of such a claim, or any payment made by or on behalf of Hospital pursuant to a judgment rendered upon such a claim; (ii) any criminal investigations or proceedings against Hospital; (iii) any convictions of Hospital for crimes involving moral turpitude or felonies; and (iv) any civil claim asserted against Hospital that may jeopardize Hospital's financial soundness.

d. **Liability Insurance.** Throughout the term of this Agreement, Hospital will maintain premises and professional liability insurance: (i) in coverage amounts appropriate for the size and nature of Hospital's facility and the nature of Hospital's health care activities; and (ii) in compliance with applicable Law and Government Program requirements. If the coverage is claims made or reporting, Hospital agrees to purchase similar "tail" coverage upon termination of the Hospital's present or subsequent policy(ies). Hospital will deliver copies of such insurance policy(ies) to Health Plan within five (5) business days of a written request by Health Plan, and will give at least fifteen (15) business days advance written notice to Health Plan prior to any change, reduction, cancellation or termination of such insurance coverage.

2.12 **Claims Payment.**

a. **Submitting Claims.** Hospital will promptly submit to Health Plan Claims for Hospital Services rendered to Members. All Claims will be submitted in a standard form (CMS-1500, UB-04 or successor format) acceptable to and approved by Health Plan, and will include any and all medical records pertaining to the Claim if requested by Health Plan or otherwise required by Health Plan's policies and procedures. Hospital will not be eligible for payment for any Claims submitted within a period of time from the Date of Service that exceeds: (i) the number of days required by the timeframes specified by applicable Law and Government Program requirements; or (ii) ninety (90) days from the Date of Service, whichever is greater. Notwithstanding the foregoing, for any Claims associated with coordination of benefits, Hospital will not be eligible for payment within a period of time that exceeds: (i) the number of days required by the timeframes specified by applicable Law and Government Program requirements; or (ii) ninety (90) days from the date the primary payor adjudicated the Claim, whichever is greater.

b. **National Provider Identifier ("NPI").** Hospital will comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (45 CFR Section 162.402, et seq.) and use only the NPI to identify HIPAA covered health care providers in standard transactions. Hospital will utilize an NPI from the National Plan and Provider Enumeration System ("NPPES") for itself or for any subpart of the Hospital. Hospital will make best efforts to report its NPI and any subparts to Health Plan. Hospital will report any changes in its NPI or subparts to Health Plan within thirty (30) days of the change. Hospital will use its NPI to identify itself on all Claims and Encounters (both electronic and paper formats) submitted to Health Plan.

c. **Compensation.** Health Plan will pay Hospital for Clean Claims for Hospital Services provided to Members, including Emergency Services, in accordance with applicable Law, Government Program requirements, and in accordance with the terms of this Agreement. Such payment will be made within the lessor of: (i) the timeframes specified by applicable Law and Government Program requirements, or (ii) sixty (60) days of the date such Clean Claim is delivered by Hospital to Health Plan and Health Plan determines such claim is a Clean Claim for Hospital Services and/or Emergency Services. Hospital agrees to accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for Hospital Services provided to Members as deemed Medically Necessary and appropriate under this Agreement, Health Plan's Quality Improvement and Utilization Review and Management Programs. Hospital will not balance bill Members for any Hospital Services.

d. **Co-payments and Deductibles.** Hospital is responsible for collection of co-payments, co-insurances and deductibles, if any.

e. **Member Hold Harmless.** Hospital, or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by Health Plan, Health Plan insolvency or breach of this Agreement, shall Hospital, or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons other than the Health Plan acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on Health Plan's behalf made in accordance with the terms of the agreement between Health Plan and its Members.

Hospital, or its assignee or subcontract, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Health Plan's Members and that (2) this provision supersedes any oral or written contract agreement now existing or

hereafter entered into between Hospital and any Member or persons acting on any Member's behalf. (Iowa Admin. Code § 191-40.18.)

f. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Hospital will make reasonable inquiry of Members to learn whether Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type, and Hospital will immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Hospital will be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payors, not to exceed the amount specified in the Compensation Schedule.

g. **Offset.** In the event of an Overpayment, Hospital will make repayment to Health Plan within thirty (30) days of receipt of written notification by Health Plan of the Overpayment or within thirty (30) days of Hospital's identification of the Overpayment. In addition to any other contractual or legal remedy, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Hospital. As a material condition to Health Plan's obligations under this Agreement, Hospital agrees that the offset and recoupment rights set forth herein will be deemed to be and to constitute rights of offset and recoupment authorized under applicable Law or in equity to the maximum extent legally permissible, and that such rights will not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Hospital.

h. **Claim Review**. Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, current Uniform Billing ("UB") manual and editor, Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS"), federal, and state billing and payment rules, National Correct Coding Initiatives ("NCCI") Edits, and Federal Drug Administration ("FDA") definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Furthermore, Hospital acknowledges Health Plan's right to conduct medical necessity reviews and apply clinical practices to determine appropriate payment. Payment may exclude certain items not billed in accordance with industry standard billing and payment rules or certain items which do not meet certain medical necessity criteria.

i. **Claim Auditing.** Hospital acknowledges Health Plan's right to conduct post-payment billing audits. Hospital shall cooperate with Health Plan's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Hospital's charging policies, and other related data. Health Plan shall use established industry claims adjudication and/or clinical practices, state, and federal guidelines, and/or Health Plan's policies and data to determine the appropriateness of the billing, coding and payment.

j. **Authorized Services.** Health Plan is responsible for the authorization of medical services provided to Members. If Hospital has obtained concurrent or prior authorization for a Covered Service provided to a Member, Health Plan will not retrospectively deny payment for such authorized Covered Service, unless: (i) Hospital's claim and/or medical record for such services do not support the specific services and/or level of care authorized by Health Plan; (ii) Health Plan may do so pursuant to applicable Law or Government Program requirement; or (iii) Hospital has been provided notice of certain policies that Health Plan is adopting through the Provider Manual or Supplemental Materials. Health Plan will conduct medical management throughout the course of treatment. Hospital acknowledges that initial and subsequent authorizations will be obtained as necessary.

k. **Reporting Requirements.** Hospital's failure to comply with Health Plan's requirements regarding Hospital's identification and reporting of institutional and outpatient services, admissions, and/or related services to Health Plan or to obtain authorization as required may result in non-payment to Hospital for all days and charges until the day that notification is received and services are authorized.

l. **Payments which are the Responsibility of a Capitated Provider.** Hospital agrees that if Hospital provides Covered Services that are the financial responsibility of a Capitated Provider, Hospital will look solely to the Capitated Provider, and not Health Plan, for payment of such Covered Services. Pursuant to the terms in the agreement between the Capitated Provider and the Health Plan, if Hospital provides Covered Services that are the financial responsibility of the Capitated Provider, Capitated Provider will compensate the Hospital at the rate set forth in the Agreement between the Hospital and the Capitated Provider. In the event there is not an agreement between the Capitated Provider and Hospital, or where the Capitated Provider and Hospital have not agreed to compensation terms, Hospital will be reimbursed, as determined by the Hospital and the Capitated Provider, at: (i) one hundred percent (100%) of the governing rates provided by applicable Law specific to the Member's enrolled benefit plan (i.e. Medicaid or Medicare, etc.) in place at the time services are rendered; or (ii) at the rates set forth in this Agreement. Except as specifically stated in this section, Hospital agrees that the other compensation terms of the Agreement will

continue to be binding upon Hospital. Furthermore, for the avoidance of doubt, Hospital will abide by all provisions of this Agreement relating to non-billing of Members with respect to all services and treatment.

m. **Timely Submission of Encounter Data**. Hospital understands that Health Plan may have certain contractual reporting obligations which require timely submission of encounter data. Therefore, as applicable, Hospital shall submit Encounter Data to Health Plan within thirty (30) days of the Date of Service.

2.13 **Compliance with Law.** Hospital will comply with all applicable Laws governing the delivery of Hospital Services to Members including, but not limited to, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Balanced Budget Act of 1997; and the Americans with Disabilities Act. In addition, Hospital shall comply with the program specific requirements set forth in the attachments to this Agreement as they apply to each product and region.

2.14 **Hospital Non-solicitation Obligations.** Hospital will not unilaterally assign or transfer patients served under this Agreement to another hospital without the prior written approval of Health Plan. Nor will Hospital solicit or encourage Members to select another health plan. Nothing in this provision is intended to limit Hospital's ability to fully inform Members of all available health care treatment options or modalities.

2.15 **Fraud and Abuse Reporting.** Hospital will report to Health Plan's compliance officer all cases of suspected fraud or abuse, as defined in 42 CFR 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) days of the date when Hospital first becomes aware of, or is on notice of, such activity. Hospital will establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and abuse in the provision of health care services under the Medicaid program. Upon the request of Health Plan and/or the state, Hospital will consult with the appropriate state agency prior to and during the course of any such investigations.

2.16 **Advance Directive.** Hospital will document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other applicable Law.

2.17 **Reassignment of Members.** Health Plan reserves the right to reassign Members from Hospital to another provider or to limit or deny the assignment or selection of new Members to Hospital during any termination notice period or if Health Plan determines that assignment of Members to Hospital poses a threat to the Members' health and safety. If Hospital requests reassignment of a Member, Health Plan, in its sole discretion, will make the determination regarding reassignment based upon good cause shown by the Hospital. When the Health Plan reassigns Member(s), Hospital will forward copies of the Member's medical records to the new provider within ten (10) business days of receipt of the Health Plan's or the Member's request to transfer the records.

2.18 **Reciprocity Agreements.** Hospital will cooperate with Affiliates of Health Plan and agrees to provide Hospital Services to Members enrolled in the various products and programs offered by any Affiliate and to assure reciprocity of such health care services. Hospital will comply with the procedures established by Health Plan or its Affiliates and this Agreement for reimbursement of such services or treatment. Hospital will not encourage Members to receive Hospital Services from non-Participating Providers. Hospital will abide by all provisions of this Agreement relating to non-billing of Members with respect to all services and treatment subject to this reciprocity arrangement.

2.19 **Notification of Network Change.** Where Hospital operates a network of facilities, Hospital will provide Health Plan and Members with timely prior written notification in the event a constituent provider terminates its contract with Hospital. Said written notification will be in compliance with applicable Law or Government Program requirements.

2.20 **Members Condition Changes or Deaths.** Upon becoming aware of or suspecting: (i) a significant change in a Member's health or functional status that could affect Member's level of care determination; (ii) a Member is being abused or neglected; or (iii) a Member death, Hospital will notify Health Plan's Member Services Department as soon as possible but not later than seven (7) days.

ARTICLE THREE – HEALTH PLAN'S OBLIGATIONS

3.1 **Compensation.** Health Plan will pay Hospital in accordance with the terms and conditions of this Agreement.

3.2 **Member Eligibility Determination.** Health Plan will maintain data on Member eligibility and enrollment. Health Plan will promptly verify Member eligibility at the request of Hospital.

3.3 **Prior Authorization Review.** Health Plan will timely respond to requests for prior authorization and/or determination of Hospital Services.

3.4 **Medical Necessity Determination.** Health Plan's determination with regard to Medically Necessary services and scope of Hospital Services, including determinations of level of care and length of stay benefits available under the Member's

health program will govern. The primary concern with respect to all medical determinations will be in the interest of the Member.

3.5 **Member Services.** Health Plan will provide services to Members including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan Participating Providers.

3.6 **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Hospital Services, limitations and exclusions, and coordination of benefits information. Health Plan will make available a Hospital Services Department that, among other Health Plan duties, will be available to educate Hospital regarding Health Plan's policies and procedures.

3.7 **Medical Director.** Health Plan will retain a physician as medical director who will be responsible for the management of the scientific, technical, medical and behavioral health aspects of Health Plan.

ARTICLE FOUR – TERM AND TERMINATION

4.1 **Term.** This Agreement will commence on the Effective Date indicated by Health Plan and will continue in effect for one (1) year; thereafter, it will automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with the provisions of this Agreement or in accordance with applicable state and federal provisions set forth in the Attachments hereto.

4.2 **Termination without Cause.** At any time during this Agreement, this Agreement, a product/program provided pursuant to this Agreement, or an individual Hospital under this Agreement may be terminated without cause by either party on at least one hundred twenty (120) days written notice to the other party.

4.3 **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach may give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination will have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this thirty (30) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the party who provided the notice of termination will have the right to immediately terminate this Agreement, a product/program provided pursuant to this Agreement, or an individual Hospital under this Agreement. Notwithstanding the forgoing, either party may immediately terminate this Agreement, a product/program provided pursuant to this Agreement, or an individual Hospital under this Agreement without providing the other party the opportunity to cure a material breach should the terminating party reasonably believe the material breach of this Agreement to be non-curable.

4.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, or unless otherwise mutually agreed to in writing by both parties, this Agreement, a product/program provider pursuant to this Agreement, or an individual Hospital under this Agreement, may immediately be terminated upon written notice to the other party in the event of any of the below. Upon termination, Health Plan may transfer Member(s) to another provider.

a. Hospital's license or certificate to render health care services is limited, suspended or revoked, or disciplinary proceedings are commenced against Hospital by the state licensing authority;

b. Either party fails to maintain insurance required by this Agreement;

c. Hospital has not or is unable to comply with Health Plan's credentialing requirements, including but not limited to, having or maintaining credentialing status;

d. Either party becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Hospital or Health Plan is appointed by appropriate authority;

e. If Hospital is capitated and Health Plan determines Hospital is financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;

f. Health Plan reasonably determines that Hospital's facility or equipment is insufficient to render Hospital Services;

g. Either party is excluded from participation in Medicare or state health care programs pursuant to Section 1128;

h. Hospital is terminated as a provider by any state or federal health care program;

i. Either party engages in fraud or deception, or permits fraud or deception by another in connection with each party's obligations under this Agreement;

j. Health Plan reasonably determines that health care services are not being properly provided, or arranged for by Hospital and that such failure poses a threat to Members' health and safety;

k. Hospital violates any state or federal law, statute, rule, regulation or executive order; or

l. Hospital fails to satisfy the terms of a corrective action plan.

4.5 **Notice of Nonrenewal or Termination**. Health Plan will provide written notice of nonrenewal or termination of Hospital to the Members served by Hospital as soon as practicable, but in no event later than fifteen (15) days following termination. Hospital will not contact Health Plan's Members upon termination of this Agreement, a product/program provided pursuant to this Agreement, or an individual Hospital under this Agreement. Immediate written notice will be provided without sixty (60) days' notice in the event Hospital's license has been disciplined by a state licensing board.

ARTICLE FIVE – GENERAL PROVISIONS

5.1 **Indemnification.** Each party will indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

5.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor will it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained will prevent any of the parties from entering into similar arrangements with other parties. Each of the parties will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will be construed to create, any right in any third party, including but not limited to, Members. Nor will any third party have any right to enforce the terms of this Agreement.

5.3 **Governing Law.** The laws of the State of Iowa will govern this Agreement.

5.4 **Entire Agreement.** This Agreement, including attachments, addenda, amendments, and incorporated documents or materials, contains the entire agreement between Health Plan and Hospital relating to the rights granted and obligations imposed by this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, between the parties and relating to the subject matter of this Agreement are of no force or effect. Additionally, as to the Medicaid products offered by Health Plan, the State Contract is incorporated herein by reference and shall be the guiding and controlling document when interpreting the terms of this Agreement.

5.5 **Severability.** If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.

5.6 **Headings and Construction.** The headings in this Agreement are for reference purposes only and shall not be considered a part of this Agreement in construing or interpreting any of its provisions. It is the parties' desire that if any provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is to be construed against its drafter shall not apply to the interpretation of the ambiguous provision.

5.7 **Non-exclusivity.** This Agreement will not be construed to be an exclusive Agreement between Health Plan and Hospital. Nor will it be deemed to be an Agreement requiring Health Plan to refer Members to Hospital for health care services.

5.8 **Amendment.** Health Plan may, without Hospital's consent, immediately amend this Agreement to maintain consistency and/or compliance with any applicable Law, policy, directive, or Government Program requirement. Health Plan may otherwise amend this Agreement upon thirty (30) days prior written notice to Hospital. If Hospital does not deliver to Health Plan a written notice of rejection of the amendment within that thirty (30) day period, the amendment will be deemed accepted by and will be binding upon Hospital.

5.9 **Delegation or Subcontract.** Hospital will not delegate or enter into any subcontract agreement for the provision of Covered Services without the prior written consent of Health Plan. Any subcontract agreement entered into by Hospital for the delivery of Covered Services will be in writing and will bind the subcontractor to the terms and conditions of this Agreement including, but not limited to, licensure, insurance, and billing of Members for Covered Services.

5.10 **Assignment.** Hospital may not assign or transfer, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Health Plan and Hospital and their respective successors in interest and assigns.

5.11 **Arbitration.** Any claim or controversy arising out of or in connection with this Agreement will first try to be resolved through the Grievance Program and Health Plan's internal appeals process. In the event that the claim or controversy

cannot be resolved through the Grievance Program or Health Plan's internal appeal process, Hospital and Health Plan will engage in mandatory good faith meetings and discussions, which can include multiple writings, telephonic meetings or in person meetings, but will at least include one written communication by each party setting forth their position and one in person meeting, with decision makers present to try and resolve the claim or controversy. Any remaining claim or controversy will be resolved through binding arbitration administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures, then in effect, in Des Moines, Iowa; provided, however, matters that primarily involve Hospital's professional competence or conduct will not be eligible for arbitration. A panel of three (3) arbitrators will be appointed unless the parties agree to utilize a single arbitrator. In the event a panel of three (3) arbitrators will be used, the claimant will select one (1) arbitrator; the respondent will select one (1) arbitrator; and the two (2) arbitrators selected by the claimant and respondent will select the third arbitrator. If possible, each arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care. The arbitration will be conducted in English. Arbitration must be initiated within one (1) year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise, it will be deemed waived. The use of binding arbitration will not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

The parties will conduct a mandatory settlement conference at the initiation of arbitration, to be administered by JAMS. The arbitrator(s) will have no authority to provide a remedy or award damages that would not be available to such prevailing party in a court of law, nor will the arbitrator(s) have the authority to award punitive damages. Each party will bear its own costs and expenses, including its own attorneys' fees, and will bear an equal share of the arbitrator's and administrative fees of arbitration. Furthermore, the parties agree that either party may request a court reporter transcribe the entire proceeding, in which case the parties will divide the cost of the court reporter; however, each party may elect to purchase or forego purchasing a transcript.

The parties agree that any decision made by the arbitrator(s) must provide a reasoned decision as to the facts and law in writing. Furthermore, the parties agree that any arbitration decision must be grounded in applicable law, and any failure to make a decision grounded in law will give any party the right to appeal the decision in addition to those rights of vacatur or appeal already existing pursuant to the Federal Arbitration Act and/or applicable state arbitration laws. Such appeal may be made to a court having jurisdiction over the parties and/or the dispute. If the court having jurisdiction over the parties and/or the dispute for appeal purposes does not permit appeal of an arbitration award to a court, for any reason, the parties agree to submit such appeal to arbitration pursuant to the JAMS rules regarding Optional Arbitration Appeal Procedure (requiring three arbitrators), and any appeal will be held in the same city in which the arbitration occurred. Notice of intent to appeal based on failure to provide a decision grounded in law must be given within fifteen (15) days after the decision is communicated to the parties; and the appeal must be formally initiated by filing in court or commencing arbitration by sending a notice of appeal to JAMS within thirty (30) days after the decision is communicated to the parties. If a court decides it will not hear an appeal because it deems appeals from arbitration not subject to appeal these timelines are tolled until such order is issued, at which time the parties will have thirty (30) days to submit a notice of intent to appeal to JAMS. If a court generally permits appeals from arbitrations, but deems the particular issue not appealable, there is no right for an additional appeal to arbitration. Judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction, after receiving the arbitrator's written reasoned decision and after confirming neither party intends to appeal.

5.12 **Notice.** All notices required or permitted by this Agreement will be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, by Federal Express or other overnight courier that guarantees next day delivery, by facsimile transmission, or by electronic mail or other means of electronic delivery, including but not limited to, Health Plans website and interactive web portal. All notices will be deemed sufficiently given if served in the manner specified in this section. The mailing names and addresses set forth under the Signature Authorization section of this Agreement will be the particular party's address for delivery or mailing of notice purposes. Each party may change their name and address through written notice in compliance with this section. Any notice sent by registered or certified mail, return receipt requested, will be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery will be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice will be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

5.13 **Waiver.** A failure or delay of any party to exercise or enforce any provision of this Agreement shall not be deemed a waiver of any right of that party. Any waiver must be specific, in writing and executed by both the Health Plan and Hospital.

5.14 **Execution in Counterparts and Duplicates**. This Agreement shall be executed in duplicate and each duplicate may also be executed in counterparts, each of which shall be deemed a duplicate original, but all of which together shall constitute one and the same instrument. It is further agreed that facsimile signatures, electronic signature, pdf signatures, or a signature scanned and sent via e-mail shall have the same effect as original signatures.

5.15 **Conflict with Health Plan Product**. Nothing in this Agreement modifies any benefits, terms or conditions contained in the Member's Health Plan product. In the event of a conflict between this Agreement and the benefits, terms, and conditions of the Health Plan product, the benefits, terms or conditions contained in the Member's Health Plan product will govern.

5.16 **Force Majeure.** Neither party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either party's employees, or any other similar cause beyond the reasonable control of such party.

5.17 **Confidentiality.** Any information maintained or generated by either party in fulfillment of its obligations under this Agreement, including healthcare information, shall be kept confidential in accordance with and to the extent required by applicable Laws. Further, all information provided to Hospital, including, but not limited to, Member lists, QI Program, credentialing criteria, compensation methodologies and rates, and any other administrative protocols or procedures of Health Plan, is the proprietary property of Health Plan. Hospital shall not disclose or release such material to any third party without the written consent of Health Plan.

ATTACHMENT A
DEFINITIONS

Capitalized words or phrases in this Agreement mean the following:

1.1 **Accreditation Organization** means any organization, including, without limitation, the National Committee for Quality Assurance ("NCQA"), engaged in accrediting or certifying Health Plan or Hospital.

1.2 **Advance Directive** means a Member's written instructions, recognized under Law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under Law. Examples of Advance Directives are living wills and durable powers of attorney for health care.

1.3 **Affiliate** means an entity owned or controlled by Health Plan or Molina Healthcare, Inc. ("Molina").

1.4 **Agreement** means this Hospital Services Agreement, including all attachments addenda, amendments, and incorporated documents or materials.

1.5 **Authorized Representative** means the person with legal authority to agree to and execute this Agreement.

1.6 **Capitated Provider** shall mean a provider that has accepted financial responsibility for certain Covered Services and Members, which can be demonstrated through the agreement the Capitated Provider has with Health Plan.

1.7 **Centers for Medicare and Medicaid Services** ("CMS") means an administrative agency of the United States Government, responsible for administering the Medicare program.

1.8 **C.F.R** means Code of Federal Regulations.

1.9 **Claim** means an invoice for Hospital Services rendered to a Member by Hospital, submitted in a format approved by Health Plan and with all service and Encounter information required by Health Plan.

1.10 **Clean Claim** means a Claim for Hospital Services that is submitted on an industry standard form (e.g. CMS-1500, UB-04), and has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the Claim.

1.11 **Completion of Audit** means the completion of audit by the Department of Health and Human Services ("DHHS"), the Government Accountability Office ("GAO"), or their designees of Health Plan, Medicare and Medicaid Plan contractor or related entity.

1.12 **Covered Services** means those health care services, supplies and benefits that are (i) Medically Necessary, (ii) benefits of the applicable Health Plan Product(s)/Program(s), and (iii) required to be provided by Health Plan pursuant to the Government Contract(s) as applicable, which covers the Member(s).

1.13 **Cultural Competency Plan** means a plan that ensures Covered Services are provided to Members in a manner that takes into account, but is not limited to, developmental disabilities, physical disabilities, differential abilities, cultural and ethnic backgrounds and limited English proficiency.

1.14 **Date of Service** means the date on which Hospital renders services to a Member, or for inpatient services, the date the Member is discharged.

1.15 **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between a health plan (or applicant) and a First Tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.16 **Emergency Services** are health care services furnished in the emergency department of a hospital for the treatment of a medical emergency; ancillary services routinely available to the emergency department of a hospital for the treatment of a medical emergency; and emergency medical services transportation.

1.17 **Encounter** means a distinct set of services provided to a Member enrolled by Health Plan on the dates that the services were delivered.

1.18 **Encounter Data** means: (i) all data captured during the course of a single health care Encounter that specify the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative) pharmaceuticals, medical devices and equipment associated with a Member receiving services during the Encounter; (ii) the identification of the Member receiving and the provider delivering the health care services during the single Encounter; and (iii) a unique, i.e. unduplicated, identifier for the single Encounter.

1.19 **Final Contract Period** means the final term of the contract between CMS and the Health Plan.

1.20 **First Tier Entity** means any Party that enters into a written arrangement, acceptable to CMS, with Health Plan to provide administrative services or health care services for a Medicare eligible Member under the Medicare Advantage program.

1.21 **Iowa Department of Human Services ("DHS")** means the agency within the State of Iowa that is responsible for the oversight and administration of the Medicaid and CHIP programs.

1.22 **Government Contracts** means those contracts between Health Plan and state and federal agencies for the arrangement of health care service for Members through Government Programs, including but not limited to, the State Contract(s).

1.23 **Grievance Program** means the procedures established by Health Plan to timely address Member and Hospital complaints or grievances.

1.24 **Health Plan** means Molina Healthcare of Iowa, Inc., a Iowa Corporation.

1.25 **Hospital** means the person(s) and/or entity(ies), any constituent physicians, allied health professionals, staff persons, and any employed, subcontracted and/or affiliated entities, and are all bound by the terms and conditions of this Agreement.

1.26 **Hospital Providers** are hospital-based physicians and independent licensed non-physician health care professionals who are employed by, contract with, or on the medical staff of Hospital to provide Covered Services to Members.

1.27 **Hospital Services** are those Covered Services that are within the normal scope of practice and licensure of Hospital and its Hospital Providers, and which includes, but are not limited to, short term inpatient or outpatient general hospital services including room with customary furnishings and equipment, meals (including special diets as medically necessary), general nursing care, use of operating room and related facilities, intensive care unit and services, emergency services, drugs, including drugs to be dispensed at time of emergency room visit in amount sufficient to last until such time Member can reasonably be expected to fill a prescription, medications, biological, anesthesia and oxygen services, ambulatory care services, diagnostic laboratory and x-ray services, special duty nursing as medically necessary, physical therapy, respiratory therapy, administration of blood and blood products, and diagnostic, therapeutic and rehabilitative services as appropriate, and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

1.28 **Law(s)** mean all federal and state statutes and regulations applicable to the subject matter of this Agreement or the parties' performance of their duties and obligations hereunder).

1.29 **Medicaid** means the joint federal-state program provided for under Title XIX of the Social Security Act, as amended.

1.30 **Medically Necessary** means care that is based upon generally accepted medical practices in light of conditions at the time of treatment, and are services that are: (i) appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible Member's medical condition; (ii) compatible with the standards of acceptable medical practice in the community; (iii) provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms; (iv) not provided solely for the convenience of the Member or the convenience of the provider; and (v) not primarily custodial care unless custodial care is a covered service or benefit under the Member's evidence of coverage.

1.31 **Medicare** means the various insurance health plans provided under Title XVIII of the Social Security Act, as amended.

1.32 **Medicare Advantage ("MA")** means an alternative to the traditional Medicare program in which private plans, run by health insurance companies, provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

1.33 **Medicare Advantage Special Needs Plan ("MA-SNP")** means an alternative to the traditional Medicare program in which private plans, run by health insurance companies, provide health care benefits to beneficiaries who are eligible for both Medicare and Medicaid.

1.34 **Medicare-Medicaid Program ("MMP")** means an integrated delivery system, payment model, and alternative to the traditional Medicare and Medicaid programs, aimed at improving the quality, coordination, and cost-effectiveness of services, in which private health plans, run by health insurance companies, provide health care benefits to beneficiaries who are dually eligible for both Medicare and Medicaid.

1.35 **Member** means a person enrolled in one of Health Plan's benefit products or a Health Plan Affiliate's benefit product and who is eligible to receive Covered Services.

1.36 **Overpayments** means any payment Hospital receives or retains in which Hospital, after applicable reconciliation, is not entitled to receive such payment pursuant to Law or the terms of this Agreement.

1.37 **Participating Provider(s)** means those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan.

1.38 **Provider Manual** means Health Plan's, procedures, standards and specimen documents that have been compiled by Health Plan for the use and instruction of Hospital.

1.39 **Quality Improvement Program ("QI Program")** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.

1.40 **Related Entity** means any entity that is related to the Health Plan by common ownership or control and: (i) performs some of the Health Plan's management functions under contract or delegation; (ii) furnishes services to Medicare Members under an oral or written agreement; or (iii) leases real property or sells materials to the Health Plan at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.

1.41 **State Children's Health Insurance Program ("CHIP")** means the program established pursuant to Title XXI of the Social Security Act, as amended.

1.42 **State Contract** means the contract(s) between DHS and Health Plan that govern the provision of Covered Services to Members, as may be amended.

1.43 **Utilization Review and Management Program ("UM Program")** means the policies, procedures and systems developed by Health Plan for evaluating and monitoring the medical necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective reviews, including but not limited to under-utilization and over-utilization.

ATTACHMENT B
PRODUCTS/PROGRAMS

Hospital agrees to participate as a Participating Provider for the following products/programs and successor(s).

1.1 **Medicaid -** including but not limited to the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa (hawk-i) programs.
1.2 **Medicare** – including but not limited to Molina Medicare Options (Medicare Advantage), Molina Medicare Options Plus ("MA-SNP").
1.3 **Medicare-Medicaid Program –** including, but not limited to, Dual Options (Capitated Financial Alignment Demonstration ("CFAD").

ATTACHMENT C
COMPENSATION SCHEDULE

1.1 **Medicaid**

a. **Hospital Services Payments.** Health Plan agrees to compensate Hospital for Hospital Services rendered to Members, in accordance with the products/programs specified in Attachment B, that are determined by Health Plan to be payable and submitted on a Clean Claim, on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of: (i) Hospital's billed charges; or (ii) at an allowable amount equivalent to the payable rate under the applicable Medicaid Fee-For-Service Program fee schedule set forth by the State of Iowa, in effect on the Date(s) of Service. Notwithstanding the foregoing, payment for Hospital Services, including, but not limited to, certain Hospital Services where there is no payment rate in the Iowa Medicaid Fee-For-Service Program fee schedule as of the Date(s) of Service, will not exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the Date(s) of Service.

1.2 **Medicare**

a. **Hospital Services Payments**. Health Plan agrees to compensate Hospital for Hospital Services rendered to Members, in accordance with Medicare products/programs as specified in Attachment C, that are determined by Health Plan to be payable and submitted on a Clean Claim, on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of; (i) Hospital's billed charges, or (ii) at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography), as of the date(s) of service.

ATTACHMENT D
DHS PROGRAM REQUIREMENTS

This attachment sets forth the applicable requirements that are required by the State Contract to be included in agreements between Health Plan and Participating Providers or other provisions necessary to reflect compliance with the Law. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments to the State Contract or changes or modifications to Law or Government Program requirements. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1.1 The parties acknowledge that State Contract has not been completed and that upon completion, this attachment will immediately be amended to conform to any requirement set forth therein.

ATTACHMENT E
Medicare Program Requirements – Healthcare Services

This attachment sets forth the applicable Government Program requirements, covering the provision of health care and related services, that are required by CMS to be included in contracts and/or agreements between; (i) health plans/health maintenance organizations, and (ii) clients or providers of health care or related services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1.1 Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(ies) that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein. (42 CFR 422.504(i)(3)(iii)).

1.2 Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information, including books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under Health Plan's contract with CMS, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period between Health Plan and CMS or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 42 CFR 422.504(e)(3), 42 CFR 422.504(e)(4) and 42 CFR422.504(i)(2)(ii).).

1.3 Confidentiality. Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13).)

1.4 Hold Harmless/Cost Sharing. Provider agrees it may not under any circumstances, including nonpayment of moneys due to the providers by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Member, or any persons other than the Health Plan acting on their behalf, for services provided in accordance with this Agreement. The Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. (42 CFR 422.504(g)(1)(i)) and (42 CFR 422.504(g)(1)(iii).) In addition, for Members who are dually eligible for Medicare and Medicaid and enrolled in a Medicare Advantage Special Needs Plan will not be held liable for Medicare Part A and B cost sharing when the State or another payor such as a Medicaid Managed Care Plan is responsible for paying such amounts. Health Plan will inform providers of applicable Medicare and Medicaid benefits and rules for eligible Members. Provider agrees to accept payment from Health Plan as payment in full, or bill the appropriate State source, for any Medicare Part A and B cost sharing that is covered by Medicaid. Collection from the Member of copayments or supplemental charges in accordance with the terms of the Member's contract with the Health Plan, or charges for services not covered under the Member's contract, may be excluded from this provision.

1.5 Accountability. Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions set forth in Attachment E-1 of this Agreement. (42 CFR 422.504(i)(3)(ii).)

1.6 Delegation. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(3)(iii) and 42 CFR 422.504(i)(4).)

1.7 Prompt Payment. Health Plan and Provider agree that Health Plan will pay all Clean Claims for services that are covered by Medicare within sixty (60) days of the date such Claim is delivered by Provider to Health Plan and Health Plan determines such Claim is complete/clean. Any Claims for services that are covered by Medicare that are not submitted to Health Plan within six (6) months of providing the services that are subject of the Claim will not be eligible for payment, and Provider hereby waives any right to payment therefore. Health Plan reserves the right to deny any Claims that are not in accordance with the Medicare Claims Processing Manual and Medicare rules for billing. (42 CFR 422.520(b).)

1.8 Reporting. Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310. (42 CFR 504(a)(8).)

1.9 Compliance with Medicare Laws and Regulations. Provider will comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v).)

1.10 Benefit Continuation. Provider agrees to provide for continuation of Member health care benefits (i) for all Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Members who are hospitalized on the date Health Plan's contract with CMS terminates, or, in the event of insolvency, through discharge. (42 CFR 422.504(g)(2)(i), 42 CFR 422.504(g)(2)(ii) and 42 CFR 422.504(g)(3).)

1.11 Cultural Considerations. Provider agrees that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. (42 CFR 422.112(a)(8).)

ATTACHMENT E-1
Medicare Program Requirements – Delegated Services

This attachment sets forth the applicable Government Program requirements, covering the delegation to Hospital of any management responsibilities or administrative services if any, that are required by CMS to be included in contracts and/or agreements between; (i) health plans/health maintenance organizations, and (ii) clients or providers of health care or related services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1.1 Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(s) that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein. (42 CFR 422.504(i)(3)(iii))

1.2 Medicare Compliance. Provider agrees to require all of its downstream, related entity(s) and transferees to comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v).)

1.3 Confidentiality. Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13).)

1.4 Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 42 CFR 422.504(e)(3), 42 CFR 422.504(e)(4) and 42 CFR 422.504(i)(2)(ii).)

1.5 Responsibilities and Reporting Arrangements. The Agreement specifies the delegated activities and reporting responsibilities if any. To the extent applicable, Provider will support Health Plan in complying with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 310 by providing relevant data. (42 CFR 422.504(i)(4)(i) and 42 CFR 422.504(a)(8).)

1.6 Revocation of Delegated Activities. In the event CMS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities will be revoked. (42 CFR 422.504(i)(4)(ii).)

1.7 Accountability. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(1) and 42 CFR 422.504(i)(3)(iii).)

1.8 Credentialing. If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. Health Plan retains the right to approve, suspend, or terminate any credentialing delegation arrangement. (42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5).)

1.9 Monitoring. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contractual obligations. Health Plan will monitor the performance of first tier, downstream, and related entities. (42 CFR 422.504(i)(1) and 42 CFR 422.504(i)(4).)

1.10 Further Requirements. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with Health Plan's contractual obligations. If Health Plan delegates selection of the providers, contractors, or subcontractor to another organization, Health Plan retains the right to approve, suspend, or terminate any such arrangement. (42 CFR 422.504(i)(3)(iii), 42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5).

Molina Healthcare of Iowa, Inc.
Provider Services Agreement

SIGNATURE AUTHORIZATION

In consideration of the promises, covenants, and warranties stated, the parties agree as set forth herein. The Authorized Representative for each party executes this Agreement with the intent to bind the parties in accordance with applicable Laws. The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and proper authorization to act on behalf of Provider. The Authorized Representative further acknowledges he/she received and reviewed the entirety of this Agreement.

Provider Signature

Provider's Legal Name ("Provider") – as listed on applicable tax form (i.e. Tax Form W-9) and any doing business as name		
Authorized Representative's Signature	Title	Signature Date
Authorized Representative's Name – Printed	Provider Telephone Number	

Provider Information

Mailing Address – Official Correspondence	Billing / Payment Address – if different than Mailing Address
Fax Number – Official Correspondence	Tax ID Number – as listed on applicable tax form
E-mail Address – Official Correspondence	NPI Number – that corresponds to the listed Tax ID Number

Health Plan Signature and Information

Molina Healthcare of Iowa, Inc., a Iowa Corporation ("Health Plan")		
Authorized Representative's Signature	Title	Countersignature Date
Authorized Representative's Name – Printed	Mailing Address – Official Correspondence	
E-mail Address – Official Correspondence		

PROVIDER SERVICES AGREEMENT

This Agreement is entered into between Health Plan and Provider as set forth and made effective as of the date of Health Plan's countersignature ("Effective Date").

RECITALS

A. Health Plan arranges for the provision of certain health care services to Members pursuant to contracts with various government sponsored health products/programs ("Government Programs") and other products/programs, as applicable. Health Plan intends to participate in additional Government Programs and offer other health products/programs as the opportunities become available.

B. Health Plan is a domiciled corporation that has been issued a certificate of authority by the appropriate state licensing agency to provide health care services to Members. Health Plan also is certified, licensed and/or approved by all other required agencies to provide health care services to eligible recipients.

C. Health Plan arranges for the provision of certain health care services to Members by entering into provider service agreements with individual physicians, groups of physicians, individual practice associations, hospitals, clinics, ancillary health providers, and other health providers.

D. Provider is licensed to render certain health care services and desires to provide such services to Health Plan's Members in connection with Health Plan's contractual obligations to provide and/or arrange for health care services for Health Plan's Members.

Now, therefore, in consideration of the promises, covenants and warranties stated herein, Health Plan and Provider agree as follows:

ARTICLE ONE – DEFINITIONS

1.1 Capitalized words or phrases in this Agreement have the meaning set forth in Attachment A.

ARTICLE TWO – PROVIDER OBLIGATIONS

2.1 **Provision of Provider Services.** Provider agrees to provide Provider Services to Members within the scope of Provider's business, practice and license, and in accordance with applicable Law and the terms of this Agreement including, but not limited to, the Provider Manual, Health Plan's QI and UM Programs and applicable Accreditation Organization standards.

2.2 **Provider Standards.**

a. **Standard of Care.** Provider will provide Provider Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and standards of professional conduct, and any controlling governmental licensing requirements.

b. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel and administrative services will be at a level and quality as necessary to perform Provider's duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.

c. **Prior Authorization.** If Provider determines that it is Medically Necessary to consult or obtain services from other health professionals that are Medically Necessary, Provider will obtain the prior authorization of Health Plan in accordance with Provider Manual unless the situation is one involving the delivery of Emergency Services. Upon and following such referral, Provider will coordinate the provision of such Covered Services to Members and ensure continuity of care. Except in the case of Emergency Services, prior to rendering Provider Services, Provider shall obtain prior authorization of Health Plan in accordance with Provider Manual, for those services that require a prior authorization. Failure to receive prior authorization from Health Plan may result in Claim denial.

d. **Use of Participating Providers.** Except in the case of Emergency Services or where Provider obtains the prior authorization of Health Plan, Provider will utilize Health Plan's Participating Providers to provide Provider Services to Members. Should Health Plan have no Participating Provider to render Medically Necessary Provider Services, Health Plan will use reasonable efforts to coordinate an out of network agreement with an appropriate provider.

e. **Member Eligibility Verification.** Provider will verify eligibility of Members prior to rendering services unless the situation is one involving the delivery of Emergency Services.

f. **Admissions.** Provider will cooperate with and comply with Health Plan's hospital admission and prior authorization procedures.

g. **Emergency Room Referral.** If Provider refers a Member to an emergency room for Covered Services, Provider will notify Health Plan within twenty-four (24) hours of the referral.

h. **Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Provider will abide by Health Plan's drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider will obtain prior authorization from Health Plan if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

i. **Availability of Services.** Provider will make necessary and appropriate arrangements to assure the availability of Provider Services to Members on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of Member patient visits after hours. Provider will meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

j. **Treatment Alternatives.** Health Plan encourages open Provider-Member communication regarding appropriate treatment alternatives. Health Plan promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of limitations on Covered Services. Provider is free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Health Plan's decision to terminate or refuse to contract with a Provider will not be based in whole or in part on the fact that the Provider discussed medical treatment options with a Member.

2.3 **Rights of Members.** Provider will observe, protect and promote the rights of Members.

2.4 **Corrective Action.** Health Plan and certain state and federal regulators routinely monitor the level, manner, and quality of Covered Services provided pursuant to this Agreement as well Provider's compliance with the terms of this Agreement. In the event a deficiency is identified, Health Plan or regulator, in their sole discretion, may choose to issue a corrective action plan, and Provider will be required to accept and implement such a corrective action plan. A corrective action plan is not required to be given to Provider before issuing a Termination with Cause or an Immediate Termination.

2.5 **Promotional Activities.** At the request of Health Plan, Provider will: (i) display Health Plan promotional materials in its offices and facilities as practical; and (ii) cooperate with and participate in all reasonable Health Plan marketing efforts so long as it does not violate applicable Law. Provider will not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan.

2.6 **Nondiscrimination.**

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

b. **Employment.** Provider will not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual's ability to perform the duties of the particular job or position.

2.7 **Recordkeeping.**

a. **Maintaining Member Medical Record.** Provider will maintain a medical and billing record for each Member to whom Provider renders health care services. Provider will open each Member's medical record upon the Member's first Encounter with Provider. The Member's medical record will contain all information required by Law, generally accepted and prevailing professional practice, applicable Government Programs, and all Health Plan policies and procedures. Provider will retain all such records for as long as required by applicable Law and/or Government Contracts. This section will survive the termination of this Agreement or an individual product/program.

b. **Confidentiality of Member Health Information.** Provider will comply with all applicable Law, Health Plan's policies and procedures, Government Program requirements regarding privacy and confidentiality of Members' health information and medical records, including mental health records. Provider will not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision will not affect or limit Provider's obligation to make available medical records, Encounter Data and information concerning Member care to Health Plan, any authorized state or federal agency, or other providers of health care upon authorized referral.

c. **HIPAA.** Provider will comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act and any regulations promulgated thereunder (collectively the "HIPAA Rules").

d. **Delivery of Patient Care Information.** Provider will promptly deliver to Health Plan, upon request and/or as may be required by Law, Health Plan's policies and procedures, applicable Government Programs, Health Plan's contracts with the government agencies, or third party payors, any information, statistical data, Encounter Data, or patient treatment information pertaining to Members served by Provider, including but not limited to, any and all information requested by Health Plan in conjunction with Health Plan's UM Program, grievances, peer review, Healthcare Effectiveness Data and Information Set ("HEDIS") studies, Health Plan's QI Program, Consumer Assessment of Healthcare Providers and Systems ("CAHPS"), Medicare and/or Medicaid risk adjustment, or Claims payment. The party producing the records will be responsible for any fees associated with producing such records. Provider will further provide direct access to said patient care information as requested by Health Plan and/or as required by any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan. Health Plan will have the right to withhold compensation from Provider in the event that Provider fails or refuses to promptly provide any such information to Health Plan. This section will survive the termination of this Agreement or an individual product/program.

e. **Member Access to Health Information.** Provider will give Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with applicable Law, applicable Government Programs, and Health Plan's policies and procedures. This section will survive the termination of this Agreement or an individual product/program.

2.8 **Program Participation.**

a. **Participation in Grievance Program.** Provider will participate in Health Plan's Grievance Program and will cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.

b. **Participation in Quality Improvement Program.** Provider will participate in Health Plan's Quality Improvement Program and will cooperate with Health Plan in conducting peer review and audits of care rendered by Provider.

c. **Participation in Utilization Review and Management Program.** Provider will participate in and comply with Health Plan's Utilization Review and Management Program, including all policies and procedures regarding prior authorizations, and will cooperate with Health Plan in audits to identify, confirm, and/or assess utilization levels of Provider Services.

d. **Participation in Credentialing.** Provider will cooperate with, participate in and satisfy all credentialing and re-credentialing criteria established by Health Plan prior to the Effective Date and provision of Covered Services set forth in and in accordance with and throughout the term of this Agreement. Provider will immediately notify Health Plan in writing of any change in the information submitted or relied upon by Provider in order to achieve or maintain credentialed status. All Participating Providers must be credentialed in accordance with Health Plan's policies and procedures, by Health Plan or its designee, prior to treating Members.

e. **Provider Manual.** Provider will comply with and render Covered Services in accordance with the contents, instructions and procedures set forth in the Provider Manual, which is incorporated herein by reference and which may be unilaterally amended from time to time by Health Plan. Health Plan's Provider Manual is made available to Provider at Health Plan's website.

f. **Supplemental Materials.** In addition to the contents, instructions, and procedures set forth in the Provider Manual, Health Plan may periodically promulgate bulletins or other written materials that may or may not be used to supplement the Provider Manual or may be used to provide additional instruction, guidance or information to Provider ("Supplemental Materials"). Health Plan may issue such Supplemental Materials in an electronic format. Provider can obtain paper copies upon request. Revisions to the Supplemental Materials shall become binding upon Provider as of the effective date indicated on the Supplemental Materials. If applicable, such effective date shall be determined in accordance with the terms of this Agreement.

g. **Health Plan's Electronic Processes and Initiatives.** Provider will participate in and comply with Health Plan's electronic processes and initiatives, including but not limited to, electronic submission of prior authorization, Health Plan access to electronic medical records, electronic claims filing, electronic data interchange ("EDI"), electronic remittance advice and electronic funds transfers, registration and use of Health Plan's interactive web portal. Such programs, registration, and use are contained and described in the Provider Manual or Supplemental Materials.

h. **Government Contracts.** Provider acknowledges that Health Plan has entered into contracts with state and federal agencies for the arrangement of health care services for Members through Government Programs. Provider will comply with any term or condition of those Government Contracts that are applicable to the Provider Services to be performed under this Agreement. Health Plan will give Provider a copy of any applicable Government Contract(s), upon request by Provider.

i. **Health Education/Training.** Provider will participate in and cooperate with Health Plan's Provider education and training efforts as well as Member education and related efforts. Provider will also comply with all Health Plan health education, Health Plan's Cultural Competency Plan, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Provider will ensure prompt delivery to any constituent providers all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Provider Services to Members.

2.9 **Practitioner Information.** Provider will deliver to Health Plan a complete list of its healthcare providers, facilities, and business/practice locations that it uses to provide Covered Services, together with specific information required for credentialing and administration in a format acceptable to Health Plan. Provider will deliver such information prior to the execution of this agreement and every six (6) months thereafter or promptly provide notice when there is any change to such information. Health Plan also reserves the right to request such information at any time.

2.10 **Licensure and Standing.**

a. **Licensure.** Provider warrants and represents that it is appropriately licensed to render health care services within the scope of Provider's practice, including having and maintaining a current narcotics number, where appropriate, issued by all proper authorities. Provider will provide evidence of licensure to Health Plan upon request. Provider will maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider will immediately notify Health Plan of any change in Provider's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider.

b. **Unrestricted Status.** Provider warrants and represents that it has not been and is not currently excluded from, and will immediately notify Health Plan in the event it becomes excluded from, participation in Medicare and/or state health care programs pursuant to Section 1128 of the Social Security Act (42 U.S.C. 1320a-7) ("Section 1128") for any of the following: (i) conviction of a crime; (ii) assessment of a civil penalty; (iii) entered into a contractual relationship with an entity convicted of a crime; and/or (iv) taken any other action that would prohibit it from participation in Medicare and/or state health care programs, all as set forth under Section 1128.

c. **Malpractice and Other Actions.** Provider will give immediate notice to Health Plan of: (i) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (ii) any criminal investigations or proceedings against Provider; (iii) any convictions of Provider for crimes involving moral turpitude or felonies; and (iv) any civil claim asserted against Provider that may jeopardize Provider's financial soundness.

d. **Staffing Privileges for Providers.** Consistent with community standards, Provider will have staff privileges with at least one Health Plan contracted hospital as necessary to provide services to Members under this Agreement, and will authorize each hospital at which he/she maintains staff privileges to notify Health Plan should any disciplinary or other action of any kind be initiated against such provider which could result in any suspension, reduction or modification of Provider's hospital privileges.

e. **Liability Insurance.** Throughout the term of this Agreement, Provider will maintain premises and professional liability insurance: (i) in coverage amounts appropriate for the size and nature of Provider's facility and the nature of Provider's health care activities; and (ii) in compliance with applicable Law and Government Program requirements. If the coverage is claims made or reporting, Provider agrees to purchase similar "tail" coverage upon termination of the Provider's present or subsequent policy(ies). Provider will deliver copies of such insurance policy(ies) to Health Plan within five (5) business days of a written request by Health Plan, and will give at least fifteen (15) business days advance written notice to Health Plan prior to any change, reduction, cancellation or termination of such insurance coverage.

2.11 **Claims Payment.**

a. **Submitting Claims.** Provider will promptly submit to Health Plan Claims for Provider Services rendered to Members. All Claims will be submitted in a standard form (CMS-1500, UB-04 or successor format) acceptable to and approved by Health Plan, and will include any and all medical records pertaining to the Claim if requested by Health Plan or otherwise required by Health Plan's policies and procedures. Provider will not be eligible for payment

for any Claims submitted within a period of time from the Date of Service that exceeds: (i) the number of days required by the timeframes specified by applicable Law and Government Program requirements; or (ii) ninety (90) days from the Date of Service, whichever is greater. Notwithstanding the foregoing, for any Claims associated with coordination of benefits, Provider will not be eligible for payment within a period of time that exceeds: (i) the number of days required by the timeframes specified by applicable Law and Government Program requirements; or (ii) ninety (90) days from the date the primary payor adjudicated the Claim, whichever is greater.

b. **National Provider Identifier ("NPI").** Provider will comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (45 CFR Section 162.402, et seq.) and use only the NPI to identify HIPAA covered health care providers in standard transactions. Provider will utilize an NPI from the National Plan and Provider Enumeration System ("NPPES") for itself or for any subpart of the Provider. Provider will make best efforts to report its NPI and any subparts to Health Plan. Provider will report any changes in its NPI or subparts to Health Plan within thirty (30) days of the change. Provider will use its NPI to identify itself on all Claims and Encounters (both electronic and paper formats) submitted to Health Plan.

c. **Compensation.** Health Plan will pay Provider for Clean Claims for Provider Services provided to Members, including Emergency Services, in accordance with applicable Law, Government Program requirements, and in accordance with the terms of this Agreement. Such payment will be made within the lessor of: (i) the timeframes specified by applicable Law and Government Program requirements, or (ii) sixty (60) days of the date such Clean Claim is delivered by Provider to Health Plan and Health Plan determines such claim is a Clean Claim for Provider Services and/or Emergency Services. Provider agrees to accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for Provider Services provided to Members as deemed Medically Necessary and appropriate under this Agreement, Health Plan's Quality Improvement and Utilization Review and Management Programs. Provider will not balance bill Members for any Provider Services.

d. **Co-payments and Deductibles.** Provider is responsible for collection of co-payments, co-insurances and deductibles, if any.

e. **Member Hold Harmless.** Provider, or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by Health Plan, Health Plan insolvency or breach of this Agreement, shall Provider, or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons other than the Health Plan acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on Health Plan's behalf made in accordance with the terms of the agreement between Health Plan and its Members.

   Provider, or its assignee or subcontract, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Health Plan's Members and that (2) this provision supersedes any oral or written contract agreement now existing or hereafter entered into between Provider and any Member or persons acting on any Member's behalf. (Iowa Admin. Code § 191-40.18.)

f. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider will make reasonable inquiry of Members to learn whether Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type, and Provider will immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Provider will be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payors, not to exceed the amount specified in the Compensation Schedule.

g. **Offset.** In the event of an Overpayment, Provider will make repayment to Health Plan within thirty (30) days of receipt of written notification by Health Plan of the Overpayment or within thirty (30) days of Provider's identification of the Overpayment. In addition to any other contractual or legal remedy, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider. As a material condition to Health Plan's obligations under this Agreement, Provider agrees that the offset and recoupment rights set forth herein will be deemed to be and to constitute rights of offset and recoupment authorized under applicable Law or in equity to the maximum extent legally permissible, and that such rights will not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Provider.

h. **Claim Review**. Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, current Uniform Billing ("UB") manual and editor, Current Procedural Terminology

("CPT") and Healthcare Common Procedure Coding System ("HCPCS"), federal, and state billing and payment rules, National Correct Coding Initiatives ("NCCI") Edits, and Federal Drug Administration ("FDA") definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Furthermore, Provider acknowledges Health Plan's right to conduct medical necessity reviews and apply clinical practices to determine appropriate payment. Payment may exclude certain items not billed in accordance with industry standard billing and payment rules or certain items which do not meet certain medical necessity criteria.

i. **Claim Auditing.** Provider acknowledges Health Plan's right to conduct post-payment billing audits. Provider shall cooperate with Health Plan's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan shall use established industry claims adjudication and/or clinical practices, state, and federal guidelines, and/or Health Plan's policies and data to determine the appropriateness of the billing, coding and payment.

j. **Payments which are the Responsibility of a Capitated Provider.** Provider agrees that if Provider provides Covered Services that are the financial responsibility of a Capitated Provider, Provider will look solely to the Capitated Provider, and not Health Plan, for payment of such Covered Services. Pursuant to the terms in the agreement between the Capitated Provider and the Health Plan, if Provider provides Covered Services that are the financial responsibility of the Capitated Provider, Capitated Provider will compensate the Provider at the rate set forth in the Agreement between the Provider and the Capitated Provider. In the event there is not an agreement between the Capitated Provider and Provider, or where the Capitated Provider and Provider have not agreed to compensation terms, Provider will be reimbursed, as determined by the Provider and the Capitated Provider, at: (i) one hundred percent (100%) of the governing rates provided by applicable Law specific to the Member's enrolled benefit plan (i.e. Medicaid or Medicare, etc.) in place at the time services are rendered; or (ii) at the rates set forth in this Agreement. Except as specifically stated in this section, Provider agrees that the other compensation terms of the Agreement will continue to be binding upon Provider. Furthermore, for the avoidance of doubt, Provider will abide by all provisions of this Agreement relating to non-billing of Members with respect to all services and treatment.

k. **Timely Submission of Encounter Data**. Provider understands that Health Plan may have certain contractual reporting obligations which require timely submission of encounter data. Therefore, as applicable, Provider shall submit Encounter Data to Health Plan within thirty (30) days of the Date of Service.

2.12 **Compliance with Law.** Provider will comply with all applicable Laws governing the delivery of Provider Services to Members including, but not limited to, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Balanced Budget Act of 1997; and the Americans with Disabilities Act. In addition, Provider shall comply with the program specific requirements set forth in the attachments to this Agreement as they apply to each product and region.

2.13 **Provider Non-solicitation Obligations.** Provider will not unilaterally assign or transfer patients served under this Agreement to another medical group, Independent Practice Association ("IPA"), or provider without the prior written approval of Health Plan. Nor will Provider solicit or encourage Members to select another health plan. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

2.14 **Fraud and Abuse Reporting.** Provider will report to Health Plan's compliance officer all cases of suspected fraud or abuse, as defined in 42 CFR 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) days of the date when Provider first becomes aware of, or is on notice of, such activity. Provider will establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and abuse in the provision of health care services under the Medicaid program. Upon the request of Health Plan and/or the state, Provider will consult with the appropriate state agency prior to and during the course of any such investigations.

2.15 **Advance Directive.** Provider will document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other applicable Law.

2.16 **Reassignment of Members.** Health Plan reserves the right to reassign Members from Provider to another provider or to limit or deny the assignment or selection of new Members to Provider during any termination notice period or if Health Plan determines that assignment of Members to Provider poses a threat to the Members' health and safety. If Provider requests reassignment of a Member, Health Plan, in its sole discretion, will make the determination regarding reassignment based upon good cause shown by the Provider. When the Health Plan reassigns Member(s), Provider will forward copies of the Member's medical records to the new provider within ten (10) business days of receipt of the Health Plan's or the Member's request to transfer the records.

2.17 **Reciprocity Agreements.** Provider will cooperate with Affiliates of Health Plan and agrees to provide Provider Services to Members enrolled in the various products and programs offered by any Affiliate and to assure reciprocity of such health care services. Provider will comply with the procedures established by Health Plan or its Affiliates and this Agreement for reimbursement of such services or treatment. Provider will not encourage Members to receive Provider Services from non-Participating Providers. Provider will abide by all provisions of this Agreement relating to non-billing of Members with respect to all services and treatment subject to this reciprocity arrangement.

2.18 **Notification of Network Change.** Where Provider is a medical group, independent practice association, or any other similar entity/organization, Provider will provide Health Plan and Members with timely prior written notification in the event a constituent provider terminates its contract with Provider. Said written notification will be in compliance with applicable Law or Government Program requirements.

2.19 **Members Condition Changes or Deaths.** Upon becoming aware of or suspecting: (i) a significant change in a Member's health or functional status that could affect Member's level of care determination; (ii) a Member is being abused or neglected; or (iii) a Member death, Provider will notify Health Plan's Member Services Department as soon as possible but not later than seven (7) days.

ARTICLE THREE – HEALTH PLAN'S OBLIGATIONS

3.1 **Compensation.** Health Plan will pay Provider in accordance with the terms and conditions of this Agreement.

3.2 **Member Eligibility Determination.** Health Plan will maintain data on Member eligibility and enrollment. Health Plan will promptly verify Member eligibility at the request of Provider.

3.3 **Prior Authorization Review.** Health Plan will timely respond to requests for prior authorization and/or determination of Provider Services.

3.4 **Medical Necessity Determination.** Health Plan's determination with regard to Medically Necessary services and scope of Provider Services, including determinations of level of care and length of stay benefits available under the Member's health program will govern. The primary concern with respect to all medical determinations will be in the interest of the Member.

3.5 **Member Services.** Health Plan will provide services to Members including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan Participating Providers.

3.6 **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Provider Services, limitations and exclusions, and coordination of benefits information. Health Plan will make available a Provider Services Department that, among other Health Plan duties, will be available to educate Provider regarding Health Plan's policies and procedures.

3.7 **Medical Director.** Health Plan will retain a physician as medical director who will be responsible for the management of the scientific, technical, medical and behavioral health aspects of Health Plan.

ARTICLE FOUR – TERM AND TERMINATION

4.1 **Term.** This Agreement will commence on the Effective Date indicated by Health Plan and will continue in effect for one (1) year; thereafter, it will automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with the provisions of this Agreement or in accordance with applicable state and federal provisions set forth in the Attachments hereto.

4.2 **Termination without Cause.** At any time during this Agreement, this Agreement, a product/program provided pursuant to this Agreement, or an individual Provider under this Agreement, may be terminated without cause by either party on at least one hundred twenty (120) days written notice to the other party.

4.3 **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach may give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination will have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this thirty (30) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the party who provided the notice of termination will have the right to immediately terminate this Agreement, a product/program provided pursuant to this Agreement, or an individual Provider under this Agreement. Notwithstanding the forgoing, either party may immediately terminate this Agreement, a product/program provided

pursuant to this Agreement, or an individual Provider under this Agreement, without providing the other party the opportunity to cure a material breach should the terminating party reasonably believe the material breach of this Agreement to be non-curable.

4.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, or unless otherwise mutually agreed to in writing by both parties, this Agreement, a product/program provider pursuant to this Agreement, or an individual Provider under this Agreement, may immediately be terminated upon written notice to the other party in the event of any of the below. Upon termination, Health Plan may transfer Member(s) to another provider.

a. Provider's license or certificate to render health care services is limited, suspended or revoked, or disciplinary proceedings are commenced against Provider by the state licensing authority;

b. Either party fails to maintain insurance required by this Agreement;

c. Provider has not or is unable to comply with Health Plan's credentialing requirements, including but not limited to, having or maintaining credentialing status;

d. Either party becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider or Health Plan is appointed by appropriate authority;

e. If Provider is capitated and Health Plan determines Provider is financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;

f. Health Plan reasonably determines that Provider's facility or equipment is insufficient to render Provider Services;

g. Either party is excluded from participation in Medicare or state health care programs pursuant to Section 1128;

h. Provider is terminated as a provider by any state or federal health care program;

i. Either party engages in fraud or deception, or permits fraud or deception by another in connection with each party's obligations under this Agreement;

j. Health Plan reasonably determines that health care services are not being properly provided, or arranged for by Provider, and that such failure poses a threat to Members' health and safety;

k. Provider violates any state or federal law, statute, rule, regulation or executive order; or

l. Provider fails to satisfy the terms of a corrective action plan.

4.5 **Continuation of Care.** Where Provider is a primary care provider or practitioner, Provider will furnish health care services to each Member assigned to their panel for ninety (90) days after the date of the notice of a termination for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure statute, for each assigned Member:

a. Who was receiving health care services from Provider before the notice of termination; and

b. Who after receiving notice of the termination of Provider, requests to continue receiving health care services from Provider.

4.6 **Notice of Nonrenewal or Termination.** Health Plan will provide written notice of nonrenewal or termination of Provider to the Members served by Provider as soon as practicable, but in no event later than fifteen (15) days following termination. Provider will not contact Health Plan's Members upon termination of this Agreement, a product/program provided pursuant to this Agreement, or an individual Provider under this Agreement. Immediate written notice will be provided without sixty (60) days' notice in the event Provider's license has been disciplined by a state licensing board.

ARTICLE FIVE – GENERAL PROVISIONS

5.1 **Indemnification.** Each party will indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

5.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor will it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained will prevent any of the parties from entering into similar arrangements with other parties. Each of the parties will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will be construed to create, any right in any third party, including but not limited to, Members. Nor will any third party have any right to enforce the terms of this Agreement.

5.3 **Governing Law.** The laws of the State of Iowa will govern this Agreement.

5.4 **Entire Agreement.** This Agreement, including attachments, addenda, amendments, and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, between the parties and relating to the subject matter of this Agreement are of no force or effect. Additionally, as to the Medicaid products offered by Health Plan, the State Contract is incorporated herein by reference and shall be the guiding and controlling document when interpreting the terms of this Agreement.

5.5 **Severability.** If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.

5.6 **Headings and Construction.** The headings in this Agreement are for reference purposes only and shall not be considered a part of this Agreement in construing or interpreting any of its provisions. It is the parties' desire that if any provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is to be construed against its drafter shall not apply to the interpretation of the ambiguous provision.

5.7 **Non-exclusivity.** This Agreement will not be construed to be an exclusive Agreement between Health Plan and Provider. Nor will it be deemed to be an Agreement requiring Health Plan to refer Members to Provider for health care services.

5.8 **Amendment.** Health Plan may, without Provider's consent, immediately amend this Agreement to maintain consistency and/or compliance with any applicable Law, policy, directive, or Government Program requirement. Health Plan may otherwise amend this Agreement upon thirty (30) days prior written notice to Provider. If Provider does not deliver to Health Plan a written notice of rejection of the amendment within that thirty (30) day period, the amendment will be deemed accepted by and will be binding upon Provider.

5.9 **Delegation or Subcontract.** Provider will not delegate or enter into any subcontract agreement for the provision of Provider Services without the prior written consent of Health Plan. Any subcontract agreement entered into by Provider for the delivery of Provider Services will be in writing and will bind the subcontractor to the terms and conditions of this Agreement including, but not limited to, licensure, insurance, and billing of Members for Provider Services.

5.10 **Assignment.** Provider may not assign or transfer, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Health Plan and Provider and their respective successors in interest and assigns.

5.11 **Disputes and Venue.** Any claim or controversy arising out of or in connection with this Agreement will first try to be resolved through the Grievance Program and Health Plan's internal appeals process. In the event that the claim or controversy cannot be resolved through the Grievance Program or Health Plan's internal appeal process, Provider and Health Plan will engage in mandatory good faith meetings and discussions, which can include multiple writings, telephonic meetings or in person meetings, but will at least include one written communication by each party setting forth their position and one in person meeting, with decision makers present to try and resolve the claim or controversy. Any remaining claim or controversy, which results in a court action or proceeding with respect to this Agreement, will commence and proceed in Des Moines, Iowa.

5.12 **Notice.** All notices required or permitted by this Agreement will be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, by Federal Express or other overnight courier that guarantees next day delivery, by facsimile transmission, or by electronic mail or other means of electronic delivery, including but not limited to, Health Plans website and interactive web portal. All notices will be deemed sufficiently given if served in the manner specified in this section. The mailing names and addresses set forth under the Signature Authorization section of this Agreement will be the particular party's address for delivery or mailing of notice purposes. Each party may change their name and address through written notice in compliance with this section. Any notice sent by registered or certified mail, return receipt requested, will be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery will be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice will be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

5.13 **Waiver.** A failure or delay of any party to exercise or enforce any provision of this Agreement shall not be deemed a waiver of any right of that party. Any waiver must be specific, in writing and executed by both the Health Plan and Provider.

5.14 **Execution in Counterparts and Duplicates**. This Agreement shall be executed in duplicate and each duplicate may also

be executed in counterparts, each of which shall be deemed a duplicate original, but all of which together shall constitute one and the same instrument. It is further agreed that facsimile signatures, electronic signature, pdf signatures, or a signature scanned and sent via e-mail shall have the same effect as original signatures.

5.15 **Conflict with Health Plan Product**. Nothing in this Agreement modifies any benefits, terms or conditions contained in the Member's Health Plan product. In the event of a conflict between this Agreement and the benefits, terms, and conditions of the Health Plan product, the benefits, terms or conditions contained in the Member's Health Plan product will govern.

5.16 **Force Majeure.** Neither party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either party's employees, or any other similar cause beyond the reasonable control of such party.

5.17 **Confidentiality.** Any information maintained or generated by either party in fulfillment of its obligations under this Agreement, including healthcare information, shall be kept confidential in accordance with and to the extent required by applicable Laws. Further, all information provided to Provider, including, but not limited to, Member lists, QI Program, credentialing criteria, compensation methodologies and rates, and any other administrative protocols or procedures of Health Plan, is the proprietary property of Health Plan. Provider shall not disclose or release such material to any third party without the written consent of Health Plan.

ATTACHMENT A
DEFINITIONS

Capitalized words or phrases in this Agreement mean the following:

1.1 **Accreditation Organization** means any organization, including, without limitation, the National Committee for Quality Assurance ("NCQA"), engaged in accrediting or certifying Health Plan or Provider.

1.2 **Advance Directive** means a Member's written instructions, recognized under Law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under Law. Examples of Advance Directives are living wills and durable powers of attorney for health care.

1.3 **Affiliate** means an entity owned or controlled by Health Plan or Molina Healthcare, Inc. ("Molina").

1.4 **Agreement** means this Provider Services Agreement, including all attachments addenda, amendments, and incorporated documents or materials.

1.5 **Authorized Representative** means the person with legal authority to agree to and execute this Agreement.

1.6 **Capitated Provider** shall mean a provider that has accepted financial responsibility for certain Covered Services and Members, which can be demonstrated through the agreement the Capitated Provider has with Health Plan.

1.7 **Centers for Medicare and Medicaid Services ("CMS")** means an administrative agency of the United States Government, responsible for administering the Medicare program.

1.8 **C.F.R** means Code of Federal Regulations.

1.9 **Claim** means an invoice for Provider Services rendered to a Member by Provider, submitted in a format approved by Health Plan and with all service and Encounter information required by Health Plan.

1.10 **Clean Claim** means a Claim for Provider Services that is submitted on an industry standard form (e.g. CMS-1500, UB-04), and has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the Claim.

1.11 **Completion of Audit** means the completion of audit by the Department of Health and Human Services ("DHHS"), the Government Accountability Office ("GAO"), or their designees of Health Plan, Medicare and Medicaid Plan contractor or related entity.

1.12 **Covered Services** means those health care services, supplies and benefits that are (i) Medically Necessary, (ii) benefits of the applicable Health Plan Product(s)/Program(s), and (iii) required to be provided by Health Plan pursuant to the Government Contract(s) as applicable, which covers the Member(s).

1.13 **Cultural Competency Plan** means a plan that ensures Covered Services are provided to Members in a manner that takes into account, but is not limited to: developmental disabilities, physical disabilities, differential abilities, cultural and ethnic backgrounds and limited English proficiency.

1.14 **Date of Service** means the date on which Provider renders services to a Member, or for inpatient services, the date the Member is discharged.

1.15 **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between a health plan (or applicant) and a First Tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.16 **Emergency Services** are health care services furnished in the emergency department of a hospital for the treatment of a medical emergency; ancillary services routinely available to the emergency department of a hospital for the treatment of a medical emergency; and emergency medical services transportation.

1.17 **Encounter** means a distinct set of services provided to a Member enrolled by Health Plan on the dates that the services were delivered.

1.18 **Encounter Data** means (i) all data captured during the course of a single health care Encounter that specify the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative) pharmaceuticals, medical devices and equipment associated with a Member receiving services during the Encounter; (ii) the identification of the Member receiving and the provider delivering the health care services during the single Encounter; and (iii) a unique, i.e. unduplicated, identifier for the single Encounter.

1.19 **Final Contract Period** means the final term of the contract between CMS and the Health Plan.

1.20 **First Tier Entity** means any Party that enters into a written arrangement, acceptable to CMS, with Health Plan to provide administrative services or health care services for a Medicare eligible Member under the Medicare Advantage program.

1.21 **Iowa Department of Human Services ("DHS")** means the agency within the State of Iowa that is responsible for the oversight and administration of the Medicaid and CHIP programs.

1.22 **Government Contracts** means those contracts between Health Plan and state and federal agencies for the arrangement of health care service for Members through Government Programs, including but not limited to, the State Contract(s).

1.23 **Grievance Program** means the procedures established by Health Plan to timely address Member and Provider complaints or grievances.

1.24 **Health Plan** means Molina Healthcare of Iowa, Inc., a Iowa Corporation.

1.25 **Law(s)** mean all federal and state statutes and regulations applicable to the subject matter of this Agreement or the parties' performance of their duties and obligations hereunder.

1.26 **Medicaid** means the joint federal-state program provided for under Title XIX of the Social Security Act, as amended.

1.27 **Medically Necessary** means care that is based upon generally accepted medical practices in light of conditions at the time of treatment, and are services that are: (i) appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible Member's medical condition; (ii) compatible with the standards of acceptable medical practice in the community; (iii) provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms; (iv) not provided solely for the convenience of the Member or the convenience of the provider; and (v) not primarily custodial care unless custodial care is a covered service or benefit under the Member's evidence of coverage.

1.28 **Medicare** means the various insurance health plans provided under Title XVIII of the Social Security Act, as amended.

1.29 **Medicare Advantage ("MA")** means an alternative to the traditional Medicare program in which private plans, run by health insurance companies, provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

1.30 **Medicare Advantage Special Needs Plan ("MA-SNP")** means an alternative to the traditional Medicare program in which private plans, run by health insurance companies, provide health care benefits to beneficiaries who are eligible for both Medicare and Medicaid.

1.31 **Medicare-Medicaid Program ("MMP")** means an integrated delivery system, payment model, and alternative to the traditional Medicare and Medicaid programs, aimed at improving the quality, coordination, and cost-effectiveness of services, in which private health plans, run by health insurance companies, provide health care benefits to beneficiaries who are dually eligible for both Medicare and Medicaid.

1.32 **Member** means a person enrolled in one of Health Plan's benefit products or a Health Plan Affiliate's benefit product and who is eligible to receive Covered Services.

1.33 **Overpayments** means any payment Provider receives or retains in which Provider, after applicable reconciliation, is not entitled to receive such payment pursuant to Law or the terms of this Agreement.

1.34 **Participating Provider(s)** means those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan.

1.35 **Provider** means the person(s) and/or entity(ies), any constituent physicians, allied health professionals, staff persons, and any employed, subcontracted and/or affiliated entities, and are all bound by the terms and conditions of this Agreement.

1.36 **Provider Manual** means Health Plan's, procedures, standards and specimen documents that have been compiled by Health Plan for the use and instruction of Provider.

1.37 **Provider Services** means those Covered Services that are within the normal scope of practice and licensure of Provider.

1.38 **Quality Improvement Program ("QI Program")** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.

1.39 **Related Entity** means any entity that is related to the Health Plan by common ownership or control and: (i) performs some of the Health Plan's management functions under contract or delegation; (ii) furnishes services to Medicare Members under an oral or written agreement; or (iii) leases real property or sells materials to the Health Plan at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.

1.40 **State Children's Health Insurance Program ("CHIP")** means the program established pursuant to Title XXI of the Social Security Act, as amended.

1.41 **State Contract** means the contract(s) between DHS and Health Plan that govern the provision of Covered Services to Members, as may be amended.

1.42 **Utilization Review and Management Program ("UM Program")** means the policies, procedures and systems developed by Health Plan for evaluating and monitoring the medical necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective reviews, including but not limited to under-utilization and over-utilization.

ATTACHMENT B
PRODUCTS/PROGRAMS

Provider agrees to participate as a Participating Provider for the following products/programs and successor(s).

1.1 **Medicaid** - including but not limited to the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa (hawk-i) programs.

1.2 **Medicare** – including but not limited to Molina Medicare Options (Medicare Advantage), Molina Medicare Options Plus ("MA-SNP").

1.3 **Medicare-Medicaid Program –** including, but not limited to, Dual Options (Capitated Financial Alignment Demonstration ("CFAD").

ATTACHMENT C
COMPENSATION SCHEDULE

1.1 **Medicaid**

a. **Provider Services Payments.** Health Plan agrees to compensate Provider for Covered Services rendered to Members, in accordance with the products/programs specified in Attachment B, that are determined by Health Plan to be payable and submitted on a Clean Claim, on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of: (i) Provider's billed charges; or (ii) at an allowable amount equivalent to the payable rate under the applicable Medicaid Fee-For-Service Program fee schedule set forth by the State of Iowa, in effect on the Date(s) of Service. Notwithstanding the foregoing, payment for Covered Services, including, but not limited to, certain Covered Services where there is no payment rate in the Iowa Medicaid Fee-For-Service Program fee schedule as of the Date(s) of Service, will not exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the Date(s) of Service.

1.2 **Medicare**

a. **Provider Services Payments**. Health Plan agrees to compensate Provider for Provider Services rendered to Members, in accordance with Medicare products/programs as specified in Attachment C, that are determined by Health Plan to be payable and submitted on a Clean Claim, on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of; (i) Provider's billed charges, or (ii) at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography), as of the date(s) of service.

ATTACHMENT D
DHS PROGRAM REQUIREMENTS

This attachment sets forth the applicable requirements that are required by the State Contract to be included in agreements between Health Plan and Participating Providers or other provisions necessary to reflect compliance with the Law. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments to the State Contract or changes or modifications to Law or Government Program requirements. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1.1 The parties acknowledge that State Contract has not been completed and that upon completion, this attachment will immediately be amended to conform to any requirement set forth therein.

ATTACHMENT E
Medicare Program Requirements – Healthcare Services

This attachment sets forth the applicable Government Program requirements, covering the provision of health care and related services, that are required by CMS to be included in contracts and/or agreements between; (i) health plans/health maintenance organizations, and (ii) clients or providers of health care or related services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1.1 Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(ies) that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein. (42 CFR 422.504(i)(3)(iii)).

1.2 Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information, including books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under Health Plan's contract with CMS, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period between Health Plan and CMS or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 42 CFR 422.504(e)(3), 42 CFR 422.504(e)(4) and 42 CFR422.504(i)(2)(ii).).

1.3 Confidentiality. Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13).)

1.4 Hold Harmless/Cost Sharing. Provider agrees it may not under any circumstances, including nonpayment of moneys due to the providers by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Member, or any persons other than the Health Plan acting on their behalf, for services provided in accordance with this Agreement. The Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. (42 CFR 422.504(g)(1)(i)) and (42 CFR 422.504(g)(1)(iii).) In addition, for Members who are dually eligible for Medicare and Medicaid and enrolled in a Medicare Advantage Special Needs Plan will not be held liable for Medicare Part A and B cost sharing when the State or another payor such as a Medicaid Managed Care Plan is responsible for paying such amounts. Health Plan will inform providers of applicable Medicare and Medicaid benefits and rules for eligible Members. Provider agrees to accept payment from Health Plan as payment in full, or bill the appropriate State source, for any Medicare Part A and B cost sharing that is covered by Medicaid. Collection from the Member of copayments or supplemental charges in accordance with the terms of the Member's contract with the Health Plan, or charges for services not covered under the Member's contract, may be excluded from this provision.

1.5 Accountability. Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions set forth in Attachment E-1 of this Agreement. (42 CFR 422.504(i)(3)(ii).)

1.6 Delegation. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(3)(iii) and 42 CFR 422.504(i)(4).)

1.7 Prompt Payment. Health Plan and Provider agree that Health Plan will pay all Clean Claims for services that are covered by Medicare within sixty (60) days of the date such Claim is delivered by Provider to Health Plan and Health Plan determines such Claim is complete/clean. Any Claims for services that are covered by Medicare that are not submitted to Health Plan within six (6) months of providing the services that are subject of the Claim will not be eligible for payment, and Provider hereby waives any right to payment therefore. Health Plan reserves the right to deny any Claims that are not in accordance with the Medicare Claims Processing Manual and Medicare rules for billing. (42 CFR 422.520(b).)

1.8 Reporting. Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310. (42 CFR 504(a)(8).)

1.9 Compliance with Medicare Laws and Regulations. Provider will comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v).)

1.10 Benefit Continuation. Provider agrees to provide for continuation of Member health care benefits (i) for all Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Members who are hospitalized on the date Health Plan's contract with CMS terminates, or, in the event of insolvency, through discharge. (42 CFR 422.504(g)(2)(i), 42 CFR 422.504(g)(2)(ii) and 42 CFR 422.504(g)(3).)

1.11 Cultural Considerations. Provider agrees that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. (42 CFR 422.112(a)(8).)

ATTACHMENT E-1
Medicare Program Requirements – Delegated Services

This attachment sets forth the applicable Government Program requirements, covering the delegation to Provider of any management responsibilities or administrative services if any, that are required by CMS to be included in contracts and/or agreements between; (i) health plans/health maintenance organizations, and (ii) clients or providers of health care or related services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1.1 Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(s) that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein. (42 CFR 422.504(i)(3)(iii))

1.2 Medicare Compliance. Provider agrees to require all of its downstream, related entity(s) and transferees to comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v).)

1.3 Confidentiality. Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13).)

1.4 Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 42 CFR 422.504(e)(3), 42 CFR 422.504(e)(4) and 42 CFR 422.504(i)(2)(ii).)

1.5 Responsibilities and Reporting Arrangements. The Agreement specifies the delegated activities and reporting responsibilities if any. To the extent applicable, Provider will support Health Plan in complying with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 310 by providing relevant data. (42 CFR 422.504(i)(4)(i) and 42 CFR 422.504(a)(8).)

1.6 Revocation of Delegated Activities. In the event CMS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities will be revoked. (42 CFR 422.504(i)(4)(ii).)

1.7 Accountability. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(1) and 42 CFR 422.504(i)(3)(iii).)

1.8 Credentialing. If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. Health Plan retains the right to approve, suspend, or terminate any credentialing delegation arrangement. (42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5).)

1.9 Monitoring. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contractual obligations. Health Plan will monitor the performance of first tier, downstream, and related entities. (42 CFR 422.504(i)(1) and 42 CFR 422.504(i)(4).)

1.10 Further Requirements. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with Health Plan's contractual obligations. If Health Plan delegates selection of the providers, contractors, or subcontractor to another organization, Health Plan retains the right to approve, suspend, or terminate any such arrangement. (42 CFR 422.504(i)(3)(iii), 42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5).

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (this "BAA"), effective Month Day, Year (the "Effective Date"), is entered into by and between _____ (the "Business Associate"), and Molina Healthcare, Inc., and its subsidiaries and affiliates (the "Company") (each a "Party" and collectively the "Parties").

WHEREAS, the Parties have engaged or intend to engage in one or more agreements (each, an "Agreement" and collectively, the "Agreements") which may require the use or disclosure of PHI in performance of services described in such Agreement or Agreements (the "Services") on behalf of the Company;

WHEREAS, the Parties are committed to complying with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") and any regulations promulgated thereunder (collectively the "HIPAA Rules"); and

WHEREAS, this BAA, in conjunction with the HIPAA Rules, sets forth the terms and conditions pursuant to which protected health information (in any format) that is created, received, maintained, or transmitted by, the Business Associate from or on behalf of the Company, will be handled between the Business Associate and the Company and with third parties during the term of the Agreement(s) and after its termination.

NOW THEREFORE, the Parties agree as follows:

1. DEFINITIONS

Unless otherwise provided for in this BAA, terms used in this BAA shall have the same meanings as set forth in the HIPAA Rules including, but not limited to the following: "Availability," "Confidentiality," "Data Aggregation," "Designated Record Set," "Health Care Operations," "Integrity," "Minimum Necessary," "Notice of Privacy Practices," "Required By Law," "Secretary," and "Subcontractor." Specific definitions are as follows:

"Breach" shall have the same meaning as the term "breach" at 45 CFR 164.402.

"Business Associate" shall have the same meaning as the term "business associate" at 45 CFR 160.103 and in reference to the party to this BAA, shall mean the first party listed in the first paragraph of this BAA.

"Compliance Date" shall mean, in each case, the date by which compliance is required under the referenced provision of the HIPAA, the HITECH Act or the HIPAA Rules, as applicable; provided that, in any case for which that date occurs prior to the effective date of this BAA, the Compliance Date shall mean the effective date of this BAA.

"Electronic Protected Health Information" or "Electronic PHI" shall have the same meaning as the term "electronic protected health information" at 45 CFR 160.103.

"HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

"Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" at 45 CFR 160.103.

"Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

"Security Incident" shall have the same meaning as the term "security incident" at 45 CFR 164.304.

"Security Rule" means the Security Standards for the Protection of Electronic Protected Health Information, set forth at 45 CFR Parts 160 and 164.

"Services" shall mean, to the extent and only to the extent they involve the creation, use or disclosure of PHI, the services provided by the Business Associate to the Company under the Agreement(s), including those set forth in this BAA, as amended by written consent of the parties from time to time.

"Unsecured PHI" shall have the same meaning as the term "unsecured Protected Health Information" at 45 CFR 164.402.

2. GENERAL PROVISIONS

2.1 Effect. This BAA supersedes any prior business associate agreement between the Parties and those portions of any Agreement between the Parties that involve the disclosure of PHI by the Company to Business Associate. To the extent any conflict or inconsistency between this BAA and the terms and conditions of any Agreement exists, the terms of this BAA shall prevail.

2.2 Amendment. The Company may, without Business Associate's consent, amend this BAA to maintain consistency and/or compliance with any state or federal law, policy, directive, regulation, or government sponsored program requirement, upon forty-five (45) business days' notice to the Business Associate unless a shorter timeframe is necessary for compliance. The Company may otherwise materially amend this BAA only after forty-five (45) business days prior written notice to the Business Associate and only if mutually agreed to by the parties as evidenced by the amendment being executed by each party hereto. If the Parties fail to execute a mutually agreeable amendment within forty-five (45) days of the Business Associate's receipt of the Company's written notice to amend this BAA, the Company shall have the right to immediately terminate this BAA and any Agreement(s) between the Parties which may require the Business Associate's use or disclosure of PHI in performance of services described in such Agreement(s) on behalf of the Company.

3. SCOPE OF USE AND DISCLOSURE

3.1 The Business Associate may use or disclose PHI as required to provide Services and satisfy its obligations under the Agreement(s), if such use or disclosure of PHI would not violate the Privacy Rule.

3.2 The Business Associate may not use or further disclose PHI in a manner that would violate the Privacy Rule if done by the Company, except that the Business Associate may use or disclose PHI as necessary:

a. for the proper management and administration of the Business Associate as provided in Section 3.3; and

b. to provide Data Aggregation services relating to the Health Care Operations of the Company if required under the Agreement.

3.3 The Business Associate may use or disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Any disclosures of PHI under this section may be made only if:

a. the disclosures are required by law, or

b. the Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

3.4 The Business Associate shall not request, use or release more than the Minimum Necessary amount of PHI required to accomplish the purpose of the use or disclosure and shall comply with 42 U.S.C. § 17935(b) as of its Compliance Date. The Business Associate hereby acknowledges that all PHI created or received from, or on behalf of, the Company, is as between the parties, the sole property of the Company.

3.5 The Business Associate or its agents or Subcontractors shall not perform any work outside the United States of America that involves access to, use of, or disclosure of, PHI without the prior written consent of the Company in each instance.

4. OBLIGATIONS OF THE BUSINESS ASSOCIATE

The Business Associate shall:

4.1 Not use or disclose PHI other than permitted or required by this BAA or as Required by Law.

4.2 Establish and use appropriate safeguards to prevent the unauthorized use or disclosure of PHI.

4.3 Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Company. The Business Associate shall, as of the Compliance Date, comply with the applicable standards at Subpart C of 45 CFR Part 164.

4.4 Promptly report to the Company any unauthorized use or disclosure of PHI, or Security Incident, within no more than five (5) days, after Business Associate becomes aware of the unauthorized use or disclosure of PHI or Security Incident. The Business Associate shall take all reasonable steps to mitigate any harmful effects of such Breach or Security Incident. The Business Associate shall indemnify the Company against any losses, damages, expenses or other liabilities including reasonable attorney's fees incurred as a result of the Business Associate's or its agent's or Subcontractor's unauthorized use or disclosure of PHI or Breach of Unsecured PHI including, but not limited to, the costs of notifying individuals affected by a Breach of Unsecured PHI. Indemnification is subject to an ability to demonstrate that no agency relationship exists between the parties.

4.5 The Business Associate shall, following discovery of a Breach of Unsecured PHI, notify the Company of such Breach as required at 45 CFR 164.410, without unreasonable delay, and in no event more than thirty (30) days after the discovery of the Breach. The notification by the Business Associate to the Company shall include: (1) the identification of each individual whose Unsecured PHI was accessed, acquired, used or disclosed during the Breach; and (2) any other available information that the Company is required to include in its notification to individuals affected by the Breach including, but not limited to, the following:

a. a brief description of what happened, including the date of the Breach and the date of the discovery of the Breach;

b. a description of the types of Unsecured PHI that were involved in the Breach; and

c. a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches.

4.6 In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any Subcontractors or agents that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.

4.7 Within ten (10) days of receiving a request, make available PHI in a Designated Record Set to the Company as necessary to satisfy the Company's obligations under 45 CFR 164.524.

4.8 Within fifteen (15) days of receiving a request, make any amendment(s) to PHI in a Designated Record Set as directed or agreed to by the Company pursuant to 45 CFR 164.526.

4.9 Maintain and make available to the Company, within twenty (20) days of receiving a request, the information required to provide an accounting of disclosures to the individual as necessary to satisfy the Company's obligations under 45 CFR 164.528.

4.10 Make its internal practices, books and records relating to the use or disclosure of PHI received from or on behalf of the Company available to the Company or the U. S. Secretary of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

4.11 To the extent the Business Associate conducts Standard Transaction(s) (as defined in the HIPAA Rules) on behalf of the Company, Business Associate shall comply with the HIPAA Rules, "Administrative Requirements," 45 C.F.R. Part 162, by the applicable compliance date(s) and shall not: (a) change the definition, data condition or use of a data element or segment in a standard; (b) add any data elements or segments to the maximum defined data set; (c) use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s); or (d) change the meaning or intent of the standard's implementation specifications. The Business Associate shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under subsection (h) of Title 42 U.S.C. Section 1320d-2.

4.12 To the extent the Business Associate is to carry out one or more of the Company's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the Company in the performance of such obligation(s).

5. MISCELLANEOUS

5.1 Indemnification. In addition to any indemnities set forth in the Agreement(s), each party will indemnify and defend the other party from and against any and all claims, losses, damages, expenses or other liabilities, including reasonable attorney's fees, incurred as a result of any breach by such party of any representation, warranty, covenant, agreement or other obligation expressly contained herein by such party, its employees, agents, Subcontractors or other representatives.

5.2 Interpretation. Any ambiguity in this BAA shall be interpreted to permit compliance with the HIPAA Rules.

5.3 No Third Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

5.4 Governing Law and Venue. This BAA shall be governed by California law notwithstanding any conflicts of law provisions to the contrary. The venue shall be Los Angeles, California.

5.5 Notices. Any notices to be given hereunder to a Party shall be made via certified U.S. Mail or express courier to such Party's address given below, and/or (other than for the delivery of fees) via facsimile to the facsimile telephone numbers listed below:

If to Business Associate, to:	**If to the Company, to:**
	Molina Healthcare, Inc.
	200 Oceangate, Suite 100
	Long Beach, CA 90802
Attn:	Attn: Privacy Official
Fax:	Fax: 562-499-0789

6. TERM AND TERMINATION OF BAA

6.1 Term. The Term of this BAA shall be effective as of the effective date set forth in the first paragraph of this BAA, and shall terminate on date that the last Agreement remaining in force between the parties is terminated or expires, or on the date the Company terminates for cause as authorized in paragraph 6.2 below, whichever is sooner.

6.2 Termination for Cause. Notwithstanding any other provision of this BAA or the Agreement(s), the Company may terminate this BAA and any or all Agreement(s) upon five (5) days written notice to Business Associate if the Company determines, in its sole discretion, that Business Associate has violated a material term of this BAA .

6.3 Obligations of Business Associate Upon Termination. Upon termination of this BAA for any reason, Business Associate shall return to the Company or, if agreed to by the Company, destroy all PHI received from the Company, or created, maintained, or received by Business Associate on behalf of the Company, that the Business Associate still maintains in any form. If PHI is destroyed, Business Associate agrees to provide the Company with certification of such destruction. Business Associate shall not retain any copies of PHI except as Required By Law. If return or destruction of all PHI, and all copies of PHI, received from the Company, or created, maintained, or received by Business Associate on behalf of the Company, is not feasible, Business Associate shall:

a. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section 6, for as long as Business Associate retains the PHI; and

b. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set forth in Section 3 above which applied prior to termination.

6.4 Survival. The obligations of Business Associate under this Section shall survive the termination of this BAA and remain in force as long as Business Associate stores or maintains PHI in any form or format (including archival data). Termination of the BAA shall not affect any of the provisions of this BAA that, by wording or nature, are intended to remain effective and to continue in operation.

INTENDING TO BE LEGALLY BOUND, the parties hereto have caused this Agreement to be executed by their duly authorized representatives.

"Business Associate"	**"Company"**
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name
_____ _____	_____ _____
Title Date	Title Date

MOLINA HEALTHCARE

JOB PROFILE

POSITION TITLE: President II	JOB CODE: 1741	FLSA STATUS: Exempt	CLASSIFICATION: Exec/Sr Lvl Off & Mgrs
DEPT/LOCATION: Various State Health Plans	REPORTS TO (TITLE): Regional Vice President	PAY GRADE: E51	COMPLETION DATE: 1-22-13

Job Summary/Essential Functions:

The position's essential functions are as follows:

- Ability to manage a Health Plan with 350K+ members and 250+ employees.
- Formulate and implement business plans and strategies to provide for the profitable operations, to meet short-term objectives and ensure long term growth and success.
- Direct the growth of the state plan, including overseeing business development activities. Identify, analyze and recommend strategic alliances and/or acquisitions to provide better products and services to members.
- Develop and implement adequate measures to meet the fiscal needs of the company, to conserve its assets and to maintain an effective system of budgetary control.
- Review forecasts and proposed capital expenditures. Recommend programs and policies by analyzing the changing needs of the membership and industry; identify and analyze trends and evaluate options.
- Amend existing policies to improve operations and create new policies as needed. Present reports and recommendations on the operations and finances of the state plan and propose changes to major policies.
- Ensure the overall level of quality for delivery of medical services meet or exceed appropriate standards.
- Provide personal leadership that encourages employee productivity and responsiveness to the needs of current and prospective members.
- Ensure programs are established to comply with all relevant federal, state and local regulations.
- Effectively represents Molina Healthcare with state regulators, legislators, advocates and other constituents.
- Fosters and builds a collaborative working environment with internal and external colleagues and constituents.

Molina Healthcare Core Competencies: Generally, the ability to understand, internalize, exhibit and promote behaviors that reflect Molina Healthcare's Core Values to varying degrees.

- **Customer/Mission Orientation:** The ability to demonstrate genuine concern for satisfying one's internal and external customers, mindful advocates of our mission to provide quality health services to financially vulnerable families and individuals covered by government programs, and to remove barriers to health services.
- **Goal-Oriented Quality Performance:** The ability to manage and motivate one's own and one's employees' performance, ensuring commitment to exemplary performance and high quality work by setting clear goals and expectations, and tracking progress, with frequent feedback to allow the celebration of achievements and prompt correction of performance issues.
- **Empathetic, Culturally Competent Interpersonal Awareness:** The ability to notice, anticipate and interpret the needs, concerns and feelings of a diverse network of coworkers, members and providers, and to communicate this awareness empathetically in a respectful and culturally competent manner.
- **Personal/Company Credibility:** Demonstrated concern that one be perceived as an ethical, responsible, reliable, and trustworthy member and representative of the Molina Healthcare family at all times in all business affairs.
- **Prudent Financial Stewardship:** The desire and ability to carefully manage our financial resources as prudent stewards of the public's funds.

Behavioral Competencies: Generally, the knowledge-based functional competencies shared by all jobs within this Job Family.

- Model relentless commitment to the company's mission in all activities and at all times
- Differentiate Molina in every stakeholder interaction
- Use data as the foundation to insight, challenge data and "status quo" thinking
- Collaborate and engage others in broader thinking and gather input
- Move with a sense of urgency from data evaluation to management action
- Simplify solutions whenever possible

- Focus on achieving the six areas of Molina's strategic plan: Our Team, Quality and Value, Financial Strength, Growth, Customer Experience and Compliance
- Set clear expectations for each employee that align with expected results and metrics
- Once Molina leaders agree on direction, support the decision and champion change throughout your organization
- Ensure there are adequate resources for effective execution
- Freely and openly admit one's own mistakes or errors
- Routinely spend time with staff at all levels to increase comfort-level, approachability, and to establish rapport
- Create a safe environment in team meetings by drawing people out and facilitating communication flow by taking off "organizational hat and title"
- Excite team members and peers about challenges by using motivation vs. coercion
- Inspire others to reach beyond what they think they know or can do and lead them to places they might not have gotten on their own
- Explain the "why" behind the "what" to ensure others have the contextual understanding needed to move to action
- Recognize excellent work, reinforce good performance; leverage Above the Branches program
- Make it a priority to coach and mentor staff; hold routine one-on-one meetings with direct reports, have all leaders within the organization do the same
- Possesses expertise and comfort with public speaking; can easily convey information to both internal and external constituents (leadership and employees, legislators, regulators, etc.); ability to influence up, down and across; can engage in and lead difficult conversations with one or many

Functional Competencies: Generally, the specific technical and professional competencies required to perform the essential duties of this job.

- Expertise in resolution and solution development for administrative processes (i.e., develop action plans to reduce budget, root cause analysis re: increase in appeals and grievances, etc.)
- Knowledge and expertise in managed healthcare, government programs – Medicaid, Medicare, CHIP, ABD, etc.
- Experience in P&L and budgeting process and management of government programs in a $100M organization
- Understanding and experience in Health Care law and regulation
- Ability to understand and successfully negotiate contracts
- Ability to function in matrixed organization
- Expertise in Business Development; understands growth drivers, new market products and procurement
- Expertise in provider network composition and reimbursement
- Expertise in strategic planning and implementation – growth, positioning and financial projections
- Knowledge and expertise in Health Care Services (HCS); proven experience successfully leading and optimizing utilization management
- Ability to work with state regulators to resolve difficult issues while maintaining positive and productive working relationships at all levels

Leadership Competencies: Generally, the ability to collaborate effectively in a team setting and provide enterprise level leadership.

- Ability to collaborate and provide enterprise level leadership, exhibiting dedication to Molina's mission, modeling, embodying and advocating Molina's core competencies, values and leadership behaviors.
- Ability to create and develop new systems and models by making tough, data-driven decisions without prejudice, accepting, and acting on, facts.
- Ability to lead people engagement at all organizational levels.
- Ability to engage, coach, evaluate, influence and motivate others, providing frequent feedback and positive reinforcement.

TITLE(S) OF DIRECT REPORT(S):

MINIMAL QUALIFICATIONS	PREFERRED QUALIFICATIONS

Required Education:
Bachelors' and/or Masters' degree in Business, Health Services Administration or related field.

Preferred Education:

Required Experience:
10+ year's progressive healthcare experience in managed care industry.
5+ years of management experience

Preferred Experience:
Transition and/or acquisition experience.

Required Licensure/Certification/Associations: N/A

Preferred Licensure/Certification/Associations: N/A

TRAVEL REQUIREMENTS

This position requires same day out of office automobile travel approximately 35% of the time.
This position requires multiple day out of town overnight travel approximately 10% of the time.

PHYSICAL DEMANDS

Required: Working environment is generally favorable and lighting and temperature are adequate. Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions. Must have the ability to sit for long periods.

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EQUAL OPPORTUNITY EMPLOYER

Molina Healthcare is an Equal Opportunity Employer M/F/D/V.

JOB DESCRIPTION

POSITION TITLE:	JOB CODE:	FLSA STATUS:	EEO-1 CLASSIFICATION:
Vice President, Medical Affairs & Chief Medical Officer	1635	Exempt	Exec/Sr Lvl Off and Mgrs
DEPT/LOCATION:	**REPORTS TO (TITLE):**	**PAY GRADE:**	**COMPLETION DATE:**
Medical Affairs / State Plan	President	E49	01/05/11

POSITION SUMMARY (Briefly describe the purpose of the position):
Responsible for the day-to-day management of the Medical Affairs Department. Work collaboratively with the VP Healthcare Services to develop and implement clinical policies and provide clinical oversight. Direct the Medical Affairs team to work with the HealthCare Services team to develop and implement effective and efficient standards, protocols, decision support systems, reports and benchmarks that meet annual cost and quality targets. Manage credentialing policies and provide oversight. Serve as the "clinical face" of Molina Healthcare to the community.

ESSENTIAL FUNCTIONS

Duties and Responsibilities (List all essential duties and responsibilities in order of importance)

- Responsible for meeting annual healthcare cost and quality targets for the plan and achieving/retaining NCQA "Excellent" rating.
- Responsible for day to day oversight and management of the Medical Affairs Department and staff including: the Medical Directors, Director of Quality Improvement, Director of Behavioral Health and Director of Pharmacy Services. Supports each department's strategic planning and operational improvement process with emphasis on improved healthcare cost and quality.
- Provide oversight, support and direction for health plan's Quality programs in the areas of Health Care Services, Delegation Oversight, Credentialing and NCQA (HEDIS & CAHPS).
- Provide oversight, support and direction to the Director of Quality Improvement and drive the HEDIS and NCQA processes to achieve and maintain an excellent rating.
- Provide oversight, support and direction to the Director of Pharmacy Services to develop cost effective clinical protocols. Participates on the P&T (Pharmacy & Therapeutics) Committee and assist in formulary management process.
- Support Provider Network Management activities that improve unit cost, access and quality. Assist with contracting and solidifying provider relationships with key providers.
- Be the chief clinical spokesperson to the community.
- Support and supervise the Medical Directors for daily utilization management decision making using evidence based medicine guidelines, monitor and improve productivity, healthcare cost and quality. Provide clinical oversight including inter-rater review annually.
- Oversee regularly scheduled claims review sessions (DCRR – denied claims review requests) between the Medical Directors and the internal Provider Network Management staff.
- Support and supervise the Director of Behavioral Health and drive integration of behavioral and physical health components in all aspects of service to members.
- Support the credentialing processes and oversee the Molina Credentialing Committee.
- Influence changes that benefit Molina and our members by participating in community committees and task forces with the state, network providers and community organizations. Develop advocates among the State's clinical community that can be called upon to speak on behalf of issues that are important to Molina Healthcare before legislators, regulators and other key influencers.
- Chair the Executive Quality Improvement Committee, and participate in all quality committees such as the Clinical Quality Improvement Committee, the Satisfaction Committee, and other internal task forces and work groups required by NCQA.
- Accountable for insuring compliance with contractual, accreditation and regulatory requirements for all Medical Affairs teams.
- Work with staff at Molina direct delivery clinics for assistance with UM and other health plan functions. Collaborate with Lead Physician at each clinic on healthcare cost and quality. Monitor unit cost, utilization and quality scores and drive performance improvements in these areas to meet budget targets.
- Other duties, as assigned.

State Plan / Department Specific Duties and Responsibilities (List all essential duties other than those listed above in order of importance)

-

Knowledge, Skills and Abilities (List all knowledge, skills and abilities that are necessary to perform the job satisfactorily)

- Strong leadership capabilities, and ability to initiate and maintain cross-team relationships.
- Computer literacy

- Organizational and management skills.
- Problem solving & analytical ability
- Excellent interpersonal/teaming and verbal and written communication skills
- Ability to abide by Molina's policies
- Ability to maintain attendance to support required quality and quantity of work
- Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA)
- Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers

NON-ESSENTIAL FUNCTIONS

List other duties which are of secondary importance and marginal to the position's purpose.

- Other duties as assigned.

QUALIFICATIONS

Required Education:
Doctorate Degree in Medicine (MD or DO).

Preferred Education:
Masters in Business Administration, Public Health, Healthcare Administration, Health Care Management or similar degree.

Required Experience:

- Minimum 7 years Managed Care experience with line management responsibility including, quality, credentialing, utilization management and clinical policy oversight.
- Experience working within applicable state, federal, and third party regulations.
- Meeting Quality Accreditation Standards (NCQA/HEDIS).
- Minimum 5 years clinical practice experience.

Preferred Experience:
Familiarity and experience in the local market desirable.

Required Licensure/Certification:
Valid state medical license. No restrictions on medical license (free of sanctions from Medicaid & Medicare).

Preferred Licensure/Certification:
Board Certification in recognized ABMS medical specialty, primary care.

PHYSICAL DEMANDS

Work environment is generally favorable and lighting and temperature are adequate. Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions.

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

NUMBER OF DIRECT REPORT(S): 1-6 **NUMBER OF INDIRECT REPORT(S):**
TITLES OF DIRECT REPORT(S): Medical Directors, Director of Quality Improvement, Director of Pharmacy Services, Director of Behavioral Health and Executive Assistant.

The information in this position description indicates the general nature and level of work to be performed. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job. Management reserves the right to revise the job description or require that other tasks be performed when the circumstances of the job change (for example, emergencies, change in personnel, workload, or technical development).

By signing this document I, the employee, affirm that I understand that my employment is on an at-will basis. This means that I and my employer are mutually free to end the relationship at any time, for any reason or no reason, with or without notice.

Employee Signature

_____

Signature

_____ _____

Print Name Date

Manager Signature

Signature

Print Name Date

MOLINA HEALTHCARE

JOB DESCRIPTION

POSITION TITLE: Vice President, Finance and Analytics	JOB CODE: 1586	FLSA STATUS: Exempt	EEO-1 CLASSIFICATION: Exec/Sr Lvl Off & Mgrs
DEPT/LOCATION: Various/State Plans	REPORTS TO (TITLE): Plan President	PAY GRADE: E45	COMPLETION DATE: 1-10-2011

JOB SUMMARY (Briefly describe the purpose of the job):
Lead financial analysis of the health plan's performance. Lead and support financial and operational analysis for Medical Management and Provider Contracting. Review, evaluate and improve company business logic and data sources. Ensure timely creation of management reports. Ensure data integrity. Assist in developing, implementing and monitoring the health plan's strategic plan. Responsible for daily operations of Finance and Medical Data Management functions, including systems. Interact with multiple Molina Departments including UM, QI, Finance, Claims, Member Services and Provider Contracting.

ESSENTIAL FUNCTIONS

Duties and Responsibilities (List all essential duties and responsibilities in order of importance)

- Review and analyze premium rates received from the state for appropriateness. Develop analysis and arguments to support rate negotiations with the state. Monitor risk adjustment factors applied to rates (as applicable) and evaluate the financial impact of periodic adjustments.
- Review and analyze medical cost performance, including provider contract and medical management efficiency, identifying and implementing opportunities for improved profitability. Monitor and compare across regions, populations, provider panels, and external and internal benchmarks.
- Review and analyze monthly claims reserves for accuracy. Assist corporate actuarial department in setting monthly claims reserves.
- Review and analyze administrative costs, identifying and implementing opportunities for improved profitability.
- Review and interpret health plan financial performance with plan staff and corporate accounting staff. Monitor actual to budget performance. Identify and implement appropriate responses to budget variances. Develop and prepare management reports.
- Manage health plan functional departments including Reporting and Analysis, Project Management Office, Facilities Services, and Enrollment.
- Manage relationship with state department of insurance and other regulators for all financial matters.
- Develop annual budget.
- Reconcile premium receipts to eligibility in QNXT claims system.
- Support health plan strategic analysis and planning.
- Review and analyze financial terms of provider contracts and recommend changes. Develop scenario modeling and identify cost savings.
- Respond to all UM data needs, facilitating care coordination.
- Work with and support MHI Healthcare Data Analysis Department to support reporting, financial performance, common metrics and formatting and increase quality in all healthcare data analytical activities. Coordinate activities with corporate personnel to avoid duplication of work. Assure full data support with regard to data needs for quality improvement activities (HEDIS and CAHPS). Provide local plan support for provider report card/performance monitoring activities with regard to quality, pay for performance (P4P) and medical costs.
- Represent the finance function by participating on committees, task forces, work groups, and multidisciplinary teams as necessary.
- Acts as a liaison to both internal and external customers on behalf of Molina and data management areas.
- Manage the encounter process for the health plan, ensuring that all encounters are successfully submitted and that errors are resolved. Ensure the encounter process fully supports rate setting exercises, collection of case rate payments, and maximization of risk scores while complying with all applicable State guidelines.
- Maintain cooperative and effective workplace relationships and adhere to company code of conduct.

State Plan / Department Specific Duties and Responsibilities (List all essential duties other than those listed above in order of importance)

-

Knowledge, Skills and Abilities (List all knowledge, skills and abilities that are necessary to perform the job satisfactorily)

- Computer Literacy (Microsoft Office Products)
- Interpersonal communication skills
- Excellent verbal and written communication skills
- Ability to abide by Molina's policies
- Ability to maintain attendance to support required quality and quantity of work
- Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA)
- Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers

NON-ESSENTIAL FUNCTIONS

List other duties which are of secondary importance and marginal to the job's purpose.

- Other duties as assigned.

QUALIFICATIONS

Required Education:
BA, BS, in Finance, Accounting, or related field; Advanced training or experience in healthcare analytics

Preferred Education:
MBA, MS in Finance, Accounting , or post graduate training in finance

Required Experience:

- 10 years progressive healthcare finance or analytical experience.
- 5+ years managed care experience, preferably working with the Medicaid Product.
- 3+ years previous supervisory/management experience.
- 3+ years SQL, programming skills, relational database and financial analysis skills.

Preferred Experience:

- 3-plus years of accounting/finance experience

Required Licensure/Certification:

Preferred Licensure/Certification:

PHYSICAL DEMANDS

Working environment is generally favorable and lighting and temperature are adequate. Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions.

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

NUMBER OF DIRECT REPORT(S):

NUMBER OF INDIRECT REPORT(S):

The information in this job description indicates the general nature and level of work to be performed. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job. Management reserves the right to revise the job description or require that other tasks be performed when the circumstances of the job change (for example, emergencies, change in personnel, workload, or technical development).

By signing this document I, the employee, affirm that I understand that my employment is on an at-will basis. This means that I and my employer are mutually free to end the relationship at any time, for any reason or no reason, with or without notice.

Employee Signature

_____

Signature

_____ _____

Print Name Date

Manager Signature

Signature

Print Name

Date

MOLINA HEALTHCARE

POSITION DESCRIPTION

POSITION TITLE: Director, Compliance (State Health Plan)	JOB CODE: 2050	FLSA STATUS: Exempt	EEO-1 CLASSIFICATION: 1st Mid Lvl Off & Mgrs
DEPT/LOCATION: Government Contracts & Compliance, Bothell, Washington	REPORTS TO (TITLE): Director, Government Contracts	PAY GRADE: E40	COMPLETION DATE:

POSITION SUMMARY (Briefly describe the purpose of the position):
Responsible for the oversight of all ongoing activities related to the development, implementation, maintenance of, and adherence to policies and procedures and functions associated with ensuring compliance with state contracts and federal and state law.

ESSENTIAL FUNCTIONS

Duties and Responsibilities (List all essential duties and responsibilities in order of importance)

- Supervises Administrative Compliance Trainer/Internal Auditor
- Adheres to the company and/or departmental confidentiality standards and HIPAA compliance programs.
- Adheres to the company and/or departmental fraud and abuse prevention/detection policies and programs.
- This Position Description is intended to describe the essential job functions, the general job duties and the requirements for the performance of this job. It is not an exhaustive list of all duties, responsibilities and requirements of a person in the position. Other functions may be assigned and the company retains the right to add or change the duties at any time.
- Physical Demands: The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is regularly required to talk and hear. The employee regularly is required to stand, walk, sit, use the hand(s) to handle or feel objects or controls and reach with hands and arms. Climbing and balancing may be necessary on occasion. The employee may occasionally lift and/or move up to 10 pounds. Specific vision abilities required by this job include close vision and the ability to adjust focus.

Knowledge, Skills and Abilities (List all knowledge, skills and abilities that are necessary to perform the job satisfactorily)

- Ability to develop, organize, analyze and implement procedures.
- Effective interpersonal skills.
- Management and negotiation skills.
- Ability to maintain confidential information as needed.
- Skill in establishing and maintaining a variety of records necessary to provide complete information and documentation for relevant and appropriate audits
- Excellent verbal and written communication skills
- Ability to abide by Molina's policies
- Maintain regular attendance based on agreed-upon schedule
- Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA)
- Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers

NON-ESSENTIAL FUNCTIONS

List other duties which are of secondary importance and marginal to the position's purpose.

- Other duties as assigned.

QUALIFICATIONS

Required Education:
Bachelor Degree or equivalent combination of education and experience.

Required Experience:

Computer literacy. Knowledge of contract development and language helpful..

Preferred Experience:

Three to five years experience in managed health care and/or compliance related field preferred.

PHYSICAL DEMANDS

Required: Choose Applicable Physical Demands Language for the Position

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

NUMBER OF DIRECT REPORT(S):

NUMBER OF INDIRECT REPORT(S):

TITLES OF DIRECT REPORT(S):

The information in this position description indicates the general nature and level of work to be performed. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job. Management reserves the right to revise the job description or require that other tasks be performed when the circumstances of the job change (for example, emergencies, change in personnel, workload, or technical development).

By signing this document I, the employee, affirm that I understand that my employment is on an at-will basis. This means that I and my employer are mutually free to end the relationship at any time, for any reason or no reason, with or without notice.

Employee Signature

_____

Signature

_____ _____

Print Name Date

Manager Signature

_____

Signature

_____ _____

Print Name Date

POSITION DESCRIPTION

POSITION TITLE:	JOB CODE:	FLSA STATUS:	EEO-1 CLASSIFICATION:
Director Pharmacy (States)	2225	Exempt	1st Mid Lvl Off & Mgrs
DEPT/LOCATION:	**REPORTS TO (TITLE):**	**PAY GRADE:**	**COMPLETION DATE:**
Pharmacy/Molina Healthcare (of Indiana)	Chief Medical Officer/ Medical Director	E41	12-15-08

POSITION SUMMARY (Briefly describe the purpose of the position):
Responsible for monitoring drug utilization patterns for Molina Healthcare. Assists in the development, implementation and supervision of programs to promote cost-effective pharmacotherapy.

ESSENTIAL FUNCTIONS

Duties and Responsibilities (List all essential duties and responsibilities in order of importance)

- Reviews member, physician, pharmacy and drug utilization reports. Identifies trends affecting the pharmacy budget. Requests, reviews and summarizes ad hoc reports as required. Provides regular summaries of activities to Medical Director.
- Responsible for formulary development and maintenance. Coordinates Pharmacy and Therapeutics Committee. Participates in the evaluation of new drug products.
- Develops criteria for reviewing prior authorization requests. Assists in the review of prior authorization requests and summarize the approval and denial of such requests.
- Selects and maintains appropriate pharmacy reference resources. Researches and references drug therapy related questions.
- Recommends and implements appropriate actions and educational programs to influence prescribers. Ensures systems are in place to monitor results. Participates in Quality Improvement and Health Education programs related to pharmacy, including health care management and DSHS required programs. Participates in conjunction with Plan management, in management committee meetings.
- Participates in provider meetings as required.
- Performs audits as required of patient charts, provider sites and pharmacies.
- Perform other duties as assigned.
- Complies with workplace safety standards

State Plan / Department Specific Duties and Responsibilities (List all essential duties other than those listed above in order of importance)

-

Knowledge, Skills and Abilities (List all knowledge, skills and abilities that are necessary to perform the job satisfactorily)

- Ability to accurately assess and retrieve information from database.
- Ability to accurately input information from database.
- Good judgment and common sense while interfacing with outside contacts and performing job functions.
- Ability to maintain courteous, professional, business like manner.
- Ability to manage multiple simultaneous projects and prioritize functions.
- Good organizational skills.
- Excellent verbal and written communication skills
- Ability to abide by Molina's policies
- Maintain regular attendance based on agreed-upon schedule
- Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA)
- Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers

NON-ESSENTIAL FUNCTIONS

List other duties which are of secondary importance and marginal to the position's purpose.

- Other duties as assigned.

QUALIFICATIONS

Required Education:
Bachelor degree in Pharmacy (minimum).

Preferred Education:
Doctorate in Pharmacy (PharmD) is preferred. Completion of ASHP-approved residency program

Required Experience:
Minimum of two years in the health care industry or equivalent experience in managed care and/or retail pharmacy is preferred. Prior experience in the oversight of projects and managing people is desired. Must have prior work experience with vendors, outside contacts and other health care professionals to accomplish responsibilities. Knowledge of computer data extracting methods. Strong knowledge of pharmacological management of chronic disease states.

Preferred Experience:

Required Licensure/Certification:
Licensed to practice Pharmacy in the State.
Must be free of sanctions from Medicaid or any other government program and without restrictions that would affect job performance.

Preferred Licensure/Certification:

PHYSICAL DEMANDS

Working environment is generally favorable and lighting and temperature are adequate. Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions.
Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

NUMBER OF DIRECT REPORT(S): **NUMBER OF INDIRECT REPORT(S):**

The information in this position description indicates the general nature and level of work to be performed. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job. Management reserves the right to revise the job description or require that other tasks be performed when the circumstances of the job change (for example, emergencies, change in personnel, workload, or technical development).

By signing this document I, the employee, affirm that I understand that my employment is on an at-will basis. This means that I and my employer are mutually free to end the relationship at any time, for any reason or no reason, with or without notice.

Employee Signature

_____
Signature

_____ _____
Print Name Date

Manager Signature

_____
Signature

_____ _____
Print Name Date

MOLINA HEALTHCARE

POSITION DESCRIPTION

POSITION TITLE: Manager, Provider Inquiry Research & Resolution	JOB CODE: XXXX	FLSA STATUS: Exempt	EEO-1 CLASSIFICATION:
DEPT/LOCATION: [Network Management & Operations- Operations **STATE PLANS**	REPORTS TO (TITLE): Director, Network Management & Operations	PAY GRADE: E37	COMPLETION DATE:

POSITION SUMMARY (Briefly describe the purpose of the position):
This position is responsible for all Provider[/Member] Inquiry and Resolution for the Plan. Under the direct supervision of [Director or VP of Network Management & Opertions] the Manager is responsible for the submission/resolution of Provider [and Member] Inquiries and/or Dispute Resolutions. The job includes proactive assessment and audit of business processes to determine those most effective to efficiently and effectively resolve Provider[/Member] Problems. The Manager ensures documentation and reports are completed according to regulations. Serves as primary interface with Corporate Claims and Configuration counterparts and ensures standard processes are implemented. Maintains confidentiality as required.

ESSENTIAL FUNCTIONS

Duties and Responsibilities (List all essential duties and responsibilities in order of importance)

- Plans, directs and coordinates staff functions, including development and training of staff.
- Oversee research and documentation for each Provider[/Member] Inquiry and/or Dispute [and/or Appeals]. Ensure resolution is compliant.
- Coordinate workflows between departments and interface with internal and external resources.
- Manage Provider[/Member] Disputes [and/or Appeals] database.
- Oversee preparation of the narratives, graphs, flowcharts, etc. to be utilized for committee presentations, audits, and any internal/external reports.
- Oversee necessary correspondence in accordance with regulatory requirements.
- Maintain call tracking system of correspondence and outcomes for Provider[/Member]Disputes [and/or Appeals].
- Oversee monitoring of each Provider[/Member] Dispute [Appeal] to ensure all internal and regulatory timelines are met.
- Maintain well-organized, accurate and complete files for all Provider[/Member] Disputes [Appeals].
- Interface with providers and duties pertaining to participating network satisfaction (e.g. credentialing, education, communication).
- Oversight of claims policies and procedures specific to benefits, contracts and State requirements.
- Comply with all Medicaid/Medicare requirements.
- Effective staff management skills.

Knowledge, Skills and Abilities (List all knowledge, skills and abilities that are necessary to perform the job satisfactorily)

- Good judgement skills, self-motivated and able to coordinate and complete multiple complex assignments.
- Must know computerized claims processing systems.
- Data entry and 10-key skills by touch and sight.
- Knowledge of CPT/HCPC and ICD9 coding, procedures and guidelines.
- Comprehensive medical terminology and knowledge.
- Efficiency and accuracy of claim payments during processing and adjudication. Analytical ability.
  - Excellent verbal and written communication skills
  - Excellent customer service skills
  - Detail oriented
  - Ability to work independently and handle multiple projects and mulit-disciplinary teams
  - Effective time management and organizational skills; demonstrated project management sills
  - Strong decision-making skills
  - Ability to abide by Molina's policies
  - Maintain regular attendance based on agreed-upon schedule

- Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA)
- Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers

NON-ESSENTIAL FUNCTIONS

List other duties which are of secondary importance and marginal to the position's purpose.

-
- Other duties as assigned.

QUALIFICATIONS

Required Education:

- High School diploma and 2 year degree or 6+ years of work experience in field

Preferred Education:
Bachelor's Degree

Required Experience:

- 3- 4Years experience in claims review, Provider and/or Member dispute and/or appeal resolution.
- Excellent vocabulary, grammar, spelling, punctuation, and composition skills proven through the development of written communication. Comprehensive knowledge of health care customer service, regulatory requirements and Provider Dispute process. Ability to operate PC based software programs.
- Experience in reviewing all types of medical claims, e.g. HCFA 1500, Outpatient/Inpatient UB92, Universal Claims, Stop Loss, Surgery, and Anesthesia, high dollar complicated claims, COB and DRG/RCC pricing.

Preferred Experience:
6+ years

Required Licensure/Certification:

Preferred Licensure/Certification:

-

PHYSICAL DEMANDS

Required: Choose Applicable Physical Demands Language for the Position

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

NUMBER OF DIRECT REPORT(S): **NUMBER OF INDIRECT REPORT(S):**
TITLES OF DIRECT REPORT(S):

The information in this position description indicates the general nature and level of work to be performed. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job. Management reserves the right to revise the job description or require that other tasks be performed when the circumstances of the job change (for example, emergencies, change in personnel, workload, or technical development).

By signing this document I, the employee, affirm that I understand that my employment is on an at-will basis. This means that I and my employer are mutually free to end the relationship at any time, for any reason or no reason, with or without notice.

Employee Signature

_____

Signature

_____ _____

Print Name Date

Manager Signature

_____

Signature

_____ _____

Print Name Date

JOB PROFILE

POSITION TITLE: Director, Quality Improvement I	JOB CODE: 2255	FLSA STATUS: Exempt	CLASSIFICATION / LEADERSHIP COMP. LEVEL: 1st Mid Lvl Off & Mgrs / Level 5 Director/AVP
DEPT/LOCATION: STATE PLAN	REPORTS TO (TITLE): Chief Medical Officer Dotted line to MHI VP Quality	PAY GRADE: E43	COMPLETION DATE: 02/13/2013

Job Summary/Essential Functions: Acts as the Quality Leader for the State Health Plan under Corporate guidance. Manages programs surrounding HEDIS, NCQA accreditation, STAR ratings, risk scores for Medicare and Medicaid, CAHPS, HOS, Rx adherence, and state requested reports and projects.

The position's essential functions are as follows:

- Responsible for the program development, implementation, and management of Quality Management and Quality initiatives within the health plan
- Collaborates with health plan Chief Medical Officer in overseeing medical service delivery and quality of care for health plan members
- Support provision of high quality clinical care by building strategic relationships with health care providers
- Support maintenance of marketable, high quality, cost effective provider networks
- Coordinates, directs, and manages the activities of the department and the quality management program
- Responsible for the analysis of the quality of member care received and for the development of plans and programs to support continuous quality improvement
- Establishes strategic plans, policies, and procedures at all levels and with all critical operation departments to ensure quality programs are consistent with overall MHI quality strategies

Molina Healthcare Core Competencies: Generally, the ability to understand, internalize, exhibit and promote behaviors that reflect Molina Healthcare's Core Values to varying degrees.

- **Customer/Mission Orientation:** The ability to demonstrate genuine concern for satisfying one's internal and external customers, mindful advocates of our mission to provide quality health services to financially vulnerable families and individuals covered by government programs, and to remove barriers to health services.
- **Goal-Oriented Quality Performance:** The ability to manage and motivate one's own and one's employees' performance, ensuring commitment to exemplary performance and quality work by setting clear goals and expectations, and tracking progress, with frequent feedback to allow celebration of achievements and prompt correction of performance issues.
- **Empathetic, Culturally Competent Interpersonal Awareness:** The ability to notice, anticipate and interpret the needs, concerns and feelings of a diverse network of coworkers, members and providers, and to communicate this awareness empathetically in a respectful and culturally competent manner.
- **Personal/Company Credibility:** Demonstrated concern that one be perceived as an ethical, responsible, reliable, and trustworthy member and representative of the Molina Healthcare family at all times in all business affairs.
- **Prudent Financial Stewardship:** The desire and ability to carefully manage our financial resources as prudent stewards of the public's funds.

Job Family Competencies: Generally, the knowledge-based functional competencies shared by all jobs within this Job Family.

- Knowledge of HEDIS measurement and reporting
- Knowledge of quality measurement
- Knowledge of process improvement
- Knowledge of quality in healthcare
- Knowledge of application of regulatory requirements
- Knowledge of change management

Behavioral Competencies: Generally, the traits, attributes and attitudes required to get work done with and through others in order to perform the essential duties of the job.

Quality Family

- Business Acumen (developing)- Knows how businesses work; knowledgeable in current and possible future policies, practices, trends, technology, and information affecting his/her business and organization; knows the competition; is aware of how strategies and tactics

work in the marketplace.

- Creativity (proficient) - Comes up with a lot of new and unique ideas; easily makes connections among previously unrelated notions; tends to be seen as original and value-added in brainstorming settings.
- Customer Focus (proficient) - Is dedicated to meeting the expectations and requirements of internal and external customers; gets first-hand customer information and uses it for improvements in products and services; acts with customers in mind; establishes and maintains effective relationships with customers and gains their trust and respect.
- Decision Quality (proficient) - Makes good decisions (without considering how much time it takes) based upon a mixture of analysis, wisdom, experience, and judgment; most of his/her solutions and suggestions turn out to be correct and accurate when judged over time; sought out by others for advice and solutions.
- Informing (role model) - Provides the information people need to know to do their jobs and to feel good about being a member of the team, unit, and/or the organization; provides individuals information so that they can make accurate decisions; is timely with information.
- Integrity & Trust (role model) - Is widely trusted; is seen as a direct, truthful individual; can present the unvarnished truth in an appropriate and helpful manner; keeps confidences; admits mistakes; doesn't misrepresent him/herself for personal gain.
- Managerial Courage (proficient) - Doesn't hold back anything that needs to be said; provides current, direct, complete, and "actionable" positive and corrective feedback to others; lets people know where they stand; faces up to people problems on any person or situation (not including direct reports) quickly and directly; is not afraid to take negative action when necessary.
- Negotiating (proficient) - Can negotiate skillfully in tough situations with both internal and external groups; can settle differences with minimum noise; can win concessions without damaging relationships; can be both direct and forceful as well as diplomatic; gains trust quickly of other parties to the negotiations; has a good sense of timing.
- Perseverance (proficient) - Pursues everything with energy, drive, and a need to finish; seldom gives up before finishing, especially in the face of resistance or setbacks.
- Problem Solving (proficient)- Uses rigorous logic and methods to solve difficult problems with effective solutions; probes all fruitful sources for answers; can see hidden problems; is excellent at honest analysis; looks beyond the obvious and doesn't stop at the first answers.
- Drive for Results (developing) - Can be counted on to exceed goals successfully; is constantly and consistently one of the top performers; very bottom-line oriented; steadfastly pushes self and others for results.
- Self-Development (role model) - Is personally committed to and actively works to continuously improve him/herself; understands that different situations and levels may call for different skills and approaches; works to deploy strengths; works on compensating for weakness and limits.
- Time Management (proficient)- Uses his/her time effectively and efficiently; values time; concentrates his/her efforts on the more important priorities; gets more done in less time than others; can attend to a broader range of activities.

<u>Quality Leaders</u>

- Comfort Around Higher Management (developing) - Can deal comfortably with more senior managers; can present to more senior managers without undue tension and nervousness; understands how senior managers think and work; can determine the best way to get things done with them by talking their language and responding to their needs; can craft approaches likely to be seen as appropriate and positive.
- Developing Direct Reports and Others (proficient) - Provides challenging and stretching tasks and assignments; holds frequent development discussions; is aware of each person's career goals; constructs compelling development plans and executes them; pushes people to accept developmental moves; will take on those who need help and further development; cooperates with the developmental system in the organization; is a people builder.
- Managing and Measuring Work (proficient)- Clearly assigns responsibility for tasks and decisions; sets clear objectives and measures; monitors process, progress, and results; designs feedback loops into work.
- Motivating Others (role model) - Creates a climate in which people want to do their best; can motivate many kinds of direct reports and team or project members; can assess each person's hot button and use it to get the best out of him/her; pushes tasks and decisions down; empowers others; invites input from each person and shares ownership and visibility; makes each individual feel his/her work is important; is someone people like working for and with.

Functional Competencies: Generally, the specific technical and professional competencies required to perform the essential duties of this job.

- Ability to manage quality work and to enforce quality healthcare throughout the organization (proficient).
- Ability to identify barriers to quality healthcare and/or gaps in process that interfere with delivery of quality healthcare (developing).
- Ability to demonstrate strength in strategic and analytical thinking, problem solving, and presentation skills (developing).
- Ability to demonstrate strength in teaming and interpersonal skills, and the ability to initiate and maintain cross-team relationships (proficient).
- Demonstrated ability to meet mission-critical deadlines and to motivate staff to meet these deadlines; proven ability to manage personal stress and those of staff through proactive management and emotional intelligence skills (role model).

- Ability to manage projects, including the ability to manage people and time resources and the ability to monitor the effectiveness of activities (proficient).
- Ability to demonstrate organizational skills (role model).
- Demonstrated mastery of multiple healthcare knowledge areas, including clinical, coding, business operations, and IT analytics (developing).
- Ability to exhibit excellent verbal and written communication skills (proficient).
- Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA) (role model).

Leadership Competencies: Generally, the ability to collaborate effectively in a team setting, coach, engage, evaluate, influence and motivate others toward achieving both functional and core competencies.

- Ability to collaborate and to display and dedication to Molina's mission, modeling Molina core competencies/values.
- Ability to make tough, data-driven decisions without prejudice, accepting, and acting on, facts.
- Ability to champion and effect change, removing obstacles and making sacrifices for the greater good.
- Ability to engage, coach, evaluate, influence and motivate others, providing frequent feedback and positive reinforcement.

TITLE(S) OF DIRECT REPORT(S):

MINIMAL QUALIFICATIONS	PREFERRED QUALIFICATIONS
Required Education: BA / BS / BSN or equivalent work experience	**Preferred Education:** Advanced clinical degree or advanced public health or health care administration degree
Required Experience: • Minimum of 5 years experience in health plan quality improvement	**Preferred Experience:** • HEDIS reporting or collection • CAHPS improvement • State QI experience • NCQA Accreditation • Medicaid and/or Medicare QI
Required Licensure/Certification/Associations:	**Preferred Licensure/Certification/Associations:** CPHQ

TRAVEL REQUIREMENTS

This position requires same day out of office automobile travel approximately _____% of the time.

This position requires multiple day out of town overnight travel approximately 25% of the time.

PHYSICAL DEMANDS

Required: Working environment is generally favorable and lighting and temperature are adequate. Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions. Must have the ability to sit for long periods.

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EQUAL OPPORTUNITY EMPLOYER

Molina Healthcare is an Equal Opportunity Employer M/F/D/V.

MOLINA HEALTHCARE

POSITION DESCRIPTION

POSITION TITLE: Manager, Utilization Management	JOB CODE: 2935	FLSA STATUS: Exempt	EEO-1 CLASSIFICATION: 1st Mid Lvl Off & Mgrs
DEPT/LOCATION: Utilization Management /California	REPORTS TO (TITLE): Director, Utilization Management	PAY GRADE: E39	COMPLETION DATE: 4-16-12

POSITION SUMMARY (Briefly describe the purpose of the position):
Under direct supervision of the Director of Utilization Management. The manager is responsible for daily operation of utilization for Behavioral Health, in accordance with MMC policies, procedures and processes. Interacts with the respective Medical Director, MMC staff, and providers to ensure the delivery of high quality, cost effective healthcare services for MMC members. Provides administrative and leadership support to staff as directed. This is an on-site position.

ESSENTIAL FUNCTIONS

PRINCIPLE ACCOUNTABILITIES

- Functions as a "hands-on" manager responsible for supervision and coordination of daily Behavioral Health Utilization Management operations, including concurrent review, and discharge planning, in accordance with the MMC systems, processes, policies and procedures.

- Responsible for hiring, orienting and training staff to ensure maximum efficiency and productivity.
- Responsible for development and implementation of projects, policies and procedures as assigned to ensure UM Program meets NCQA standards and all contractual requirements.
- Responsible for staff Performance Appraisals, ongoing monitoring of MIS data entry, and application of medical necessity review criteria and guidelines.
- Collaborates with and keeps the Director apprised of operational issues, staffing, resources, system and program needs.
- Utilizes clinical assessment skills and knowledge of patient care to assist staff with decisions regarding appropriateness or medical necessity of services, and determine which cases should be referred to the Medical Director for evaluation.
- Responsible for coordination and reporting of Utilization Management statistics, including Plan utilization, staff productivity data, cost effective utilization of services, and triage activities.
- Identifies and reports under and over utilization management issues, delays in service or treatment, and quality of service issues per P/P.
- Acts as liaison to internal and external customers on behalf of the UM Dept. to ensure open communication, effective interface and prompt resolution of identified issues.
- Identifies and reports under and over utilization management issues, delays in service or treatment, and quality of service issues per P/P.
- Responsible for coordination of staff schedule to ensure adequate coverage during business hours, Monday-Friday (Excluding after Hours Triage Nurses).
- Perform other duties as assigned
- Complies with required workplace safety standards.

List other duties which are of secondary importance and marginal to the position's purpose.

- Other duties as assigned.

QUALIFICATIONS

Required Education:
Registered Nursing Degree

Preferred Education:
Bachelor's Degree in Nursing

Required Experience:

- Minimum 3 years UM Management experience.
- Minimum 5 years clinical nursing experience which include Behavioral Health.

Preferred Experience:

- Minimum 2 yrs working experience in Managed Health Care Field.
- Minimum 2 yrs Supervisory/ Managerial experience.
- Knowledge of applicable state, federal and third party regulations and standards.
- Background in discharge planning; critical care and home health.

Required Licensure/Certification:

- Valid California State Register Nursing license (BSN preferred)

Preferred Licensure/Certification:

- Certified Professional in Utilization Management (CPUR) Certification preferred.

PHYSICAL DEMANDS

Working environment is generally favorable and lighting and temperature are adequate. Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions.

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

NUMBER OF DIRECT REPORT(S): **NUMBER OF INDIRECT REPORT(S):**

The information in this position description indicates the general nature and level of work to be performed. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job. Management reserves the right to revise the job description or require that other tasks be performed when the circumstances of the job change (for example, emergencies, change in personnel, workload, or technical development).

By signing this document I, the employee, affirm that I understand that my employment is on an at-will basis. This means that I and my employer are mutually free to end the relationship at any time, for any reason or no reason, with or without notice.

Employee Signature

_____

Signature

_____ _____

Print Name Date

Manager Signature

_____

Signature

_____ _____

Print Name Date

POSITION DESCRIPTION

POSITION TITLE: Manager, Behavioral Health	JOB CODE: 2530	FLSA STATUS: Exempt	EEO-1 CLASSIFICATION: 1st Mid Lvl Off & Mgrs
DEPT/LOCATION: Molina Healthcare	REPORTS TO (TITLE): Director, Healthcare Services	PAY GRADE: E40	COMPLETION DATE:

POSITION SUMMARY (Briefly describe the purpose of the position):
Responsible for oversight of the behavioral health program at Molina Healthcare.

ESSENTIAL FUNCTIONS

Duties and Responsibilities (List all essential duties and responsibilities in order of importance)

- Oversee Behavioral Health Services at Molina Healthcare.
- Ensure that Behavioral Health Hotline call responsiveness meets or exceeds customer service guidelines.
- Ensure timeliness of UM review process.
- Facilitate training for BH staff.
- Participate in maintaining NCQA behavioral health accreditation.
- Maintain ongoing guidance through regular meetings and individual contact with Molina Health plan of Texas Directors.

State Plan / Department Specific Duties and Responsibilities (List all essential duties other than those listed above in order of importance)

- Provide oversight and assist in decision making on UM requests for Behavioral Health services. Support the Behavioral Health Coordinator(s) to manage the contracted benefit to meet the needs of Molina members. Assist with patient case management of Behavioral Health patients from all lines of business as needed.
- Participate in planning and review of Behavioral Health Policies and Procedures for all lines of business. Help coordinate Behavioral Health and Medical services for all lines of business.
- Participate in Molina Quality Committees as assigned.
- Initiate, develop and recommend operational Polices and Procedures for Behavioral Health and obtain appropriate committee approval.
- Provide training for BH staff, including scorecard expectations.
- Assist Molina with strategic planning activities related to Behavioral Health Services. Recommend changes and improvements where appropriate.
- Maintain ongoing guidance through regular case staffing meetings and individual contact with Molina Healthcare staff.
- Participate in meetings with State regulators as requested.

Knowledge, Skills and Abilities (List all knowledge, skills and abilities that are necessary to perform the job satisfactorily)

- Complies with required workplace safety standards.
- Adheres to the company and/or departmental confidentiality standards and HIPAA compliance programs.
- Adheres to the company and/or departmental fraud and abuse prevention/detection policies and programs.
  - Excellent verbal and written communication skills
  - Ability to abide by Molina's policies
  - Maintain regular attendance based on agreed-upon schedule
  - Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA)
  - Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers

NON-ESSENTIAL FUNCTIONS

List other duties which are of secondary importance and marginal to the position's purpose.

-

- Other duties as assigned.

QUALIFICATIONS

Required Education:
Ph.D. in Clinical Psychology preferred. Master's level in related field required.

Preferred Education:

Required Experience:
5 Years experience in the practice of Clinical Psychology
Understanding of Managed Care.

Preferred Experience:

Required Licensure/Certification:
Ph.D. preferred; minimum Licensed master's level clinician. All licensure must be free of sanctions from Medicaid or any other government program and without restrictions that would affect job performance.

Preferred Licensure/Certification:

PHYSICAL DEMANDS

Required: Choose Applicable Physical Demands Language for the Position

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

NUMBER OF DIRECT REPORT(S): **NUMBER OF INDIRECT REPORT(S):**
TITLES OF DIRECT REPORT(S):

The information in this position description indicates the general nature and level of work to be performed. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job. Management reserves the right to revise the job description or require that other tasks be performed when the circumstances of the job change (for example, emergencies, change in personnel, workload, or technical development).

By signing this document I, the employee, affirm that I understand that my employment is on an at-will basis. This means that I and my employer are mutually free to end the relationship at any time, for any reason or no reason, with or without notice.

Employee Signature

_____
Signature

_____ _____
Print Name Date

Manager Signature

_____
Signature

_____ _____
Print Name Date

MOLINA HEALTHCARE

POSITION DESCRIPTION

POSITION TITLE:	JOB CODE:	FLSA STATUS:	EEO-1 CLASSIFICATION:
Director-Member Services	2200	Exempt	1st Mid Lvl Off & Mgrs
DEPT/LOCATION:	**REPORTS TO (TITLE):**	**PAY GRADE:**	**COMPLETION DATE:**
Member Services	**MHI/Plan President**	E40	

POSITION SUMMARY (Briefly describe the purpose of the position):
This key position oversees Member Service and Marketing departments. Provides strategic guidance to Marketing and Outreach in an effort to retain and increase membership. Provides oversight to Member Services to ensure the highest level of customer service is provided and all contractual requirements met.

ESSENTIAL FUNCTIONS

Duties and Responsibilities (List all essential duties and responsibilities in order of importance)

- Develop and implement standard processes for common practices.
- Establishment of standard performance metrics and benchmarks
- Engage and work collaboratively with both corporate and state plan functional business unit
- Share and promote member services best practices across the organization
- Implement complete training and development programs
- Make recommendations to senior management on initiatives and projects that achieve Corporate Wide customer service goals
- Direct and oversee all Corporate Wide customer service initiatives and projects thru to completion/monitor benefit realization
- Track and trend data, identify areas for improvement in support of improved customer experience and administrative efficiency

Knowledge, Skills and Abilities (List all knowledge, skills and abilities that are necessary to perform the job satisfactorily)

- Ability to coordinate activities of and interact with multiple constituencies.
- Excellent interpersonal and communication skills (verbal and written).
- Excellent leadership and managerial skills.
- Ability to abide by Molina's policies
- Maintain regular attendance based on agreed-upon schedule
- Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA)
- Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers

NON-ESSENTIAL FUNCTIONS

List other duties which are of secondary importance and marginal to the position's purpose.

- Other duties as assigned.

QUALIFICATIONS

Required Education:
Bachelor's degree or equivalent work experience.

Required Experience:
Minimum 5 years supervisory experience. Minimum 3 years of hands-on experience in the Medicaid MC+ and/or CHIPS programs. Extensive knowledge of managed healthcare.

PHYSICAL DEMANDS

Required: Choose Applicable Physical Demands Language for the Position

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

NUMBER OF DIRECT REPORT(S): **NUMBER OF INDIRECT REPORT(S):**
TITLES OF DIRECT REPORT(S):

The information in this position description indicates the general nature and level of work to be performed. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job. Management reserves the right to revise the job description or require that other tasks be performed when the circumstances of the job change (for example, emergencies, change in personnel, workload, or technical development).

By signing this document I, the employee, affirm that I understand that my employment is on an at-will basis. This means that I and my employer are mutually free to end the relationship at any time, for any reason or no reason, with or without notice.

Employee Signature

_____

Signature

_____ _____

Print Name Date

Manager Signature

_____

Signature

_____ _____

Print Name Date

JOB DESCRIPTION

POSITION TITLE:	JOB CODE:	FLSA STATUS:	EEO-1 CLASSIFICATION:
AVP Provider Network Management	2047	Exempt	Exec/Sr Lvl Off and Mgrs
DEPT/LOCATION:	**REPORTS TO (TITLE):**	**PAY GRADE:**	**COMPLETION DATE:**
Provider Network Management & Operations **STATE PLANS**	Health Plan President	E44	12-05-2011

JOB SUMMARY (Briefly describe the purpose of the job): Plans, organizes, staffs, and coordinates contracting and service activities of the State Plan's Provider Network Management activities. Works with staff and Senior Management to develop and implement provider contracting strategies and provider service strategies to contain unit cost, improve member access and enhance Provider satisfaction with the Plan...

ESSENTIAL FUNCTIONS

Duties and Responsibilities (List all essential duties and responsibilities in order of importance)

- Develops and implements provider network and contract strategies, identifying those specialties and geographic locations on which to concentrate resources for purposes of establishing a sufficient network of Participating Providers to serve the health care needs of the Plan's membership.
- Develops and maintains a market-specific Provider Reimbursement Strategy consistent with Reimbursement Tolerance Parameters (across multiple specialties/geographies). Oversee the development of new reimbursement models. Obtains input from Corporate and Legal regarding new reimbursement models.
- Develops and maintains a system to track Contract Negotiation activity on an ongoing basis throughout the year; utilize and oversees departmental training on the Emptoris contract management system.
- Directs the preparation and negotiations of provider contracts and oversee negotiation of contracts in concert with established company templates and guidelines with physicians, hospitals, and other health care providers.
- Contributes as a key member of the Senior Leadership Team and other committees addressing the strategic goals of the department and organization.
- Oversees the maintenance of all Provider contract information, Provider Contract Templates and assure that all contracts negotiated can be configured in the QNXT system. Works with legal and Corporate on an as needed basis to modify contract templates to ensure compliance with all contractual and/or regulatory requirements.
- Oversees Plan specific Fee schedule management.
- Develops strategies to improve EDI/MASS rates.
- Provides oversight of Provider Services and coordinates activities with Provider Association(s) and Joint Operating Committee Management.
- Provides accountability for Delegation Oversight function in the Plan.
- Provides oversight of the Provider Network Administration area including: Provider Information Management (PIM) and business analyses of contracts and benefits to support accurate configuration for claims payment.
- Oversees all Provider/Member problem prevention, research and resolution and provide oversight of the Provider/Member Appeals and Grievance process.
- Coordinates with enrollment growth to ensure that Molina grows faster (profitable growth) than our competitors in key provider practices.

State Plan / Department Specific Duties and Responsibilities (List all essential duties other than those listed above in order of importance)

-

Knowledge, Skills and Abilities (List all knowledge, skills and abilities that are necessary to perform the job satisfactorily)

- Knowledge of Excel and Word
- Demonstrated adaptability and flexibility to changes and response to new ideas and approaches
- Ability to organize, coordinate, and accomplish a high volume of work with minimum impact on quality
- Superior interpretation and research skills in order to readily identify problems, get to the root cause and achieve prompt resolution to problems and issues
- Good analytical skills
- Exceptional interpersonal relations skills

- Superior verbal and written communication skills
- Ability to abide by Molina's policies
- Ability to maintain attendance to support required quality and quantity of work
- Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA)
- Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers

NON-ESSENTIAL FUNCTIONS

List other duties which are of secondary importance and marginal to the job's purpose.

- Other duties as assigned.

QUALIFICATIONS

Required Education:
Bachelor's Degree in a related field (Business Administration, etc.)

Preferred Education:
Master's Degree

Required Experience:
7 - 10 years minimum experience in Healthcare Administration, Managed Care, and/or Provider Services.

Preferred Experience:
Experience managing/supervising employees.

Required Licensure/Certification:

Preferred Licensure/Certification:

PHYSICAL DEMANDS

Working environment is generally favorable and lighting and temperature are adequate. Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions.

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

NUMBER OF DIRECT REPORT(S):

NUMBER OF INDIRECT REPORT(S):

TITLES OF DIRECT REPORT(S):

The information in this job description indicates the general nature and level of work to be performed. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job. Management reserves the right to revise the job description or require that other tasks be performed when the circumstances of the job change (for example, emergencies, change in personnel, workload, or technical development).

By signing this document I, the employee, affirm that I understand that my employment is on an at-will basis. This means that I and my employer are mutually free to end the relationship at any time, for any reason or no reason, with or without notice.

Employee Signature

_____

Signature

_____ _____

Print Name Date

Manager Signature

_____

Signature

_____ _____

Print Name Date

AVP, Provider Network Management

JOB DESCRIPTION

POSITION TITLE: IT Director (Core Systems)	JOB CODE: 2155	FLSA STATUS: Exempt	EEO-1 CLASSIFICATION: 1st Mid Lvl Off & Mgrs
DEPT/LOCATION: IT – Corporate	REPORTS TO (TITLE): Chief Information Officer	PAY GRADE: E43	COMPLETION DATE:

POSITION SUMMARY (Briefly describe the purpose of the position): Provides management of the Core Systems development teams. Applications included are membership/eligibility, provider, claims, capitation, HR, finance, medical management and call center. Responsible for the full spectrum of application development and support. Also responsible for collaborating on systems development life cycle methodologies, software architectural standards, project management standards, change management processes, and project portfolio management.

ESSENTIAL FUNCTIONS

Duties and Responsibilities (List all essential duties and responsibilities in order of importance)

- Provides day-to-day management and mentoring as required of department managers.
- Oversees project management for application implementation, integration, and enhancements.
- Supervises Business Analysts and Developers (Programmers).
- Ensures successful delivery of approved projects.
- Manages vendor relationships.
- Manages support activities (break fix, operations, and small requests) to exceed established service levels.
- Drives down the cost of development and support while improving quality by implementing standard processes (SDLC, architecture, project management, etc.).

State Plan / Department Specific Duties and Responsibilities (List all essential duties other than those listed above in order of importance)

-

Knowledge, Skills and Abilities (List all knowledge, skills and abilities that are necessary to perform the job satisfactorily)

- SQL and Microsoft development framework (.net, VB) skills
- Staff-management skills
- Project management skills
- Application development leadership skills
- Excellent verbal and written communication skills
- Ability to abide by Molina's policies
- Abililty to maintain attendance to support required quality and quantity
- Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA)
- Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers

NON-ESSENTIAL FUNCTIONS

List other duties which are of secondary importance and marginal to the position's purpose.

-
- Other duties as assigned.

QUALIFICATIONS

Required Education:
Bachelor's Degree in Computer Science, Business, or related field or equivalent experience.

Preferred Education:

Required Experience:
7 years managing mid- to large-systems application development preferably in the health plan industry.

Preferred Experience:

5 years managing health plan applications.
Client relationship management experience.

Required Licensure/Certification:

Preferred Licensure/Certification:

PHYSICAL DEMANDS

Working environment is generally favorable and lighting and temperature are adequate. Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions.

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

NUMBER OF DIRECT REPORT(S):
TITLES OF DIRECT REPORT(S):

NUMBER OF INDIRECT REPORT(S):

The information in this position description indicates the general nature and level of work to be performed. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job. Management reserves the right to revise the job description or require that other tasks be performed when the circumstances of the job change (for example, emergencies, change in personnel, workload, or technical development).

By signing this document I, the employee, affirm that I understand that my employment is on an at-will basis. This means that I and my employer are mutually free to end the relationship at any time, for any reason or no reason, with or without notice.

Employee Signature

Signature

Print Name

Date

Manager Signature

Signature

Print Name

Date

MOLINA HEALTHCARE

POSITION DESCRIPTION

POSITION TITLE: VP Claims	JOB CODE: 1555	FLSA STATUS: Exempt	EEO-1 CLASSIFICATION: Exec/Sr Lvl Off & Mgrs
DEPT/LOCATION: MHI- 060 Long Beach	REPORTS TO (TITLE): Senior Vice President, PPI	PAY GRADE: E49	COMPLETION DATE: 3-26-12

POSITION SUMMARY (Briefly describe the purpose of the position):

Under the general direction of the SVP, PPI, the VP of Claims is responsible for the implementation of companywide initiatives impacting any one or more of the following areas reporting to this position:

- Claims Production (i.e. Claims Production, Audit, Production Vendor Oversight) for both the Medicaid and Medicare lines of business
- Claims Shared Services for both the Medicaid and Medicare lines of business (i.e. activities supporting the production of claims including but not limited to the Corporate Recovery Team, Corporate Claims Compliance Team, Support Services, Corporate Encounter Team as well as providing overall organizational leadership of claims editing and recovery vendors aimed at managing overall healthcare costs)
- Corporate Operations PMO for both the Medicaid and Medicare lines of business (leading both business process changes and systems oriented projects requiring engagement with IT and other departments to implement changes to business processes and systems)
- Corporate Configuration of the QNXT system for both Medicaid and Medicare lines of business as well as the Care Management application for UM functions within QNXT:
    - Meeting state regulatory requirements,
    - Enabling the system to produce expected health care costs
    - Maximizing MASS Adjudication within QNXT,
    - Improving the quality of the provider payment process,
    - Reducing G&A costs as measured by both Unit Claims Costs and on a per member per month basis in each of the areas reporting to the VP, Claims as part of the enterprise wide efforts to meet or exceed budget targets and to consistently to reduce G&A.
    - Continuing to drive positive operational and financial outcomes within the other Provider Payment Initiatives reporting up to the SPV, PPI.

ESSENTIAL FUNCTIONS

Duties and Responsibilities (List all essential duties and responsibilities in order of importance)

- Hire, coordinate training and manage staff involved in creating controls, documents and tools within the Corporate Claims, Shared Services, Corporate Ops PMO or Configuration Teams or other Corporate Operations areas reporting to the VP, Claims in order to manage work in any of the assigned Corporate Operations areas for both the Medicaid and Medicare lines of business.
- Identify, develop, train appropriate staff and implement processes to standardize the overall end to end processing claims, as well as the configuring of within the various modules of the QNXT System for both the Medicaid and Medicare lines of business.
- Initiate staff and coordinate needed projects around various systems enhancements, conversions and upgrades. These projects will improve QNXT Claims MASS Adjudication results, enhance the Corporate Operations claims quality and reduce unit claims costs by reducing rework (both underpayments and overpayments) for both the Medicare and Medicaid lines of business.
- Identify projects/initiatives that reduce administrative costs for Molina and/or providers as well as identify opportunities to insure accurate claims editing is occurring to assist in the management of the organizational health care costs for both the Medicaid and Medicare lines of business. Included in this arena is to work with appropriate vendors to identify and initiate appropriate recovery opportunities. Convene work groups, develop implementation plans with identified tasks, timelines and assigned parties. Execute and measure success.
- Lead the Corporate Claims PMO and/or the team when they are leading or participating on projects throughout the organization to insure timely and effective implementation of new systems, acquisitions, or workflow processes to meet the operational and regulatory demands of the enterprise for both the Medicaid and Medicare lines of business.
- Lead the Corporate Claims Testing team to validate that systems changes and material configuration changes are tested to insure expected outcomes prior to implementation of those changes in the production environment for

both the Medicaid and Medicare lines of business.

- Participate with others in the Corporate Operational Leadership Team along with IT to analyze the root cause information of variations to the claims payment to find/propose ways to improve upon performance results, identify potential risks to the organization and lead the needed systems or configuration changes within the claims process to support the organizational needs in both the Medicaid and Medicare lines of business.
- Lead the Corporate Claims Training Team in preparing needed documentation around training of new/existing staff while also assist in preparing needed Claims Payment Guidelines to assist in the timely and accurate processing of Medicaid and Medicare claims within Corporate Claims.
- Manage direct Molina staff as well as oversee vendors involved in any of the areas reporting to the VP, Claims to enable the organization to produce operational results at the lowest possible cost, the most consistent and compliant service levels and the highest level of quality for both the Medicaid and Medicare lines of business.
- Insure all state, federal and Molina regulations, Policies/Procedures and SOP's are implemented and followed on a consistent basis to insure the highest compliance possible within the Corporate Operations areas.
- Set and manage overall costs to meet/exceed annual budgets set for each or all of the areas in Corporate Operations reporting to the VP, Claims as well as find ways to improve productivity and automation wherever possible to reduce unit costs and overall G&A for the organization.

State Plan / Department Specific Duties and Responsibilities (List all essential duties other than those listed above in order of importance)

-

Knowledge, Skills and Abilities (List all knowledge, skills and abilities that are necessary to perform the job satisfactorily)

- Excellent verbal and written communication skills
- Ability to influence and drive change among peers and others within the Molina organization
- Skill to envision, craft proposals, obtain consensus around approving and implementing future state processes and systems needed to support strategic direction set by organization.
- Ability to abide by Molina's policies
- Maintain regular attendance based on agreed-upon schedule
- Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA)
- Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers

NON-ESSENTIAL FUNCTIONS

List other duties which are of secondary importance and marginal to the position's purpose.

- Other duties as assigned.

QUALIFICATIONS

Required Education:
BA, Master's preferred or appropriate relevant healthcare experience (4 years for relevant BA background or 7 years for relevant Master's background)

Preferred Education:

Required Experience:
10 years Healthcare experience in related job or related Operational experience.

Preferred Experience:

Required Licensure/Certification:

Preferred Licensure/Certification:

PHYSICAL DEMANDS

Working environment is generally favorable and lighting and temperature are adequate. Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions. **Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.**

NUMBER OF DIRECT REPORT(S): 4-5 **NUMBER OF INDIRECT REPORT(S):** 400-500

The information in this position description indicates the general nature and level of work to be performed. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job. Management reserves the right to revise the job description or require that other tasks be performed when the circumstances of the job change (for example, emergencies, change in personnel, workload, or technical development).

By signing this document I, the employee, affirm that I understand that my employment is on an at-will basis. This means that I and my employer are mutually free to end the relationship at any time, for any reason or no reason, with or without notice.

Employee Signature

_____

Signature

_____ _____

Print Name Date

Manager Signature

_____

Signature

_____ _____

Print Name Date

MOLINA HEALTHCARE

POSITION DESCRIPTION

POSITION TITLE: Vice President, Health Care Services	JOB CODE: 1608	FLSA STATUS: Exempt	EEO-1 CLASSIFICATION: Exec/Sr Lvl Off and Mgrs
DEPT/LOCATION: Health Care Services / State Plan	REPORTS TO (TITLE): President	PAY GRADE: E45	COMPLETION DATE: 01/05/11

POSITION SUMMARY (Briefly describe the purpose of the position):
The VP Healthcare Services is responsible for the following:

- Oversight and management of the Healthcare Services (Clinical Operations) Departments.
- Work collaboratively with the VP Medical Affairs/CMO to develop and implement processes to effectively manage clinical policies set by the Medical Affairs Department to meet healthcare cost and quality targets.
- Work with the HealthCare Services team to develop and implement effective and efficient standards, protocols, processes, decision support systems, reporting and benchmarks that support ongoing improvements of clinical operations functions and promote quality cost effective health care for Molina members.
- Meet annual healthcare cost and quality targets for the health plan.

ESSENTIAL FUNCTIONS

Duties and Responsibilities (List all essential duties and responsibilities in order of importance)

- Responsible for meeting annual healthcare cost and quality targets for the plan and achieving/retaining NCQA "Excellent" rating.
- Day to Day oversight and management of the HealthCare Services (Clinical Operations) teams including Utilization Management (prior-authorization, concurrent review, case management, care transition, maternity care and appeals) Health integration (care coordination, long term care, behavioral health, chemical dependency) and Pharmacy operations. Works with the Healthcare Services management team to achieve the successful implementation of Molina clinical strategy and direction. Mentors, guides and develops skills of management team members in a consistent and effective manner.
- Develop initiatives to achieve budgeted reductions in medical expenses and increases in quality scores.
- Manage implementation of analytical studies that clearly quantify the benefits of Healthcare Services Department programs to ensure that resources are appropriately allocated to programs; that operational controls exist and efficiencies are maximized. Abandon initiatives and programs that do not produce significant quantifiable results and concentrate on driving those that do.
- Focus on continual refinement of operational processes within the Clinical Operations teams. Champion review of team processes, workflows and activities. Clearly articulate project requirements and anticipated outcomes to the Molina Project Management Office (PMO) for identified projects/strategies to improve the efficiency of the clinical operations teams to meet cost and quality goals.
- Provide oversight support and direction to the Utilization Management, Health Integration and Pharmacy Operations teams and assist staff to analyze, update and modify policies, standard operating procedures and processes to continually improve Utilization Management operations and carry out Molina clinical strategy.
- Accountable for insuring compliance with contractual, accreditation and regulatory requirements for all Healthcare Services teams.
- Participate personally or assign appropriate staff to Molina Quality Committees and external Community Committees where Healthcare Services Departments require representation. Assume responsibility for insuring effective inter-departmental collaboration and interaction between the Healthcare Services staff and other departments.
- Responsible for developing the Healthcare Services department budget and meeting budget targets, both administrative and healthcare costs.
- Provide overall support and direction to the Director, Health Integration toward the development and implementation of patient centered healthcare homes (integrating medical and behavioral health) at all Molina Direct Delivery primary care clinics in markets where they exist.
- Support and supervise the Director, Health Integration and drive integration of behavioral and physical health components in all aspects of service to members and develop Long Term Care expertise needed in order to

effectively manage vulnerable populations.

State Plan / Department Specific Duties and Responsibilities (List all essential duties other than those listed above in order of importance)

-
-

Knowledge, Skills and Abilities (List all knowledge, skills and abilities that are necessary to perform the job satisfactorily)

- Strong communication and teaming/interpersonal skills; strong leadership capabilities, and ability to initiate and maintain cross-team relationships.
- Strong interpersonal skills; Excellent verbal and written communication skills; Demonstrated ability to meet established deadlines; Organizational and management skills; Analytical problem solving capabilities, operational and process improvement experience
  - Excellent verbal and written communication skills
  - Ability to abide by Molina's policies
  - Maintain regular attendance based on agreed-upon schedule
  - Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA)
  - Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers

NON-ESSENTIAL FUNCTIONS

List other duties which are of secondary importance and marginal to the position's purpose.

-
- Other duties as assigned.

QUALIFICATIONS

Required Education:

- Required - BA/BS in Business or related field

Preferred Education:

- Preferred - Masters degree in business or healthcare management (i.e. MBA, MHA, MPH)

Required Experience:

- Minimum 7 years managed care experience with line management responsibility including clinical operations.
- Work within applicable state, federal, and third party regulations.
- Meet Quality Accreditation Standards (NCQA/HEDIS).
- Familiarity and experience in the local market desirable.

Preferred Experience:

Required Licensure/Certification:

Preferred Licensure/Certification:

PHYSICAL DEMANDS

Required: Choose Applicable Physical Demands Language for the Position

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

NUMBER OF DIRECT REPORT(S): 4 **NUMBER OF INDIRECT REPORT(S):**

TITLES OF DIRECT REPORT(S): Director, Utilization Management ; Director, Health Integration; Supervisor, Pharmacy; Executive Assistant

The information in this position description indicates the general nature and level of work to be performed. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of

employees assigned to this job. Management reserves the right to revise the job description or require that other tasks be performed when the circumstances of the job change (for example, emergencies, change in personnel, workload, or technical development).

By signing this document I, the employee, affirm that I understand that my employment is on an at-will basis. This means that I and my employer are mutually free to end the relationship at any time, for any reason or no reason, with or without notice.

Employee Signature

_____

Signature

_____ _____

Print Name Date

Manager Signature

_____

Signature

_____ _____

Print Name Date

MOLINA HEALTHCARE

POSITION DESCRIPTION

POSITION TITLE:	JOB CODE:	FLSA STATUS:	EEO-1 CLASSIFICATION:
AVP, Special Investigation Unit	2281	Exempt	TBD by HR
DEPT/LOCATION:	**REPORTS TO (TITLE):**	**PAY GRADE:**	**COMPLETION DATE:**
Corporate Compliance/ARCO	VP of Corporate Compliance	E42	1/18/2011

POSITION SUMMARY (Briefly describe the purpose of the position):
Develop and implement strategies for successfully executing a Special Investigation Unit (SIU) for the Molina Healthcare Enterprise for its Medicaid, Medicare and SCHIP line of business. The SUI will investigates allegations of fraud, waste and abuse committed against Molina Healthcare The SIU's mission is to prevent, identify, investigate, report and, when appropriate, recover money from health care fraud and abuse.
Facilitates and supports compliance with federal and state regulatory mandates, health care fraud control objectives and excellence in claims payment integrity. Manages SIU activities and associated contract staff, providing guidance and direction on Special Investigations. Develops and coordinates SIU fraud control objectives; not limited to prevent, identify, investigate, report and, when appropriate, recover money from health care fraud and abuse.
The SIU supports the Molina Enterprise Health Plans, including Claims, and Compliance departments by providing expert investigative services and consultation; ensures that the Health Plan's are provided with a timely, quality investigative product to make appropriate decisions involving health care fraud issues. Coordinates effectively with the legal department. Makes effective analytical decisions and observations for performance assessment needed to achieve investigative excellence.

ESSENTIAL FUNCTIONS

Duties and Responsibilities (List all essential duties and responsibilities in order of importance). The following duties comprise those generally believed to be the essential functions of the job. Circumstances may allow or require the person assigned to the job to perform a different combination of duties.

1. Serve as corporate subject matter expert (SME) to internal and external customers in the area of Medicare and Medicaid FWA. This position must have superior knowledge of insurance fraud schemes that affect Molina Healthcare ant its business partners.
2. Identify gaps and inefficiencies in existing FWA policies/procedures and suggest effective solutions
3. Develops systems and processes for; investigating pre and post payment claims reviews, appropriate reporting and recovery of money.
4. Reviews, routes and assigns all SIU referrals for the most effective handling. Ensures that assigned cases are investigated and reported back to the appropriate leader within the prescribed timeframe.
5. Provides leadership, and technical direction to assigned staff and oversight of contractors, subcontractors, vendors and downstream entities in connection with auditing and monitoring activities related to FWA
6. Assists in the identification of fraud control compliance and training needs and provides leadership and insight based on best practices and review of matters.
7. Assists in development of programs to enhance compliance with fraud controls such as training for the Molina employees at all skill levels. Performs and/or assists with other types of training activities as requested.
8. Regularly communicates results of Special Investigation Unit activities, major investigations, data mining, cost savings and impact of compliance with relevant Health Plans, Medicare and Senior Management.
9. Serve as main company spokesperson in addressing FWA issues with external entities (CMS, state Medicaid agencies, AG offices) and work closely with the Molina legal team in effectively responding to these external interactions.
10. Collaborates with state and national trade associations on key FWA investigations policy issues and advocacy objectives.
11. Develops and maintains departmental budget to support SIU activities.
12. Assists designated contract staff with preventing detecting and mitigating health care fraud using data analysis to examine patterns of fraud and actions required to prevent, detect, investigate and mitigate health care fraud.
13. Fosters and maintains positive relationships with representatives of relevant coordinating departments, contract support staff, members and patients, law enforcement, and the public.
14. Responsible for and maintains the case tracking system; monitors and analyzes operating results within relevant contract fraud detection systems.
15. Participates in multi-functional team leadership committees as assigned
16. Familiar with HIPAA, the False Claims Act and other relevant regulatory mandates
17. Performs other duties as assigned

- **State Plan / Department Specific Duties and Responsibilities (List all essential duties other than those listed above in**

order of importance)

- Provides updates for regulatory requirements such as audits, quarterly and annual reports to health plans upon request.
- Conducts investigations per state specific regulatory requirements and timeframes
- Response to RFP's as necessary

- **Knowledge, Skills and Abilities (List all knowledge, skills and abilities that are necessary to perform the job satisfactorily**

  - Knowledge of legal issues and litigation process including state and federal civil and criminal law
  - In-depth knowledge of the dynamic health care fraud environment, Special Investigation Unit operations, claims handling and payment operations
  - SIU operations and best practices including technical components of data mining
  - Detailed understanding of fraud investigation techniques
  - Medicare, Medicaid and department of Insurance regulatory requirements
  - Excellent verbal and written communication skills and ability to interact with all levels of internal customers, governmental investigative/prosecutorial agencies, patients, members, contract staff trade groups (such as NHCAA, ACFE, IASIU) and the general public.
  - Ability to abide by Molina's policies
  - Maintain regular attendance based on agreed-upon schedule
  - Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA)
  - Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers
  - Ability to interact with others in one-on-one situations to identify issues/problems and provide training/coaching to correct problem areas
  - Computer literacy and use of applicable systems and software,(word, excel)
  - Data analysis and trending skills; decision making/problem solving skills
  - Knowledge of how Medicare and Medicaid claims are paid, including working knowledge of CPT, ICD-9, HCPC coding
  - High level investigative experience
  - Negotiation skills/experience
  - Ability to be flexible and prioritize multiple tasks and initiatives

NON-ESSENTIAL FUNCTIONS

List other duties, which are of secondary importance and marginal to the position's purpose.

-
- Other duties as assigned.

QUALIFICATIONS

Required Education:
Bachelor's degree or equivalent experience in law enforcement, criminal justice, healthcare insurance operations, or a healthcare discipline with significant experience in health insurance investigations

Preferred Education:
Master's or other advanced Degree

Required Experience:
Minimum 5 to 7 years healthcare investigation experience
Eight years combined SIU, and claims, experience required.
Minimum 4 years healthcare management experience.
Specialized training and experience in health care fraud detection and prevention preferred
NICB (National Insurance Crime Bureau), IASIU(International Association of Special Investigative Units), ACFE (Association of Certified Fraud Examiners), or NHCAA (National Healthcare Anti-Fraud Association) certificates or training in healthcare fraud and abuse investigations, preferred but not required

Preferred Experience:

Required Licensure/Certification:
Certified claims coder
Certified investigator
Claims examiner

Preferred Licensure/Certification:

PHYSICAL DEMANDS

Required: Choose Applicable Physical Demands Language for the Position
Some travel may be necessary for conferences and to represent Molina during on site audits at health plan level.

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

NUMBER OF DIRECT REPORT(S): will vary as department grows **NUMBER OF INDIRECT REPORT(S):** 10
TITLES OF DIRECT REPORT(S): Manager, investigators , auditor

The information in this position description indicates the general nature and level of work to be performed. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job. Management reserves the right to revise the job description or require that other tasks be performed when the circumstances of the job change (for example, emergencies, change in personnel, workload, or technical development).

By signing this document I, the employee, affirm that I understand that my employment is on an at-will basis. This means that I and my employer are mutually free to end the relationship at any time, for any reason or no reason, with or without notice.

Employee Signature

_____

Signature

_____ _____

Print Name Date

Manager Signature

_____

Signature

_____ _____

Print Name Date

POSITION DESCRIPTION

POSITION TITLE: Corporate Director of Long-Term Care	JOB CODE: 2169	FLSA STATUS: Exempt	EEO-1 CLASSIFICATION: 1st Mid Lvl Off & Mgrs
DEPT/LOCATION: Care Integration/ Medical Affairs	REPORTS TO (TITLE): AVP of HCS-Care Integration	PAY GRADE: E41	COMPLETION DATE: 12-6-11

POSITION SUMMARY (Briefly describe the purpose of the position):
Direct oversight of Long Term Care (LTC) programs including the development, outcomes and monitoring of long-term support services. This oversight includes the development of clinical and social model programs to meet regulatory requirements, providing direction to state plans to implement monitor and achieve program goals. Provides leadership on the structural and clinical integration of LTC services with Medical, Behavioral, and Pharmacy services.

ESSENTIAL FUNCTIONS

Duties and Responsibilities (List all essential duties and responsibilities in order of importance)

- Refine and modify clinical and social programs to meet regulatory requirements in multiple states while maintaining the integrity of enterprise standardization.
- Actively participate with plans to hire plan directors of LTC/ABD programs with the appropriate skills and experience.
- Provide direction to Plan Healthcare Services leadership to ensure implementation of programs to meet financial, utilization and quality outcomes.
- Establish required and standardized quality and outcome measures ensure.
- Ongoing monitoring and auditing of state plan performance on quality and outcome measures to determine success in LTC standardization.
- Process ownership of Information Technology solutions for LTC services enterprise-wide.
- Provide subject matter expertise in guiding the integration of LTC within the new corporate Integrated Care Management model.
- Develop standardized turnkey solution for LTC in-sourcing enterprise-wide.
- Provide input to State RFIs, RFPs, and other relevant applications.
- Support implementation of LTC standardized model in new state health plans.

State Plan / Department Specific Duties and Responsibilities (List all essential duties other than those listed above in order of importance)

-

Knowledge, Skills and Abilities (List all knowledge, skills and abilities that are necessary to perform the job satisfactorily)

- Excellent verbal and written communication skills
- Ability to abide by Molina's policies
- Maintain regular attendance based on agreed-upon schedule
- Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA)
- Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers

NON-ESSENTIAL FUNCTIONS

List other duties which are of secondary importance and marginal to the position's purpose.

- Other duties as assigned.

QUALIFICATIONS

Required Education:
BSN or RN with good clinical experience.

Preferred Education:
Master's Degree in Nursing, Healthcare or other field preferred.
Master's Degree in Business Administration

Required Experience:

Preferred Experience:

5 years of health care management experience, including State Medicaid LTC and Waiver programs and work with chronically and medically fragile consumers (i.e., SSI, ABD, etc.).

- Experience in creating interpretive guidelines and program development.
- Proven ability to set and achieve aggressive program objectives and goals
- Proven ability to implement an effective monitoring program to include the ability to provide constructive criticism and require acceptable corrective action plans.
- Management of professional and non-professional staff.
- 3-5 years health care information systems experience.

Required Licensure/Certification:
RN licensure in at least one state in which Molina participates.

Preferred Licensure/Certification:
CCM (Certified Case Management)

PHYSICAL DEMANDS

Working environment is generally favorable and lighting and temperature are adequate. Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions.
Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

NUMBER OF DIRECT REPORT(S):

NUMBER OF INDIRECT REPORT(S):

The information in this position description indicates the general nature and level of work to be performed. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job. Management reserves the right to revise the job description or require that other tasks be performed when the circumstances of the job change (for example, emergencies, change in personnel, workload, or technical development).

By signing this document I, the employee, affirm that I understand that my employment is on an at-will basis. This means that I and my employer are mutually free to end the relationship at any time, for any reason or no reason, with or without notice.

Employee Signature

_____

Signature

_____ _____

Print Name Date

Manager Signature

_____

Signature

_____ _____

Print Name Date

MOLINA HEALTHCARE

JOB DESCRIPTION

JOB TITLE: Associate VP Government Contracts	JOB CODE: 2062	FLSA STATUS: Exempt	EEO-1 CLASSIFICATION: 1st Mid Lvl Off & Mgrs
DEPT/LOCATION: Policy & Govt Advocacy **STATE PLANS**	REPORTS TO (TITLE): Assoc VP Govt Contracts	PAY GRADE: E43	REVISION DATE: 7-17-2012

JOB SUMMARY (Briefly describe the purpose of the job): Responsible for overall administration of the Medicaid, Medicare and other contracts with the state and/or federal government to provide health care services. Serves as lead for contract knowledge and assists the Plan President with various advocacy efforts in support of plan business operations.

ESSENTIAL FUNCTIONS

Duties and Responsibilities (List all essential duties and responsibilities in order of importance)

- Contracts and relationship management for State and Federal partners (Medicaid, Medicare, Insurance) and key state elected officials (Governor's Office) :
  - Supervises the Director/Manager Medicaid and Medicare Contracts,
  - Supervises Regulatory Submissions and Filings,
  - Represents Molina at State meetings including, but not limited to, meetings with Medicaid Director, Director of Insurance, and other Medicaid officials. Develops strategies advocate for best practices that demonstratively improve contract terms or facilitate business objectives,
  - Identifies opportunities for strategic conversations with key stakeholders aligned with business needs – duals, ABD children, ACOs that promote Molina approaches,
  - Leads efforts with Plan president to expand managed care opportunities.
- Improves coordination/integration of services for dual eligible, and influences the State's implementation of the ACA provisions leading up to and in 2014.
- Works with key statewide advocacy groups and provider trade associations to advocate Molina's position and business objectives and develops strategic partnerships.
- In coordination with Legal Affairs, assesses and provides analyses for proposed changes to Medicaid and Medicare healthcare program contracts, governing regulations and new legislation and policy requirements.
- Oversees and monitors the implementation of new Medicaid and Medicare contractual and policy requirements, new legislation and regulations:
  - Educates plan staff on complying with new healthcare program requirements,
  - Institutes reporting standards to meet new program requirements,
  - In coordination with plan president and corporate resources, provides educational updates on ACA implementation and Molina readiness; and serves as point of contact for corporate lead to disseminate information from plan president's ACA readiness review team,
  - Performs routine market assessments to identify bid opportunities
  - Coordinates plan's RFI responses, as well as RFA and RFP bid efforts, in collaboration with MHI Corporate Development.
- Industry/Association Management:
  - Attends key committees and coordinates deliverables,
  - Attends and coordinates, if appropriate, AHIP, NAIC, and MHPA activities.
- Coordinates with Director Compliance initiatives to improve adherence to plan policies and procedures and represents Government Contracts on Compliance Committee.
- Coordinates the establishment of and maintain MOUs for the plan's carved-out and linked services in State healthcare programs as applicable:
  - Ensures plan meets the requirements and obligations set forth in these MOUs,
  - Serves as a key plan liaison with these carved-out and linked services providers to enhance the plan's partnership with these entities.
- Supervisory Responsibilities
  - Manages subordinate staff,
  - Acts as Ombudsperson and Coordinator,
  - Manages relationship with the state.

State Plan / Department Specific Duties and Responsibilities (List all essential duties other than those listed above in order of importance)

- Regulatory Affairs: Partners with contracted lobbyist:
  - Develops legislative plan and implements various tactics including legislative visits, plan visits, and PAC support.
  - Regulatory Communications: Works with VP of Regulatory Affairs to provide timely and informative updates on regulatory issues of concern and provide periodic reports to support regulatory communications initiatives Partners with Federal Relations Team to provide update on state issues with federal impact such as ACA implementation and CMS issues.
  - PAC: Partners with Molina PAC coordinator and contracted lobbyist on development of local health plan PAC strategy
  - Molina State Lobby Day: Partners with contracted lobbyist to plan and coordinate annual event.

Knowledge, Skills and Abilities (List all knowledge, skills and abilities that are necessary to perform the job satisfactorily)

- Extensive knowledge of Medicaid, Medicare and/or other government programs
- Computer literacy
- Knowledge of Medicaid contract development and language
- Ability to develop, organize, analyze and implement procedures
- Management, negotiation and presentation skills
- Adheres to the company and/or departmental fraud and abuse prevention/detection policies and programs
- Excellent interpersonal and verbal and written communication skills
- Ability to abide by Molina's policies
- Ability to maintain attendance to support required quality and quantity of work
- Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA)
- Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers

NON-ESSENTIAL FUNCTIONS

List other duties which are of secondary importance and marginal to the job's purpose.

- Other duties as assigned.

QUALIFICATIONS

Required Education:
Bachelor's Degree in related field or equivalent combination of education and experience.

Preferred Education:

Required Experience:
5 years experience in government programs.

Preferred Experience:

Required Licensure/Certification:

Preferred Licensure/Certification:

PHYSICAL DEMANDS

Working environment is generally favorable and lighting and temperature are adequate. Work is generally performed in an office environment in which there is only minimal exposure to unpleasant and/or hazardous working conditions.

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

NUMBER OF DIRECT REPORT(S): 1 **NUMBER OF INDIRECT REPORT(S):** 0 - 3
TITLES OF DIRECT REPORT(S): Mgr/Dir Government Contracts

The information in this job description indicates the general nature and level of work to be performed. It is not designed to be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this job. Management reserves the right to revise the job description or require that other tasks be performed when the circumstances of the job change (for example, emergencies, change in personnel, workload, or technical development).

By signing this document I, the employee, affirm that I understand that my employment is on an at-will basis. This means that I and my employer are mutually free to end the relationship at any time, for any reason or no reason, with or without notice.

Employee Signature

_____

Signature

_____ _____

Print Name Date

Manager Signature

_____

Signature

_____ _____

Print Name Date

Molina's experience serving the most vulnerable populations for the past 30 years ensures members receive cost effective, integrated care and transition services without compromising the member's quality of care.

SECTION 3 – SCOPE AND COVERED BENEFITS

Please explain how you propose to execute Section 3 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Molina understands, agrees and will comply with all Scope and Covered Benefits requirements in accordance with Section 3 of Attachment 1—Scope of Work.

3.2.2 Benefit Packages

1. Describe your proposed approach to ensure benefit packages will be delivered in accordance with a member's eligibility group.

Molina has a robust process for assessing and implementing benefit packages based on a member's eligibility group. Iowa's eligibility groups and the associated data elements to identify those groups are researched and mapped to Molina's integrated core information system, QNXT, which is used to store eligibility data as well as process authorizations and claims. Benefits are reviewed, interpreted and documented, including specific eligibility group nuances. A Molina cross-functional team comprised of representatives from Healthcare Services, including the Chief Medical Officer, provider contracting and technical staff that code and maintain QNXT, review and approve the requirements and system design for eligibility groups and their associated benefit packages. During the design phase, the cross-functional team identifies and resolves potential eligibility or process issues, and ensures appropriate coding revisions are captured in QNXT. During the testing phase of implementation, claims are processed in a test environment to ensure claims pay appropriately based on a member's eligibility category, covered benefits, and provider payment amount or fee schedule. Post implementation, the team conducts periodic coding reviews and makes ongoing revisions as necessary. Molina tracks any issues related to eligible benefits through a well-developed internal Quality Improvement process that collects data from multiple sources, shares data across departments, and if needed, refers issues for further problem-solving to the Quality Improvement Committee (QIC), a multidisciplinary team chaired by the Chief Medical Officer that includes senior management representation from all operational and administrative functions including clinical, business and administrative staff. This proven Molina process will ensure benefit packages are designed for members to receive allowed medically necessary covered services noted in Attachment 1—Scope of work, Section 3.2 and Exhibit D as well as allowable 1915(c) services based on the member's assigned waiver program.

2. Describe your ability to provide covered benefits and services.

Molina will comply with all requirements in Attachment 1—Scope of Work, Section 3.2 Covered Benefits and Exhibit D to provide all benefits and services to members that are deemed medically necessary and are covered under the Iowa High Quality Healthcare Initiative contract and in accordance with 42 CFR 438.210(a)(3). Molina Healthcare of Iowa will administer plan benefits and services using a person-centered, cost-effective combination of local health plan operations and shared resources provided by its parent, Molina Healthcare, Inc. Since Molina has the largest number of dual eligible health plan demonstrations in the country, we have the unique position to have significant experience in providing

benefits to Iowa's clinically diverse populations. To ensure flexibility to efficiently accommodate variations in membership levels and changes in covered benefits and services, the new health plan will do the following:

- Administer an efficient managed care model that provides quality services in a sustainable manner while meeting all state, regulatory and other requirements;
- Implement Molina's scalable IT system that supports compliance and growth requirements, and is capable of handling the complex data produced by the Iowa High Quality Healthcare Initiative population;
- Continue to build a robust service delivery network focused on contracting with Primary Care Physicians (PCPs) who support a Medical Home environment, as well as specialists, hospitals, long term services and supports, and ancillary providers, to ensure access to experienced practitioners. Recognizing that many of Iowa's Medicaid beneficiaries reside in rural areas, Molina will rely on experience gleaned in other rural states, such as New Mexico, to ensure that members in rural areas have access to care and appropriate transportation services; and
- Use Molina's flexible and innovative care management delivery approaches to integrate care coordination for members with disabilities, chronic medical conditions, and behavioral health and substance use disorder issues to ensure delivery of the right care, at the right time, in the right setting. Care Management at Molina includes the following programs and services, which are all critical to ensuring the comprehensive integration of health care services:
  - Care Coordination strategies, which engage members in active problem-solving directed at their own health improvement through techniques such as motivational interviewing to improve healthy behaviors, working with members to address social determinants of health and removing barriers, so members can achieve optimal health and well-being;
  - Care Coordination programs, which integrate an array of health care services that are designed to improve health outcomes for chronically ill members who are aged and/or disabled, including individuals with AIDS; Acquired Brain Injury; Children with Mental Health Conditions; or who are part of the HCBS Elderly, Health and Disability (HD), Intellectual Disability (ID) and Physical Disability (PD) waivers who need long term care support services; and individuals with acute, behavioral health and/or substance use disorder issues;
  - Disease Management programs that are designed to actively engage members in addressing their own health care needs, and which have been proven effective in reducing inpatient admissions, readmissions and Emergency Room utilization;
  - Case Management programs that are designed to risk-stratify members with complex medical conditions for dynamic assessment of needs, interventions, reassessment and evaluation of outcomes;
  - Utilization Management programs that are designed to ensure quality, cost-effective and medically necessary services are delivered across the continuum of care;
  - A dedicated Nurse Advice Line service available 24 hours per day, seven days per week that is staffed by registered nurses who provide comprehensive and personalized physical health and behavioral health telephone services with a goal of decreasing inappropriate Emergency Room utilization; and
  - Establish a transportation program and strategy designed to reduce the potential for missed services or unmet needs for members including those in rural Iowa.

Molina has established key Iowa relationships with leading organizations, such as the Iowa Primary Care Association (FQHC), Iowa Behavioral Health Association (BH), the University of Iowa Alliance (Health Systems), and the Iowa Healthcare Association (NFs). Working in collaboration with these organizations

allows Molina to develop a continuum of providers in all 99 counties to deliver the benefits required in Iowa in a coordinated, value-based fashion.

3.2.4 Integrated Care

1. Describe proposed strategies to integrate the delivery of care across the healthcare delivery system.

Molina will partner with DHS to ensure that all Iowa High Quality Healthcare Initiative covered services are delivered through a highly integrated delivery system that improves access to preventive care; manages chronic diseases; promotes respect for every member; and achieves cost management goals while preserving access and choice.

Leveraging the national experience and expertise of its parent company, Molina Healthcare, Inc., and its 12 sister health plans across 11 states and the Commonwealth of Puerto Rico, Molina will establish a proven, integrated health care management system that delivers critical physical health, behavioral health and social services to its Iowa High Quality Healthcare Initiative members. All Molina health plans operate under the guidance of core managed care principles that emphasize a careful balance of providing positive member outcomes with cost-effective quality care across the health care continuum. These startegies include:

- Improving quality of care by encouraging member participation in their own care; leveraging innovative preventive care programs; and streamlining care coordination and continuity of care;
- Ensuring appropriate care settings through provision of private physician office care in lieu of time-consuming, costly Emergency Room care;
- Leveraging evidence-based member data (e.g., HEDIS, CAHPS) to optimize quality of care and personal health outcomes;
- Ensuring appropriate use of HCBS to avoid or reduce nursing facility usage and encourage independence; and
- Investing in process improvements, provider network adequacy and other resources necessary to ensure holistic, coordinated and integrated care for every member in all appropriate care settings. Molina has established a key provider foundation in Iowa.

Molina employs these core principles in the delivery of health care services for a wide range of government health programs, including Medicaid, CHIP, Children with Special Health Care Needs, Medicare Advantage Special Needs Plans (SNP), Foster Care and others.

Our Approach to Effective Integrated Health Care Delivery

Enterprise-wide, Molina brings deep experience in effective integrated health care services delivery that include management of physical, behavioral, substance use disorder, long-term services and supports (LTSS) and other community-based social services, along with assisting the member in navigating the health care system. Molina uses a person-centered approach to health care delivery that addresses members' unique health circumstances and is especially effective in providing integrated care coordination for members who have multiple or complex conditions.

Molina's integrated approach further focuses on engaging and empowering the member and caregivers, when appropriate, at every opportunity, assigning resources based on specific member needs and promoting self-care. Molina recognizes that integration starts at the site of care and works collaboratively with providers to support integrated care. Examples include support for Medical Homes that integrate care management supports into primary care; Integrated Health Homes that combine behavioral health and primary care as well as care coordination; and the establishment of quarterly meetings with health

systems and/or ACOs to foster internal systems of coordination and care management. All of these provider-grounded integration strategies are supported by education and outreach to providers. Provider incentives drive integration at all levels of the delivery system. Molina assigns experienced Case Managers who advocate on behalf of our members. They work to remove barriers to care and support members to participate in and direct their own care. Case Managers also rely on the use of Community Connectors, who are community-based, culturally and linguistically competent members of the Interdisciplinary Care Team who administer in-person care coordination to members in the communities they serve. Together, these key Molina Care Team participants play an integral role in creating health care environments that deliver effective preventive, primary and acute care services across multiple care settings with cost efficiencies that do not compromise the quality of member care, regardless of members' unique health care needs.

Integrated Healthcare Delivery Strategies for the Iowa High Quality Healthcare Initiative

To ensure that Iowa High Quality Healthcare Initiative program members receive quality, integrated care, Molina will use its patient-centered integrated care management approach that is based on empirically validated best practices and has demonstrated positive results in numerous Molina managed care markets. Molina engages the member and their family/caregivers in the integration of physical health, behavioral health (including substance use disorder treatment), and social supports to eliminate fragmentation of care and to provide a single, highly individualized plan of care that focuses on the abilities and preferences of each member. From the time the member enters the physical health or behavioral health point of service, Molina staff are engaged in identifying member needs and initiating referrals, as appropriate, to ensure member access to quality care.

Molina recognizes that it is at the intersection of behavioral health and physical health care and services where integrated care management brings the greatest positive change for members. An individual with severe mental illness requires support in accessing behavioral health care, but also needs assistance with understanding their physical health needs and following through on necessary appointments, home-based treatment and medication management. Similarly, an individual with a chronic physical health condition may not seek the care they need due to untreated depression that causes them to become isolated and unmotivated in pursuing their treatment plan. Molina's Case Managers utilize their clinical knowledge and tools to assist in identifying these service gaps, and underdiagnosed or undertreated conditions, and work to ensure cross-communication among disparate providers within the member's Interdisciplinary Care Team in the effort to maximize the member's whole-person health outcomes.

Molina will collaborate with Iowa ACOs, including the University of Iowa Alliance, and Iowa Health + (FQHCs), Mercy Health Systems, and other ACOs. By establishing efficiency and quality targets, Molina will be able to integrate with key Iowa providers.

In addition, Molina has established a strategy for the elderly and disabled populations and received support from pre-eminent providers in Iowa to develop and implement a whole-person care plan in collaboration with Molina care management efforts. This will be a highly integrated plan spanning the physical, social, behavioral and preventive services required to achieve optimal patient outcomes and efficiencies.

3.2.5 Emergency Services

1. Describe your strategies to reduce inappropriate use of the emergency room and to address members who frequently utilize emergency services.

Molina provides a structure of health care delivery services and program performance monitoring to ensure that members access the most appropriate health care source for their needs. To meet this objective,

Molina is committed to providing adequate PCP coverage to ensure sufficient access to services; urgent care facilities to support after-hours needs; a URAC accredited Nurse Advice Line staffed with bilingual Registered Nurses with an average of 15-20 years of acute care experience and 3-4 years of telephone triage experience to help members access appropriate care and services 24 hours per day, 7 days per week; and Member Services support during normal business hours that facilitate access to the appropriate level of care, which helps decrease unnecessary Emergency Room utilization. In addition to Molina's robust network, Molina uses traditional case management techniques, along with innovative programs, to control Emergency Room utilization. This multifaceted approach demonstrates how the Molina network of services is designed to reduce unnecessary Emergency Room utilization and maximize efficiency.

Molina recognizes the importance of reaching out to members with positive messaging that reinforces the benefits of utilizing primary care services. From the Welcome Call to contact with the Case Manager and Community Connectors, Molina makes every effort to ensure members understand how to contact their PCP and navigate the health care system. Molina's Case Managers and Community Connectors often work with members to help them prepare for their appointments by ensuring they have confidence to discuss their physical and behavioral health needs with their PCP. Community Connectors, who are trained by Molina to serve as extenders for Case Managers and member navigators to provide education and social support, remove barriers to care, and work with Molina's Interdisciplinary Care Teams (ICTs) to deliver whole-person care to high utilizers. The ICT discusses the health status and healthcare services utilization for high-risk members, identifies specific drivers of Emergency Room use, such as poorly managed chronic disease or behavioral health issues, and develops a multidisciplinary approach to improving health and reducing inappropriate Emergency Room use. Molina also recognizes that a member's lack of knowledge about disease progression and prevention can contribute to Emergency Room use and avoidable hospitalizations; therefore, Molina administers wellness and prevention programs that are aimed at coaching members to have conversations with their PCPs about prevention and condition management to include topics such as immunizations (e.g., pneumovax, flu shot) and lifestyle changes (e.g., quitting smoking and weight loss, including special diets that are unique to the member's individualized needs and preferences).

A Molina Case Manager also works with the member to develop an Integrated Care Plan (ICP), which addresses gaps in care and coordination of services (e.g., physical health, behavioral health, social needs and LTSS) as well as the drivers of emergency room use and includes targeted interventions. Molina's Case Managers also utilize the ICT to ensure the ICP is a collaborative effort, addressing all identified member care needs and preferences, and incorporating feedback from all stakeholders. Molina's ICT consists of the member and/or their families/designated caregiver, the member's PCP, Molina's Case Management staff, such as the Case Manager, and additional Care Team participants, such as Specialty Providers, Behavioral Health Providers, nurses, social workers and Community Connectors, based on each member's needs and preferences. Molina's Case Management staff utilizes the ICT platform as a tool to help arrange for necessary specialty care, community-based services and behavioral health needs.

Unrecognized and unmanaged behavioral health issues are a significant driver of inappropriate Emergency Room utilization. Molina's deep experience working with Medicaid populations has enabled us to develop particular expertise in the delivery of integrated behavioral health and physical health services. Molina's Care Management team is comprised of both physical health Case Managers and licensed behavioral health professionals who work together to address the whole-health needs of members, which may include primary behavioral health interventions or the identification of behavioral health issues that are secondary to primary physical health conditions. Behavioral health issues are reviewed to identify any barriers to treatment that often go unrecognized due to broader medical complaints. This whole-person approach reduces Emergency Room use that is driven by unmet behavioral health needs.

Molina has implemented community-based intervention programs in its sister health plans that are aimed at decreasing inappropriate utilization of Emergency Rooms that have included collaborating with

primary care centers to extend operating hours, and supporting Community Health Workers programs that, in conjunction with Molina's ICTs, can deliver whole-person care to high utilizers. Molina has successfully implemented these programs in New Mexico, a state where historically high Emergency Room utilization was a challenge, and proposes to implement a similar program in its Iowa health plan.

An example of another community-based intervention program that Molina may implement in its Iowa health plan is Molina Healthcare of New Mexico's highly successful Hospital Transitions initiative that utilizes Community Connectors and Transition of Care Coaches. These teams participate in the formation and implementation of an Individualized Care Plan (ICP) that includes interventions designed to mitigate the risk of hospitalization and re-hospitalization. The Transition Coach visits the member during out-of-home placements and upon discharge to help empower the member to take a more active and informed role in their transition from one care setting to another. Major lessons learned from the New Mexico initiative include the importance of empowering members and their families to play a role in their own health care and ensuring the availability of the community resources and linkages needed to help members stay well and in their homes.

Beyond the use of specialized community resources, Molina also believes in the power of information technology to conduct hot-spotting and identify individuals who are exceptionally high utilizers of certain services, particularly Emergency Room services. Molina is very familiar with initiatives such as those of the Camden Coalition in New Jersey, and believes in the effectiveness of the Camden Coalition's intervention strategies, particularly in densely populated areas. Molina's business intelligence and data analytics systems, which incorporate big data mining and predictive modeling capabilities from nationally recognized companies such as Milliman, MEDai and [redacted], will enable Molina to systematically target individuals who will be assigned to ICTs. The ICTs will then develop Individualized Care Plans for these members, which will be managed with the collaboration of Community Connectors. Additionally, the Care Plans are developed in collaboration with the member's provider to ensure the member's designated Medical Home receives reports about the member's utilization profile. All of these resources will have access to business intelligence and predictive modeling information gathered from assessments, encounter data and clinical data gathered for ICT members. Using this insight, the ICT will design interventions that remove barriers to access and improve the management of care for these members.

Additionally, Molina proposes working with the Iowa Health Information Exchange (IHIN) to accelerate implementation of encounter notification services through which an ICT would receive alerts when members access emergency rooms, are hospitalized or receive services from certain providers. This is essential to an ICT's ability to manage the care of high utilizers.

Other Successful Emergency Room Diversion Interventions in Molina's Sister Health Plans

Molina has had successful and positive experiences with Emergency Services diversion in several of Molina's sister health plans. For example, Molina Healthcare of Illinois partners with contracted local Community Mental Health Centers' crisis teams to identify and screen all members under the age of 21 that present to the Emergency Room or other community-based location where Emergency Medical Services (EMS) are called. The contracted community crisis team member screens the member for appropriate level of care and diversion to immediate outpatient services, as applicable. The contracted community screeners utilize a standardized screening tool, the CSPI and CANS. Members who are diverted to outpatient services are engaged into community-based case management as well as outpatient therapies. These services do not require authorization and the process provides comprehensive and immediate access.

Crisis services are monitored and reimbursed not only by the service provided, but also by the outcome and follow up, whether post discharge from the hospital or in a deflection to regional services. Molina encourages providers to enrich their scope of available ambulatory services in order to provide a more robust diversionary system. As part of the Iowa High Quality Healthcare Initiative, Molina will work

CONFIDENTIAL

within regions where there is a disparity of ambulatory services to help ensure adequate access to services. Through the use of Community Connectors, Case Managers and community outreach programming, Molina will be able to identify gaps in diversionary services and can assist with coordination of, telephonic interdisciplinary care teams, and contracting for telemedicine services. Additionally, Molina will use a robust transportation strategy to ensure member access to PCPs and specialists, particularly in rural communities, to decrease emergency department visits as a primary point of access.

Molina Healthcare of Puerto Rico utilizes community partners to screen members who present at high volume Emergency Rooms and, when clinically appropriate, members are engaged into immediate outpatient services and are diverted from possible hospitalization.

Molina Healthcare of New Mexico has also partnered with local mental health care service groups to provide onsite Emergency Room assessments for members presenting with behavioral health complaints in order to engage in the appropriate level of care.

Several other Molina health plans, including our Texas, Ohio, New Mexico, Utah, Michigan, Wisconsin and Washington plans, utilize claims reports to identify members with high utilization of emergency services. Members that fall within the identified range are contacted by Health Educators, Case Managers and Community Connectors, as appropriate, for further assessment and identification of needs.

2. Describe your plans to ensure a response within one (1) hour to all emergency room providers twenty four (24)-hours-a-day, seven (7)-days-a-week.

During regular business hours, 8 a.m. to 5 p.m., Monday through Friday, Molina's Care Access and Monitoring staff are available to respond within one hour to providers requesting Emergency Room post-stabilization services. For after-hours support, Molina ensures the following coverage:

- Molina's Care Access and Monitoring staff maintains a schedule that ensures nurses are available to respond within one hour to Emergency Room providers 24 hours per day, 7 days per week. Calls are received by the Nurse Advice Line, which is available 24/7/365;
- In addition to being available to answer provider questions, after-hours staff via the Nurse Advice Line will ask the Emergency Room to fax relevant information regarding the member to Molina, so it will be available to the Care Access and Monitoring nurse who will be assigned to the case. After-hours staff/Nurse Advice Line staff will also document all information in Molina's care management system, Clinical CareAdvance. After-hours staff forwards all cases via e-mail to Care Access and Monitoring management. Care Access and Monitoring management assigns the case to a Care Access and Monitoring nurse who takes over managing the case at the start of the next business day; and
- Molina's Medical Directors are available after hours via cell phone to provide support to Care Access and Monitoring staff when physician involvement is necessary.

3. Describe your plans to track emergency services notification of a member's presentation for emergency services.

Utilizing the Emergency Department (ED) Notification and Utilization Alert, Emdeon, Molina's single-source Electronic Data Interchange (EDI) clearinghouse for claims and encounter submissions, has the ability to identify and track Emergency Room services and generate an Emergency Room utilization alert via a 278 HIPAA transaction to Molina when a Molina member arrives for emergency services. This will provide Molina the opportunity for earlier patient care management by flagging the Emergency Room visit in Molina systems to manage follow-up care and improve patient outcomes. Members are also identified via a campaign in Molina's care management system, Clinical CareAdvance.

Assessments within Clinical CareAdvance provide Emergency Department visit questions that, depending on the member's answers, trigger case management eligibility criteria. Members identified with three or more visits in a month are sent an "Initial Notice Letter," which is also copied to the member's PCP. This letter provides the member with their PCP information; a current listing of urgent care locations; an informational piece on the proper use of the Emergency Room; and a copy of an educational brochure developed by Molina to assist members in accessing health care services appropriately.

Molina also monitors emergency room visits through a comprehensive Emergency Room management and intervention program. This program identifies incorrect or over-utilization of Emergency Room Services from retrospective data reported monthly. Data is based on specific utilization markers and the use of nationally benchmarked stratification tools using the NYU ER Utilization algorithm.

Members meeting algorithm criteria are identified in the report with Date of Service, Emergency Room use, Primary Care Provider, CPT, ICD-9 codes and other essential information. Case Managers review available clinical information, including claims information, pharmacy and utilization management data. Members are notified by mail that their Emergency Room use is under review. Case Manager interventions are implemented based on assessment outcomes and include, at a minimum, one-on-one contact with the member for further assessment and education and follow-up letters to the member and his or her PCP. Interventions may also include Interdisciplinary Care Team (ICT) meetings in an effort to maximize the member's health outcomes. Complex, hard-to-resolve cases are forwarded to the Medical Director for further discussion. Cases may be escalated for more in-depth care management.

Ongoing data analysis is performed to evaluate effectiveness, the need of further intervention, referral to complex case management or other programs and analysis of cost reduction opportunities. Molina employs a team of specialized nurses and Social Workers who are part of its restriction and diversion team. This specially trained team identifies inappropriate utilization and monitors for potential fraud, waste and abuse.

Molina utilizes in-house Community Connectors to actively work with members who are over-utilizing services by identifying coordination needs and assisting members in establishing a Medical Home. Upon member request, Community Connectors can also attend physician appointments with members and provide follow-up coordination calls between members and specialists to ensure an appropriate level of care. Community Connectors work in tandem with Molina's Case Managers as an extension of the Care Management team.

4. Describe your plans for reimbursement of emergency services, including what processes will be implemented to determine if an emergency condition exists.

Molina will provide Emergency Room coverage for its members on a 24-hour, seven-days-a-week basis in accordance with 42 CFR 438.114. Molina does not require authorization for Emergency Room services. Molina's policies and procedures that pertain to emergency services, claims reimbursement and covered services comply with all applicable state and federal laws. Emergency services are paid without regard to whether the emergency provider is or is not contracted with Molina.

Molina provides reimbursement without prior authorization or the existence of a contract with the emergency care provider for emergency services to members in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition exists, including conditions that meet one the following standards:

- Include acute symptoms of sufficient severity/severe pain;
- May seriously jeopardize the health of the member or the member's unborn child;

- May result in serious impairment to bodily functions; or
- Could result in serious dysfunction of any bodily organ or part.

Coverage includes services that are needed to evaluate, screen and/or stabilize an emergency medical condition.

Molina also provides reimbursement for the following emergency-related services, including:

- Emergency medical transportation to facilitate the provision of covered benefits when the member's physical/behavioral health condition is acute and severe, necessitating immediate diagnosis and treatment, so as to prevent death or disability;
- Professional services required to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; and
- Facility services until the member is stabilized and can be safely discharged or transferred. If the member's condition necessitates Emergency Room treatment, Molina will reimburse for that treatment. If the member's condition necessitates inpatient services, prior authorization is required within one business day of admission. Molina members are not held financially liable for any Emergency Room services.

5. Describe your plans to document a member's PCP referral to the emergency room and pay claims accordingly.

Molina documents a member's PCP referral during the claims review process. PCP referrals to the Emergency Room do not require authorization to facilitate appropriate reimbursement of Emergency Room services. Molina's policies and procedures that pertain to emergency services, claims reimbursement and covered services comply with all applicable state and federal laws. Emergency care, and other services that are subject to member eligibility, do not require any utilization management review or prior authorization by Molina. Molina checks member eligibility as the claim is processed for payment without regard to whether the emergency provider is or is not contracted with Molina. Upon confirmation of eligibility, the claim is then deemed medically appropriate and is paid according to applicable claims payment schedules.

3.2.6 Pharmacy Services

1. Describe your proposed approach for delivering pharmacy benefits, including the use of any subcontractors.

Molina currently manages pharmacy benefits for over 3.2 million Medicaid and Medicare lives, and is therefore confident in its ability to execute and manage a pharmacy benefit for DHS and Iowa High Quality Healthcare Initiative program populations. Molina's success in this area is the result of a long-term coordinated partnership between Molina and its pharmacy benefit manager (PBM), CVS Caremark. CVS Caremark is delegated to perform critical services for Molina, such as pharmacy claims processing, reporting and provision of pharmacy software systems, such as those used to perform prior authorizations and utilization management.

Through a process compliant with NCQA standards, Molina will follow and enforce the PDL under the Medicaid FFS Pharmacy benefit with Prior Authorization criteria, including quantity limits and days' supply limitations. Molina, through its presence in Texas and Florida, has extensive experience in administering State formularies and PDLs. As directed by DHS, the Formulary/PDL will exclude coverage for any drug marketed by a company (or labeler) that is not a participant in the federal rebate program, and/or any drug classified by the FDA as a DESI drug.

Molina Pharmacy staff will utilize special Internet-based software provided by the PBM to input and manage all Prior Authorization requests. This software includes a built-in fax server so that images of faxes and related correspondence can be viewed on-screen at the time of review and stored electronically for future reference. The software houses Prior Authorization criteria in decision tree logic, which allows Molina to ensure that all criteria are applied consistently, regardless of the employee handling the request. Prior Authorization activity will be tracked and trended for continuous improvement, and the Prior Authorization process will be performed in accordance with all DHS requirements related to timelines and emergency (72-hour) supplies.

In accordance with NCQA and DHS standards, Molina will internally conduct the Prior Authorization process as follows:

- Prescription is presented at the pharmacy, which processes the prescription online and receives a computerized message that Prior Authorization is required. Or alternatively, prior to writing the prescription the prescriber identifies the desired drug as one requiring Prior Authorization with Molina.
- The dispensing pharmacist telephones the physician to request that a Prior Authorization call be made to Molina's Pharmacy department (not applicable if prescriber submits request to Molina for prior authorization beforehand).
- The prescriber or prescriber's representative faxes a completed Prior Authorization Request Form to Molina or calls Molina's Pharmacy department with the patient information. Alternatively, the provider may answer questions through electronic prior authorization (ePA) software and receive an immediate, automated response.
- A Molina pharmacy technician evaluates the medication request according to criteria set by DHS. If necessary, the technician will consult with the Molina Pharmacy Director. Molina may ask the prescriber to provide additional information depending on the nature of the request. In the absence of pre-determined criteria, Molina Pharmacy staff will utilize the FDA label as well as well-regarded pharmaceutical texts (e.g., AHFS, Drug Facts and Comparisons, etc.) when reviewing the request.
- If the request is approved, the pharmacy technician will inform the physician/representative of approval via fax or telephone and will update the online system to reflect the approval. All decisions will be rendered within 24 hours of having received a complete request.
  - The physician's office calls the member, who then can go to the pharmacy to pick up the medication. In situations where the member's condition does not meet the approval criteria set for the drug, the request will be denied. Only the Molina Pharmacy Director (or Medical Director/CMO) can make a denial determination. A notice of denial will be sent in writing to the member and prescriber within 24 hours of the complete request being made. Members will also have the right to appeal a denial decision, per any requirements set forth by DHS. If a member or provider is disputing a denial of a prescription drug or pharmacy service through the Grievance or Appeals process, Molina will allow a one-time fill of a prescription for:
    - Seventy-two (72) hour supply of prescription drugs that are administered or taken daily or more than once per day; or
    - One full course for prescription drugs that are administered or taken less frequently than once per day.
  - Unless the member directs otherwise, Molina will contact the provider who wrote the prescription to resolve any outstanding issues with respect to the prescription while the Grievance or Appeal is pending.
- Molina will allow a 72-hour emergency supply of prescribed medication for dispensing at any time that a Prior Authorization is not available, and a prescription must be filled without delay for a medical condition. If the prescribing provider cannot be reached or is unable to request a Prior Authorization,

the pharmacy will be allowed to submit an emergency 72-hour prescription. This procedure will not be allowed for routine and continuous overrides. In regard to 72-hour fills:

- Molina's PBM will set up a process to allow a 72-hour override for all non-formulary medications through a Point-of-Sale override function.
- The PBM's network team will send periodic reminders to pharmacies within the Molina network regarding 72-hour fills.
- Based on requirements, the PBM can track the number of 72-hour fills and provide denials to Molina to share with DHS.
- Molina will work with its PBM to monitor/respond to member complaints regarding 72-hour fill denials.

- Prior Authorization activity (tracking and trending) will be monitored by Molina. Decisions to modify, delete or add Prior Authorization criteria may result from this review process. Additionally, practitioners found to excessively utilize the Prior Authorization process may be contacted by Molina for education on use of the PDL/Formulary.

Molina's PBM Subcontractor

Molina currently manages pharmacy benefits through a partnership with its Pharmacy Benefit Manager (PBM), CVS Caremark. Together, Molina and CVS Caremark perform critical activities and processes through a coordinated approach in compliance with all CMS and NCQA standards. Molina typically implements and manages a comprehensive Drug Formulary via its Pharmacy and Therapeutics Committee, although per Iowa High Quality Healthcare Initiative requirements, that will not be the case for this program. Molina also designs and implements utilization programs, such as prior authorization, step therapies, quantity limits and dose optimization.

CVS Caremark offers prescription benefit management services through a fully integrated network that utilizes over 68,000 retail pharmacies and mail services. Molina will provide pharmacy access in accordance with standards set by DHS. Members have pharmacy access in all 50 states as well as Puerto Rico and the Virgin Islands.

2. Describe your ability and experience in obtaining and reporting drug rebates.

Molina obtains and reports Medicaid drug rebates in eight of its sister health plans through its PBM, CVS Caremark, who is responsible for negotiating and maintaining rebate contracts with pharmaceutical manufacturers on Molina's behalf. Rebates are negotiated based on the degree of Formulary access of specific drugs in relation to other drugs. In some cases, additional rebates may also be awarded based on a drug's market share in relation to other drugs. The PBM collects the rebates and passes on all or a portion of the rebate to Molina. Rebates are calculated and reported as specified in the contract(s) that the PBM has with each pharmaceutical manufacturer. The calculations depend on the contractual relationship with the drug manufacturer. In most cases the rebate is determined by taking a unit cost and multiplying it by the number of units, and multiplying that figure by a rebate percentage as defined within the contract to yield the final rebate. Unit is defined in terms of the lowest volume for the product, such as a tablet, gram or milliliter.

CVS Caremark maintains sophisticated, accurate and reliable capabilities in both standard and ad-hoc rebate reporting. At a minimum, CVS Caremark's Rebate Summary report will be provided to Molina on a quarterly basis and include the following information: total rebate dollars collected; CVS Caremark's share of rebates; net rebates to Molina; Molina's total rebates paid to date; and total rebates earned from each manufacturer.

The rebate proceeds are delivered to Molina on a quarterly basis, as early as 6 months after the end of a claims quarter. Molina reviews and audits all rebate proceeds/reports to ensure accurate receipt of rebates meeting requirements as outlined in the PBM contract. Molina provides supporting detail regarding rebates received as required by Medicaid programs. Rebate data will be available at the drug and/or manufacturer level. Molina's understanding is that drug rebate collection is prohibited under this program per 3.2.6.10.3 of Attachment 1 – Scope of Work; however, Molina is willing to provide any further information that DHS requires regarding its ability to collect such rebates.

3. Describe any relevant experience resolving drug rebate disputes with a manufacturer.

In all 10 states in which it participates as a Medicaid pharmacy provider, Molina voluntarily provides support for any drug rebate disputes encountered by the Medicaid program. State Medicaid programs will typically report back to Molina any claims that are in dispute for Federal, and in a few cases where applicable, supplemental rebate programs. Molina then reviews the claims and works with its PBM, when necessary, to determine if any were adjudicated in error. All findings are then reported back to the State Medicaid program, and if necessary, further support is provided to resolve the issue. In some situations, support involves re-adjudicating a pharmacy claim. In other cases, support may involve providing additional claim information in order to satisfy the concerns raised by the pharmaceutical manufacturer in question. Regardless, to date, Molina has not encountered a dispute situation where full resolution was not obtained.

4. Describe your plans for responding to all drug prior authorization requests within twenty-four (24) hours and dispensing at least a seventy-two (72) hour supply in an emergency situation.

Molina will comply with DHS requirements to respond to all drug prior authorization requests within 24 hours and will dispense at least a 72-hour supply of medication in an emergency situation. Molina's process for complying with DHS's requirements includes the following steps:

1. If the prescriber's medication request is approved, the pharmacy technician will inform the physician/representative of approval via fax or telephone and will update the online system to reflect the approval. All approvals will be given within 24 hours of having received a complete request.
2. The physician's office calls the member, who then can go to the pharmacy to pick up the medication. In situations where the member's condition does not meet the approval criteria set for the drug, the request will be denied. Only the Molina Pharmacy Director (or Medical Director/CMO) can make a denial determination. A notice of denial will be sent in writing to the member and prescriber within 24 hours of the complete request being made. Members will also have the right to appeal a denial decision, per any requirements set forth by DHS. If a member or provider is disputing a denial of a prescription drug or pharmacy service through the Grievance or Appeals process, Molina will allow a one-time fill of a prescription for:
   - A seventy-two (72) hour supply of prescription drugs that are administered or taken daily or more than once per day; or
   - One full course for prescription drugs that are administered or taken less frequently than once per day.
3. Unless the member directs otherwise, Molina will contact the provider who wrote the prescription to resolve any outstanding issues with respect to the prescription while the Grievance or Appeal is pending.
4. Molina will allow a 72-hour emergency supply of prescribed medication for dispensing at any time that a Prior Authorization is not available, and a prescription must be filled without delay for a medical condition. If the prescribing provider cannot be reached or is unable to request a Prior Authorization, the pharmacy will be allowed to submit an emergency 72-hour prescription. This

procedure will not be allowed for routine and continuous overrides. In regard to 72-hour fills:

- Molina's PBM will set up a process to allow a 72-hour override for all non-formulary medications through a Point-of-Sale override function.
- The PBM's network team will send periodic reminders to pharmacies within the Molina network regarding 72-hour fills.
- Based on requirements, the PBM can track the number of 72-hour fills and provide denials to Molina to share with DHS.
- Molina will work with its PBM to monitor/respond to member complaints regarding 72-hour fill denials.

5. In the event a timely response cannot be given, the member will be allowed to receive at a minimum, a 72-hour supply of medication until an appropriate response can be made. If a pharmacy claim rejects due to a prior authorization, Molina will educate the pharmacy to dispense a 72-hour supply to give the pharmacy and/or Molina time to reach the prescriber. In situations where the dispensing pharmacist views that dispensing the drug will harm the member or pose a safety risk, Molina will not require the pharmacy to dispense the special supply and instead will require the pharmacist attempt to reach the prescriber.

5. Describe your method for providing online and real-time rules-based point-of-sale claims processing for pharmacy benefits.

Molina's PBM's claims processing system performs eligibility verification, claim adjudication, provider validation, duplicate claims edits and concurrent drug utilization review (DUR) edits online, in real time. Other edits include member cost share calculation, incorrect price, expiration date and claim cost. This single platform, point-of-service technology maintains complete member history and instantly updates plan and eligibility specifications.

Following are the claims data factors that can be used to screen claims for possible duplication:

- Member identification number;
- Date of fill;
- NDC number/GCN;
- NCPDP;
- Refill code; and
- Prescription number.

These system edits, applied at the point of service, act as an automated management tool to monitor and ensure compliance with our pharmacy program parameters before a prescription is dispensed.

To further elaborate on the online prospective DUR technology employed, our PBM's concurrent Point-of-Sale (POS) Drug Utilization Review (DUR) program is an automatic, system-driven DUR program performed on all prescriptions. It is implemented through its single-platform information systems, which powers the online national retail pharmacy network and the mail service pharmacy facilities. The system includes industry-standard reviews, such as drug-to-drug interaction, gender-age conflicts, ingredient and therapeutic duplication, excessive duration, early refills, and high-dose situations. It conducts up to 500 edits on every prescription to ensure that prescriptions meet administrative, plan-design, and member safety criteria. Molina is also able to recommend and/or enhance DUR criteria specific to Molina member claims and will do so as clinical needs warrant.

The DUR program is not intended to replace the expertise or sound professional judgment of the pharmacy or prescriber. The pharmacy is responsible for acting or not acting upon the DUR information

generated and transmitted through the claims system and for performing pharmacy services in each jurisdiction consistent with the scope of their respective licenses. Drug use inconsistent with the CVS Caremark DUR criteria may be appropriate in certain clinical settings.

To ensure DUR is performed at the point of sale, the PBM's Provider Agreements and Provider Manual require that pharmacies be compliant to DUR alerts and counseling. Network pharmacies agree that Molina/PBM may audit, as necessary, their compliance with the Provider Agreement and Provider Manual. This is accomplished by (1) reviewing claims at the point of service; (2) creating and reviewing reports that target potential discrepant claims; (3) conducting, in certain instances, on-site audits; and (3) proactively educating and training pharmacists and pharmacy staff.

6. Describe your plans to implement retrospective drug use review to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving benefits, or associated with specific drugs or groups of drugs.

Molina has extensive experience in conducting both prospective and retrospective drug utilization review. Molina continually reviews key reports summarizing various aspects of pharmacy utilization, including top drugs by volume and cost; top prescribers; top pharmacies by volume and dollars spent; utilization trends of individual drugs/classes; prior authorization trending by drug and prescriber; and generic utilization.

Review of Drug Utilization trends may result in targeted interventions that affect and/or correct abnormal utilization. Initiatives will be tracked in order to document results and/or need for further action or closure. Examples of unique DUR activities resulting from retrospective DUR may include:

- "First-fill" drug utilization reports that identify members the next day who have filled for the first time; and key medications that may be indicative of the need for complex case management and/or disease management. HIV, antipsychotics, and prenatal vitamins are frequently used as indicators that members may need extra help in managing their care.
- Emergency Room prescription reports that identify members who have likely been prescribed medications subsequent to an Emergency Room visit. This allows for timely communication with members regarding their recent Emergency Room visit and other options that may be available to them in the future in lieu of visiting the Emergency Room (PCP, urgent care, etc.).
- Polypharmacy reports will be reviewed in order to identify members with polypharmacy claims histories. When appropriate, Molina will work with members and their providers to help simplify their drug regimens.
- Controlled substance reports will be reviewed that identify members whose prescription patterns may be indicative of drug-seeking behavior. When appropriate and when approved by DHS, Molina will establish protocols for special "lock-in programs" where such members may be limited to individual prescribers/pharmacies in order to correct the behavior.

Molina evaluates reports and implements corrective actions and improvements targeting over-utilization, including the impact of Drug Utilization Review alerts (e.g., high dose, overuse, early refill, excessive duration), use without indication, potential for misuse or abuse, therapeutic duplication, ingredient duplication and additive toxicity, as well as potential fraud. The following examples of utilization patterns may be considered provider over-utilization:

- Prescribing or dispensing a high volume for off-label uses and doses (e.g., antipsychotic drugs for children under 6 years of age);
- Prescribing or dispensing a high volume of narcotics/opioids (e.g., opioid analgesics to members who have more than three prescriptions for select narcotics within a rolling 30 days);
- Prescribing or dispensing a high dose of acetaminophen through acetaminophen-containing (APAP)

drugs such as hydrocodone/APAP (e.g., daily APAP consumption of 4 grams or more, may result in hepatotoxicity); and

- Prescribing or dispensing a disproportionate volume of brand name drugs versus generic.

Molina monitors the quality and relevance of drug use and encourages appropriate prescribing and dispensing practices by employing a number of strategies to identify over-utilization (e.g., using technology at the point of sale to prevent errors and over-utilization; using drug claims data and education to change prescribing behavior; auditing claims data to profile providers).
Molina analyzes and trends pharmacy data and prior authorization activity to identify outliers in prescribing. Controls are in place to discourage over-utilization of drug therapy and promote safe prescribing practices, which prevent adverse events. Molina consistently monitors to ensure best practices are followed by network providers through regular analysis of warnings generated at the point of sale. This analysis enables Molina to identify providers responsible for a disproportionate number of warnings. For example, when a prescription is filled, the claims system compares the quantity prescribed to the day's supply to ensure the dosage recommendations are not exceeded. If the control identifies an inappropriate dosage, a rejection message is sent to the pharmacist to counsel the member and/or contact the prescriber.

Molina's PBM, CVS Caremark, conducts audits on pharmacy claims as well as on-site pharmacy audits to ensure prescriptions are appropriate and are dispensed and billed correctly. These audits serve two functions:

- Uncover fraudulent behavior and increase cost recoveries; and
- Prevent over-utilization or fraud, waste and abuse by deterring such behaviors as pharmacies are made aware of the potential for claims and onsite audits.

7. Describe your plan for monitoring your PBM as described in Sections 3.2.6.6.1.3 and 3.2.6.6.1.4.

Molina's PBM, CVS Caremark is a subsidiary of CVS Health which also owns CVS Pharmacies. Molina will have audit rights to monitor and review CVS Caremark for delivery of PBM services for our Iowa High Quality Healthcare Initiative members, including delivery of services by participating pharmacies owned and operated by CVS Health as well as other major chains and independent pharmacies. A Molina-selected independent auditor will conduct PBM audits in full compliance with requirements of the PBM agreement as well as HIPAA-related regulations and rules that protect patient confidentiality and proprietary information.

Molina Healthcare of Iowa will leverage the current best practices of its 12 sister health plans across the United States and the Commonwealth of Puerto Rico by managing PBM oversight through regular review of PBM performance information. Enterprise-wide, this oversight review is conducted within each health plan's Pharmacy department with support of other departments, and includes analysis of pharmacy claims payment, service level and formulary adherence.

Molina will prepare a draft plan that will include policies and procedures for monitoring the PBM and will further identify necessary steps supported by timelines and target dates to meet this requirement. Molina understands that DHS may provide input or changes that are to be incorporated in the final plan.

3.2.7 EPSDT Services

1. Describe your plans to ensure the completion of health screens and preventive visits in accordance with the Care for Kids periodicity schedule.

In accordance with the Scope of Work, Molina will ensure that all Iowa High Quality Healthcare

Initiative members under twenty-one years of age will receive the services available under the federal EPSDT Benefit known as "Care for Kids" in the state of Iowa in accordance with the periodicity schedule.

Molina recognizes that preventive and wellness care, such as the EPSDT benefit, serve to promote member health and help to maximize member health outcomes. Molina's staff, including Case Managers, Member Services, Quality Improvement, Nurse Advice Line and other front-line staff assist members in accessing services, such as EPSDT. Case Managers work with the member's PCP and other physicians to ensure the member is able to access needed care in the appropriate timeframe at the appropriate level. Preventive service reminders, including reminders for EPSDT screenings, are regularly sent to PCPs and members to educate and inform them about the benefit.

Molina uses its provider engagement teams to educate providers and office staff on the importance of preventive visits and adhering to the American Academy of Pediatrics and Bright Futures pediatric periodicity schedules, as well as maximizing visits to include all components of the EPSDT exam. In addition, Molina promotes the use of validated developmental surveillance and screening tools, such as the Ages and Stages Questionnaire (ASQ) and Modified Checklist for Autism in Toddlers (M-CHAT). Molina also supports Iowa's 1st Five Healthy Mental Development Initiative since this innovative program allows for the earlier identification and treatment of developmental issues. Molina will help promote referrals to this program to our network providers through various methods, including provider engagement visits, newsletters and fax blasts.

Molina's Strategies to Ensure Member Completion of EPSDT Requirements

Molina's goal is to ensure that all newly enrolled EPSDT-eligible children will receive an initial health and screening visit within 90 calendar days of enrollment and within 24 hours of birth for all newborns. For this initial screening upon enrollment and all other required EPSDT screens, Molina's Case Managers and other staff (including the HEDIS Appointment Team, as needed) will work closely with the member's PCP and other stakeholders to identify and contact eligible members to assess specific needs. Case Managers will then assist members in coordinating referrals to medically necessary follow-up treatment, such as treatment recommendations resulting from an EPSDT screen. Molina's Case Managers provide the primary link between the member and the various providers of care. For screening of newborns, Molina educates expectant mothers during pregnancy on the need for early and periodic well child visits, and coordinates appointment access during the delivery hospitalization.

IT Solutions for Tracking Members Requiring EPSDT Services

Molina also utilizes electronic systems and applications to track members that require EPSDT services to monitor if members have received required care and to drive appropriate interventions.

QNXT

Molina uses a secure, web-based information technology system that operates on a consolidated set of applications in the QNXT claims processing system to track referrals, service authorizations and care delivered. QNXT is Molina's core system application that includes claims, membership, provider, authorization and other encounter data, including pharmacy data. The key features of the QNXT system include simplified data retrieval from a centralized database; synchronized data in one central location; and a flexible, powerful and user-friendly Windows interface.

"HEDIS Alerts" are activated in the QNXT member management system to flag members who have missed services, such as EPSDT services, and prompt Member Services Representatives to remind the member to obtain those services during incoming member calls. The HEDIS Appointment Team makes outbound calls when needed services are identified to remind the member/parent of the needed service(s) and assist with appointment scheduling. These calls to members and parents identify barriers to keeping appointments. Barriers are tracked and presented to the quality team for review and exploration of potential interventions.

Clinical CareAdvance

Clinical CareAdvance, Molina's comprehensive, integrated care management system, provides a single source for assessments, configurable care planning, consent tracking, task and team management, alerts, progress tracking, communication creation, and ongoing monitoring.

This custom-developed application is designed to interoperate and receive data via export feeds from QNXT. Molina's Case Managers can view a member's missed EPSDT services in the Clinical CareAdvance application and use this information to create targeted interventions and ensure appropriate services are delivered based on a member's entire health profile. Case Managers utilize Clinical CareAdvance to ensure timely communication; share information; track and monitor progress; identify issues; and ensure appropriate care planning. Clinical CareAdvance provides a systematic and objective means to monitor, measure and evaluate Molina member care, services and outcomes at both the individual level and the systemic level.

Molina's Web Portal

Molina offers a secure online provider and member Web Portal available 24 hours a day, 7 days a week. Molina identifies members with EPSDT missed services and publishes the information via the Web Portal to communicate gaps in care to Molina providers. The provider Web Portal includes a monthly report of the provider's patients who need preventive services. The provider Web Portal also allows providers to view their performance in key HEDIS and clinical metrics compared to national benchmarks and their peers. Prompts about needed services are communicated to members in the secure member Web Portal when the member logs into the interactive Web Portal home page. The preventive health prompts are specific to the member's care needs and are age and gender appropriate.

CONFIDENTIAL

Community Connectors

Molina also utilizes Community Connectors to help determine members' reasons for their lack of compliance with the EPSDT schedule and to provide needed support. Molina's experience has shown that Community Connectors can serve as valuable members of Molina's Integrated Care Management team,

and can assist in coordinating health services and locating transient members. One important advantage of Community Connectors is that they share ethnicity, language, socioeconomic status and life experiences with the people they help and can therefore be a valuable resource in identifying barriers to obtaining services, such as the EPSDT benefit. Community Connectors also help members navigate the health care system and ensure the member's basic needs are met by connecting them with housing, education and employment resources.

2. Describe your proposed outreach, monitoring and evaluation strategies for EPSDT.

Outreach to Members

Molina engages in proactive activities, evaluation and follow-up interventions with members to promote their compliance with the EPSDT periodicity schedule. Molina intends to improve performance in Iowa's *Care for Kids* EPSDT program for children, which according to 2013 data, is 81% participation.

Proactive Outreach

New Molina members receive an initial enrollment packet that includes information on benefits, such as EPSDT. The materials provided to members include educational materials on the importance of obtaining regular well checks and getting immunized, current immunization schedules and charts, as well as Health Education and Disease Management program information. The Disease Management program supports practitioner practices by providing education and other resources to members to assist them in achieving optimal self-management knowledge and skill.

Proactive activities include written "birthday reminders" to members about screenings that need to occur to follow the periodicity schedule. In addition to the birthday reminder, Molina regularly sends written preventive services reminders to PCPs and members for EPSDT screenings. EPSDT, preventive care and evidence-based clinical practice guidelines are also regularly promoted in member newsletters and on Molina's website to remind members of the importance of well visits and keeping immunizations up to date. A well visit is stressed as an important first step in establishing a Medical Home. Additionally, EPSDT services are promoted in educational documents, the Member Handbook, newsletters, brochures and special mailings, which are mailed, distributed at outreach events, and available on Molina's website.

Molina systematically produces target lists of members with gaps in care related to EPSDT. Staff and providers receive copies of these lists for targeted outreach. Molina conducts live EPSDT reminder outreach calls to encourage members to receive preventive health screenings and well child visits and to provide assistance in making appointments. Interactive Voice Response, a Cisco-based platform that supports telephony rules/services for member and provider contact, is also used to notify members of gaps in care and provide preventive health care tips and information.

Follow-up Outreach

In addition to proactive outreach about EPSDT services, Molina engages in focused activities to assist members in obtaining preventive health services, such as EPSDT, by engaging in follow-up outreach, including:

- Targeted reminder mailings to those within the identified population not on schedule with preventive health or chronic care screenings and tests;
- Multiple outbound reminder calls;
- Telephonic reminders and health education; and
- Member incentives to increase compliance with needed services.

Molina's Community Engagement team also implements additional community programs, including back to school fairs, community education and health promotion events. Molina's Value-added Transportation Service can be utilized to overcome any member transportation barriers, particularly in rural areas. Our

culturally competent staff will be able to communicate to the member to remove language or other barriers that can sometimes impede services.

When members miss EPSDT screenings and services, alerts will be activated in the QNXT member management system to flag those members with missed services. This will prompt Member Services Representatives to remind the member to obtain those services during incoming and outbound member calls. These missed services are also published on the secure online provider and member Web Portal, available 24 hours a day, 7 days a week, so gaps in care are communicated both to members and their providers.

Molina's Case Manager can view a member's missed EPSDT services in the Clinical CareAdvance application, an integrated care management system, and use this information to create targeted interventions and ensure appropriate services are delivered based on a member's entire health profile. Case Managers use Clinical CareAdvance to ensure timely communication, share information, track and monitor progress, identify issues and ensure appropriate care planning. Clinical CareAdvance provides a single source for assessments, configurable care planning, consent tracking, task and team management, alerts, progress tracking, communication creation, and ongoing monitoring.

Outreach to Providers

Molina's Provider Services staff will initially train providers on Molina's policies and procedures to ensure understanding of Iowa High Quality Healthcare Initiative contract requirements, including EPSDT requirements, either face-to-face through scheduled office visits; group training at public conference sites or large provider sites (e.g., hospital conference rooms or auditoriums); or via Webinars for providers with Internet access. Prior to go-live, Provider Services staff will conduct initial orientations to train providers on the Provider Manual and related policies and procedures. Molina conducts training upon completion of the contracting process. Molina has dedicated Provider Services staff in each contracted service area to ensure access to training. Provider training includes an overview of processes, requirements and responsibilities, as well as provider-specific information by provider type. Training is further required for those providers who do not participate within expected timeframes. Re-training is also required on a case-by-case basis for providers who may experience difficulty.

Molina utilizes a variety of approaches to continuing education and training for its network providers, including in-person provider presentations/trainings, webinars, and written materials including the Provider Manual, and Provider Newsletter and bulletins, all of which are accessible electronically via the secure provider Web Portal 24/7. Molina further offers education and training on Molina policies and procedures to its participating providers on an ongoing basis.
Relevant training topics will be identified through trend tracking and national recommendations; frequently asked questions received by Provider Services Representatives; Molina's Quality Improvement Committee; or by direct request to the Chief Medical Officer. In addition, resources and materials to help providers understand their responsibilities and role in ensuring EPSDT compliance are available through Molina's Provider Services department.

Molina's Pay for Performance value program also incorporates economic incentives for provider performance in EPSDT outcomes. We believe this will improve provider engagement and EPSDT results. Molina will work closely with organizations like Visiting Nursing Services of Iowa, who provide approximately 38,000 EPSDT services per year as well as strategic partners like IPCA, whose providers are critical to improving results.

Molina will also collaborate with the 22 statewide Iowa EPSDT Coordinators on their historical experiences and opportunities to identify additional strategies to improve outcomes. Molina will also continue dialogue with key organizations, such as Charles Bruner and the Iowa Child and Family Policy Center about EPSDT improvement strategies, Kristie Oliver from Coalition for Family, and Children's Services in Iowa.

Monitoring and Evaluation of Provider Compliance with EPSDT Requirements

In 2013, data indicates that the greatest challenges to achieving at least the 80% minimum target for compliance are for children between the ages of 3 and 14 years old, particularly children between 10 and 14 years old, which have a 72% compliance rate. To improve these results, Molina conducts ongoing monitoring and evaluation of PCP/provider compliance with EPSDT service requirements and appointment standards, and results are reviewed through Molina's Quality Improvement Program. Trends are monitored according to individual providers, groups and geographical areas. Molina tracks members that require EPSDT services and reviews the outcomes of services provided. Member access to care is monitored on an ongoing basis by network management staff and reported on a quarterly basis to Molina's Quality Improvement committee and more frequently during the first year of the health plan's operation. These reports measure the network against the documented access standards; identify areas for improvement; and identify progress made to remedy any deficiencies identified in the previous quarter.

Molina identifies providers who are not meeting appointment access standards through multiple means, including member complaint data, CAHPS surveys, and internal access and availability studies. Molina's Quality Improvement staff oversees a provider access study each year, and also conducts random office audits whereby staff calls the provider's office, posing as patients, in order to verify that patients can get appointments scheduled within the state-required timeframes. Any office that does not meet the standards is contacted by Molina's Provider Services department for focused intervention with the provider to effect timely access. Molina's Provider Services staff educates providers about mandated appointment and access standards, which are also published in the Provider Manual and in periodic newsletters. Molina's provider contracts and policies and procedures reflect access standards and requirements to ensure adherence to all appointment standards.

Periodically, profiled providers who do not meet performance goals will be contacted by Provider Services Representatives, who will reinforce performance objectives and the importance of partnering with Molina to deliver preventive and appropriate clinical care, including EPSDT screenings and services, to members according to contract requirements and best practice guidelines.

Lists of providers who fall short of the established threshold for appointment standards and who do not meet EPSDT screening requirements will also be submitted to Molina's Peer Review and Quality Improvement committees to determine if there is a need for a corrective action plan and recommendations that target the specific areas of non-compliance. Outcomes data supplied in these reports will:

- Identify any need to intervene with a specific provider;
- Identify results that may be indicative of a systemic problem/need;
- Identify solutions to address the problem/need; and
- Identify opportunities for further improvements and enhancements to quality of care practices.

If providers fail to show improvement when re-audited, and it is evident that recommended actions have not been implemented, the Peer Review Committee will review the audit findings and make recommendations to the Quality Improvement Committee (QIC). Molina utilizes a multidisciplinary committee process to review, analyze and act upon the results of network and provider monitoring. The results of the QIC's analysis will determine if the provider's panel should be frozen, or if removal from the network is warranted. This multidisciplinary approach also ensures that interrelated issues are communicated effectively throughout the organization and analyzed from multiple perspectives, and integrated solutions are developed. All monitoring, outcomes analysis and follow-up is overseen operationally by Molina's Chief Medical Officer (CMO) and Director of Quality Improvement.

This reporting and monitoring is viewed as a first step rather than as a definitive step in identifying aberrant practice patterns. No conclusions will be made or actions taken without thorough evaluation of the data and the practice context.

3.2.8 Behavioral Health Services

1. Describe your proposed approach for delivering behavioral health services, including the use of any subcontractors.

Molina is committed to services that support and maximize the recovery, rehabilitation and resilience of all members in need of behavioral health care. Molina adheres to the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration's (SAMHSA) Guiding Principles of Recovery and believes that behavioral health services will be reviewed and authorized with the goal of providing and maximizing recovery, rehabilitation and resilience to the degree possible given the individualized treatment needs evident within each psychiatric presentation.

Molina characterizes resilience as the increasing ability to sustain treatment responses, or incur fewer treatment setbacks or setbacks of shorter duration on the path toward recovery Molina subscribes to an integrated model of care, which includes a multidisciplinary staff who manage the behavioral health services within the same teams as those that manage the physical health services. This approach allows for a more integrated approach to care and provides access to a member's total health record. The teams collaborate through utilization and case management team interactions, multidisciplinary rounds and Interdisciplinary Care Teams (ICTs) that will review all aspects of an individualized psychiatric treatment plan and provide the authorization of medically necessary services that build resilience, foster recovery and generally utilize rehabilitation efforts. Molina builds and maintains a provider network and range of services available for appropriate authorization and utilization across behavioral health disciplines (e.g., licensed behavioral health professionals, substance abuse professionals, psychiatrists and nurse practitioners).

Molina's Behavioral Health program is founded in a Recovery Oriented System of Care (ROSC) and developed and implemented in close alliance with consumers and consumer advocacy groups. It has been demonstrated repeatedly that including the "consumer voice" in these efforts leads to improved treatment adherence, support service utilization and preferred outcomes. This is the core of the ROSC model – member centric and member led treatment and care. Molina uses SAMSHA recommended factors in care management, including self-direction; individualized and person-centered planning; individual empowerment; holistic care; non-linear interventions; strengths-based growth; utilization of peer support; respect for the individual; and the fostering of responsibility and hope.

Molina Case Managers utilize a person-centered approach to collaboratively develop a comprehensive plan of care that promotes the highest level of functioning while living in the least restrictive setting. The Care Management team is comprised of physical health Case Managers and licensed behavioral health professionals who work together to address the whole-health needs of members, which may include primary behavioral health interventions or the identification of behavioral health issues that are secondary to primary physical health conditions. Behavioral health issues are reviewed to identify any barriers to treatment that often go unrecognized due to broader medical complaints. One of Molina's fundamental Care Management principles is to ensure every member has a choice of options and is empowered to achieve or maintain the highest level of self-sufficiency. Molina believes true consumer engagement encourages members to play an active role in their treatment by allowing members to voice their opinions and goals, and participate in the establishment of care plans.

All Molina Case Managers follow a strict code of ethics to respect members' rights, provide information for informed decision-making, and promote empowerment to choose the best service options available. Case Managers act as member advocates to ensure members' needs are well-served and that care is delivered with transparency, individualization, recognition, respect, linguistic and cultural competence, and dignity, with an ongoing focus on member services.

Molina's Corporate Behavioral Health Program is comprised of behavioral health clinical leaders who

work across all areas of the Molina enterprise to ensure that an appropriate focus on person-centered care and members' behavioral health needs are an integral part of business operations. The Corporate Behavioral Health team acts as subject matter experts and liaisons for all Molina Healthcare, Inc., health plans and corporate teams to help develop policy; provide advice on best practices; educate and train employees to ensure behavioral health core competencies are achieved; and promote accountability through targeted interventions and tools to maximize member health outcomes. The Corporate Behavioral Health team focuses on quality, operations, business implementation, systems training and oversight, as well as clinical oversight, demonstrating Molina's commitment to truly integrated care. All Molina Healthcare, Inc., health plans, with the exception of one, have fully integrated utilization management and care management teams to ensure that behavioral health benefits and needs are managed within the health plan. Molina is committed to implementing this approach to integrated care in Iowa.

2. Describe how your proposed approach will incorporate the values outlined in Section 3.2.8.1.

Molina subscribes to the Recovery Oriented System of Care (ROSC) Model in which person-centered community-based services and supports are utilized in all treatment planning, coordination and referrals. Our ROSC Model is based on the strengths and resiliencies of individuals, families and communities to achieve improved health, wellness and quality of life. Molina's model achieves these goals by focusing on the following:

- **Member, Family and Community** – We meet the member where they are—both mentally and physically—in order to develop a trusting relationship. Molina's Case Managers assess members telephonically and in person, as needed, in order to empower a positive and meaningful relationship and reduce stigma.
- **Services and Supports** – We provide our members with vital services and supports through our diverse provider community and community partnerships that reflect the member's own preferences and experiences. Molina recognizes the uniqueness of a community and ensures that the right supports and access to the right level and style of care is available in the comfort and convenience of the member's community. Molina understands that services and support could include traditional healing, peer supports, spiritual supports, and vocational or educational supports, as well as family supports, and looks to partner with agencies and providers that cover the entire spectrum of services within a community.

Molina's Case Manager includes all necessary supports (funded or not by Molina) in the member's Care Plan to reflect the member's preferences in a timely manner. This model allows members to get their lives back on track within their own community and make recovery personally valued. It further empowers them to sustain their self-directed goals and remain productive in their own community as the entire focus of care coordination is based on their individual views, values and choices. All supports are included in the treatment planning as well as in any Interdisciplinary Care Team, if the member desires. The member is required to sign off on all aspects of their Care Plan, including approval of all identified supports in the planning process and approving access to the member's Care Plan for these supports.

Molina also understands that recovery in all health concerns, especially behavioral health, is not necessarily linear. There are many paths to recovery. It has been Molina's experience that when the path is paved by the member in collaboration with the Case Manager, the road to recovery is improved. Our ROSC Model approach requires member involvement and partnerships with Molina's Case Managers, which further promotes member self-direction and encourages members to take personal responsibility for their health management.

The integrated multidisciplinary team approach that Molina uses within all aspects of a member's health management allows promotion of these values and provides an empowered approach to health for the member.

3. Describe how your proposed approach will engage families, natural supports, advocacy organizations and network providers in the behavioral health care planning and care delivery process.

Molina's integrated and interdisciplinary care approach includes all member-identified supports. In order to better engage members and encourage them to be personally responsibility for elements of their care, Molina believes that the identification of all natural supports and available resources, including family, advocacy organizations and network providers, is important to the development of member self-management skills. Case Managers work with Community Connectors, Member Engagement Specialists, Provider Relations Specialists and other community partners to identify all available resources within the community. Molina's Care Management staff work diligently to verify and engage community resources, and document this information in a resource log maintained at Molina Healthcare, Inc., as well as in Clinical CareAdvance, for the use of all staff to equip them to assist members with obtaining services. This approach can be best observed in Molina's use of Interdisciplinary Care Teams (ICT) meetings. These meetings encompass the member's entire health support team from health plan and provider involvement as well as community and family supports.

Molina's sister health plans also partner with Molina Healthcare, Inc.'s Behavioral Health team to develop and maintain community resource lists to share with other Molina Healthcare, Inc. teams that may interact with members, including Health Management and the Nurse Advice Line. Community Connectors, who are trusted members of the communities they serve, act as extenders of Molina's Care Management staff, and are integral to ensuring community and resource engagement to the benefit of our members. Molina is committed to ensuring that Community Connectors represent the populations they serve and that Molina staff is comprised of behavioral health clinicians who have clinical experience with the community resources with which they interact. This specialized knowledge and experience allows Molina to have a better understanding of available care, resources and possible barriers the member may face in order to address those issues.

Molina's sister health plans have also successfully partnered with local behavioral health resources in their respective states in order to support innovative approaches to meeting member needs. Some examples of these successful community partnerships include Community Mental Health Centers without boundaries, a statewide collaboration of providers in Ohio who engage members post discharge and serve members in more rural areas; telemedicine approaches; promoting home health services to assist with access issues; providing transportation for follow up after hospitalization, provider and pharmacy visits; and incorporating community mental health boards into provider and community engagement meetings.

Molina also is committed to and has experience with creating Family and Community Resource Councils. One example of this type of community engagement is the experience of Molina's sister health plan, Molina Healthcare of Illinois. Molina Healthcare of Illinois has had great success with their Family Leadership Council, which is designed for the TANF population. The Family Leadership Council was created to engage consumers and families directly regarding issues with Children's Mental Health. The Council is member- and family-centric, and has provided the opportunity for Molina Healthcare of Illinois leadership to have access to direct consumer feedback. The Council is co-chaired by Molina Healthcare of Illinois' Behavioral Health Director and a parent of a young adult member who has utilized behavioral health services within the Community Mental Health System and other public serving systems (i.e., welfare, education). The Council is comprised of at least 51% of family and young adult members who have experienced public serving systems. The Council is also open to and includes members from the provider community, advocates, educators and other community partners.

4. Describe your proposed peer support/counseling program.

Members will receive Peer Support when review of the clinical presentation, diagnostic status and

treatment history determine appropriate medical necessity for this level of care. Peer Support Services are provided by peer counselors to members under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Members actively participate in decision-making and the operation of the programmatic supports. Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the member's ability to function in the community. These services may occur at locations where members are known to gather (e.g., churches, parks, community centers, etc.). Drop-in centers are required to maintain a log documenting identification of the member, including their Medicaid eligibility. Services provided by peer counselors to the member are noted in the member's Care Plan, which delineates specific goals that are flexible and tailored to the member, and attempt to utilize community and natural supports. Monthly progress notes document member progress relative to goals identified in the Care Plan, and indicate where treatment goals have not yet been achieved.

Molina's sister health plan, Molina Healthcare of New Mexico, has successfully provided peer support as a value-added benefit in its Centennial Care line of business. Molina Healthcare of New Mexico provides certification for Peer Supports Specialists, who offer both internal support to Molina staff and external support to Molina's members, providers, community and state officials. Peer Support Specialists attend rounds and provide consultation and trainings to Molina staff regarding the impact of mental illness and substance use disorders on health care treatment. They also educate staff and providers on how to increase engagement and adherence to treatment plans from a member's perspective, and accompany field case managers and Community Connectors on member visits to improve relationship building and a therapeutic alliance. Peer Support Specialists partner with community and State officials in the promotion of the Recovery Oriented System of Care (ROSC), a model to which Molina is committed to companywide and considers a cornerstone of its Care Management approach. Within the community and within provider settings, Molina Peer Support Specialists educate and promote member-centric practices and inclusion of peer supports in settings such as Psycho Social Rehabilitation and Wellness Centers. They are also currently used in Emergency Room diversion projects across New Mexico.

Molina was recognized by the State of New Mexico for its Peer Support Specialists program and is working to expand the successful model to other Molina Healthcare, Inc. health plans where substance use disorder services are included as a covered benefit. For the Iowa High Quality Healthcare Initiative population, Molina will build upon the experience of its sister health plan and work with Community Mental Health Providers and Health Home providers to incorporate and encourage peer support. Molina is committed to community education and will work with local partners in the development of peer support best practices in its service to Iowa High Quality Healthcare Initiative members.

5. Describe your services for prevention and early intervention.

Molina recognizes the essential need for prevention and early intervention approaches that seek to achieve optimal coordination of behavioral health services with physical health care management. For the Iowa High Quality Healthcare Initiative, Molina, supported by its statewide network of physical and behavioral health providers, will screen members for risk factors and early signs of mental health or substance use disorder symptoms upon initial enrollment and throughout the member's participation under Molina's care.

Molina will further leverage the deep experience of its Behavioral Health team, staffed by behavioral health professionals familiar with the needs and treatment of its members in community-based care, ensuring that the medical care issues of members enrolled in its managed care health plan are identified early and needs are well understood. The team then coordinates with appropriate contracted providers in the development and implementation of evidenced-based preventive and early intervention strategies,

ensuring members have the resources needed for improved behavioral health outcomes.

This coordinated and collaborative approach results in timelier, positive outcomes and has shown to reduce accidents and injury related to secondary psychological factors. Molina's Behavioral Health team is skilled at reducing inappropriate utilization of Emergency Room services for non-emergent behavioral health care by helping the member to establish an ongoing relationship with their outpatient behavioral health provider.

Initial Health Risk Assessment

All new members are initially assessed and stratified into one of three risk levels through Molina's Clinical CareAdvance Care Management and Disease Management predictive modeling platform. Clinical CareAdvance enables a member-centric view for clinical users and includes documentation of assessments; development of Individualized Care Plans; maintenance of automated task lists for visit and contact requirements; management of ongoing recipient goals; information about authorizations; and data regarding all health care providers utilized by the recipient, including primary care and ongoing specialty care needs. This evidence-based approach assists Molina staff in prioritizing outreach to identify potential gaps in a member's behavioral and physical health care needs and ensuring a smooth transition.

Shortly after a new member's enrollment, a Molina team member also conducts an initial Health Risk Assessment addressing the new member's behavioral health, physical health and, if applicable, Long-term Services and Supports (LTSS) needs, any gaps in related care, and potential opportunities for preventive and/or early intervention measures. Molina's Care Management staff has access to many other assessment tools to more thoroughly assess and define the member's needs, including PHQ2; PHQ9; Edinburgh Postnatal Depression Scale; APA DSM-5 Cross-Cutting Functional Assessment Tool for adults and children/adolescents; SF-12; CAGE-AID; and ASAM assessment. These tools allow for early detection of and intervention in behavioral health-related issues. Molina's Case Managers are trained to identify family triggers and subsequently recommend appropriate interventions that may reduce the risk that a child in the family will suffer from a serious behavioral health condition. Molina's sister health plan staff companywide also have access to tools such as the Ages and Stages Questionnaire, Pediatric QL, CANS and CSPI.

The member is then assigned to a level of care according to their identified needs and complexity of care. A Molina Case Manager is assigned to more complex members for further assessment, follow-up, and Individualized Care Plan (ICP) development, which addresses gaps in care and coordination of services (e.g., physical health, behavioral health, social and LTSS). Molina's Case Managers also utilize the Interdisciplinary Care Team (ICT) to ensure the ICP is a collaborative effort addressing all identified member care needs and preferences.

Behavioral Health Preventive and Early Intervention Measure for the Iowa High Quality Healthcare Initiative

Molina is currently working with Molina Healthcare of California and Molina Medical Group (Molina's clinics) on a model for early behavioral health intervention based on the Impact Model out of Washington State. Molina will look to explore opportunities in Iowa to expand upon this model, which revolves around supporting primary care providers in the implementation of a collaborative care model based on the University of Washington's Improving Mood Promoting Access to Collaborative Treatment (IMPACT) study. The model includes the use of a consulting psychiatrist and dedicated care manager to support the primary care provider in the detection and treatment of uncomplicated depression. This unique model of collaborative care utilizes systematic screening of all patients (using the PHQ-9), regardless of past medical history, in an effort to diagnose and treat previously unrecognized depression and comorbid depression. Outcomes of the IMPACT study have shown savings in total health care costs; improved patient and provider satisfaction; and improved patient productivity. The study has been successfully replicated in all demographic populations, including the underserved. Currently, Molina's

efforts to implement the model with members have been focused on our direct delivery clinics in California with the collaboration of Molina Healthcare of California. Molina will use this model to expand into potential partnerships with PCP groups and primary medical groups and will propose the possible use of Molina Medical Group resources to meet the collaborative care needs of its members.

The PCP's Role in Prevention and Early Intervention

As a key component of Molina's focus on prevention and early intervention for potential member behavioral health issues, Molina PCPs are contractually required to screen and evaluate members for behavioral health problems and refer them to a behavioral health specialist as appropriate, with the members' consent. In addition, PCPs may provide clinically appropriate behavioral health services that are within the scope of their practice.

For Molina's providers participating in the Iowa High Quality Healthcare Initiative, Molina will provide training and reference materials for specific behavioral health screening services (e.g., ADHD, depression, brief screening tools, etc.) in addition to implementing the IMPACT model proposal. Additionally, Molina's Behavioral Health team will be available to assist in referring and engaging members in appropriate preventive behavioral health treatment and/or early intervention once identified by the PCP screening process. PCPs are instructed how to work with the Molina Behavioral Health team in accessing behavioral health care and in continuing to communicate treatment planning needs between the physical health and behavioral health providers.

Similarly, behavioral health providers are contractually required to refer members to their PCPs for medical care, with member and/or parental or guardian consent, when physical problems are known or suspected. They are also required to send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the PCP, with member and/or parental or legal guardian's consent, as appropriate. These requirements are stated in the Provider Manual. PCP contract language requires contact initiation with a behavioral health provider when this provider is known to the PCP (by member report) and the behavioral health provider has not already initiated contact.

Molina also promotes prevention and early detection of behavioral health issues through Quality Improvement programs, such as a focus on members newly diagnosed with depression who have been placed on an antidepressant medication. Molina Healthcare of Texas is piloting a pharmacist-led telephonic intervention focused on those members most at risk for antidepressant medication non-compliance. Utilizing Motivational Interviewing techniques, the pilot focuses on member education, and the identification of barriers contributing to non-adherence. Interventions include making direct contact with the prescribing practitioner; providing assistance with utilizing the transportation benefit; and/or setting up mail order delivery of the medication to the member. The pilot has been successful in improving adherence scores measured by the HEDIS Antidepressant Medication Management (AMM) measure, which indicates positive prevention and intervention strategies.

Interventions for Institutionalized Populations

Molina understands the challenges of ensuring the Severe and Persistent Mentally Ill (SPMI), Severely Emotionally Disturbed (SED), and other similarly classified behavioral health populations are at particular risk for adverse impact of their illness on their general physical health. Molina sees the critical need for an intensive care management program focusing on prevention and/or early intervention for high-risk, high-need members who are vulnerable to worsening SPMI and poor physical health outcomes. The SED population represents a similarly vulnerable group at risk who require particular care management attention.

Additional Services for SPMI/SED Members

To better serve these populations by ensuring care through the health care continuum and across multiple health care settings, Molina will contract with select providers to provide a value-added continuum of wrap-around behavioral health services. These entities will provide individualized intervention and

ongoing treatment plans that include, as indicated, in-home face-to-face visits, intensive case management (ICM), Assertive Community Treatment services (ACT), mobile crisis intervention, intensive outpatient programs, partial hospitalization, and onsite discharge and aftercare follow-up for inpatient stays. Expected outcomes for this program include enhanced recovery and resiliency; reduced Emergency Room utilization; fewer inpatient admissions or re-admissions; shortened lengths of stay; less need for crisis intervention; in-home or out-of-home placement stabilization; and reduced involvement with the criminal justice system. Molina is also committed to the "no wrong door" model of care. Molina believes that access to care should be accessible, and therefore has prior authorization requirements that do not prohibit access to the right ambulatory level of care at the right time for the member. Molina also promotes relationships with community mental health providers to provide crisis assessment and stabilization services to members in order to prevent unnecessary hospitalizations. Molina will work with Iowa community providers to promote this approach to care delivery.

6. Describe how you will ensure providers conduct outreach activities for IDPH participants who are IV drug users.

Molina is aware of the important role IDPH plays in population health for Iowans who are IV drug users. In its January 28, 2015 report to the Iowa legislature, IDPH noted a 43% reduction in arrests and 50% reduction in avoidable hospitalizations as well as a 60% increase in employment due to effective substance abuse treatment.

Molina recognizes that IV drug use is a complex health problem that crosses both the physical and behavioral health spectrums. Molina provides members and providers with educational resources that discuss the physical and mental health effects of drug use. In addition, Molina's sister health plans work collaboratively with community outreach providers, including free clinics, homeless shelters and resources, food banks, and other social service agencies to locate members to educate them on the dangers of IV drug use as well as other important health education topics. For the Iowa High Quality Healthcare Initiative program, Molina will explore opportunities to create a quality improvement project promoting provider engagement with IDPH participants who are IV drug users to encourage healthy choices. Molina will contract with available buprenorphine providers to ensure alternative medication assisted treatments are available and educate community providers on how members can access services. In addition, providers (particularly those who administer services in drop-in clinics) will be encouraged to offer educational resources on recovery and the risks of IV drug use in their clinics, including communicable diseases. Molina will also partner with providers at community engagement events to promote healthy living and connect members to providers. Molina will convene Iowa's safety net providers—FQHCs, Community Mental Health Centers and substance abuse providers—with IDPH leadership to develop additional outreach opportunities. Molina understands that about 70% of substance abuse treatment is provided by Iowa Behavioral Health Association (IBHA) members, so collaborating with IBHA is a key step in ensuring effective outreach that is pertinent to the local community. Our objective is to increase the number of referrals of IV drug users who have not been reached or who need additional services for treatment and education through effective outreach.

Additionally, Molina employs Community Connectors and Peer Support Specialists to help engage members within their own communities and provide education and support. Molina may explore utilizing the Community Connector/Peer Support Specialist approach to engage IV drug-using Iowa High Quality Healthcare Initiative program members and connect them with providers. Molina's Peer Support Specialists and Community Connectors often attend appointments with members, which help engage members in treatment while providing an opportunity to identify provider outreach opportunities. Molina is also offering a Substance Abuse Recovery Support value-added service that we believe will further improve substance abuse results in Iowa.

Molina was proud to be a sponsor at this year's 38th Annual Governor's Conference on Substance Abuse and was pleased to engage Iowans on opportunities to improve substance abuse outcomes.

7. Describe how you will support IDPH-funded Women and Children services.

Molina understands the crucial role that IDPH plays in delivering a vast array of important Women's and Children's services throughout Iowa with public-private partnerships.

For children, access to health care is provided through contracts with 22 agencies covering all 99 Iowa counties. Services provided include interpretation, education, nutrition counseling, transportation, oral health, immunizations, home visits, developmental testing, enrollment outreach for Medicaid and hawk-I, Medical Homes, and lab services, such as blood lead testing. In Iowa, 28% of all children are enrolled in Medicaid. Molina agrees with the Iowa Maternal Health, Child Health, and Family Planning Business Plan that indicates that the future health of the U.S. population and the nation's health care costs are dependent upon healthy behaviors established in childhood.

For women, access to maternal health is provided through 21 community-based maternal health agencies covering all 99 counties. Health care is improved by linking women to community-based, culturally appropriate services, and supporting their ability to get the services they need. Care coordination is provided through health education and health screening for depression, tobacco and substance abuse, domestic violence, nutrition counseling, interpretation, oral health, home visits, social assessments, and transportation. In 2012, 11,105 women and their infants were provided with these services. Additionally, IDPH provides for Title X Family Planning Services in all Iowa counties. These services include pregnancy testing and counseling, and numerous preventive health services, including screenings, reproductive life counseling, education, and FDA-approved contraceptive methods and counseling. In 2012, 17,996 clients were provided with these services.

Molina will support and integrate IDPH-funded Women and Children services through the administration of the following care and services to our members in accordance with requirements in Attachment 1—Scope of Work:

- Substance use disorder treatment programs for pregnant women, women with dependent children, and women attempting to regain custody of their children;
- Medical care for women, including prenatal care and child care;
- Pediatric care for their children, including immunizations;
- Gender-specific interventions that address relationships, abuse, parenting and child care;
- Interventions for children that address developmental needs, abuse and neglect;
- Sufficient case management and transportation to ensure access to the above services; and
- Assistance in establishing eligibility for public assistance; employment and training; education; drug-free housing; prenatal and other health care services; therapeutic daycare; and early childhood programs.

Molina will ensure that our provider network includes mental health and substance use disorder services that are specifically tailored to the needs of pregnant women and new mothers. Molina recognizes that a key component to effective care for members who are eligible for IDPH-funded Women and Children services is ensuring access to and the availability of comprehensive services that address children's needs in conjunction with their mother's needs while reinforcing and supporting the existing family structure.

Using a combination of care management, Community Connectors, Peer Supports and community partners, Molina staff will be able to support women and children eligible for this benefit by coordinating IDPH-funded services and facilitating care that is seamless to the member. Molina's approach to care will

promote member adherence to treatment plans and maximize member health outcomes.

Molina believes that IDPH service providers will be an important component of our provider network, and we will collaborate with IDPH on population health initiatives to consistently improve women and children services.

8. Describe your screening and treatment protocol for children with serious behavioral health conditions. Provide a sample crisis plan and describe how you will work in collaboration with local school systems.

People with Severe and Persistent Mental Illness (SPMI) are at particular risk for adverse impact of their illness on their general physical health. Molina sees the critical need for an intensive care coordination program for high-risk, high-need members who are vulnerable to worsening SPMI and poor physical health outcomes. The Severely Emotionally Disturbed (SED) population represents a similarly vulnerable group of children at risk who require particular care management attention.

Screening Protocol for Children with Serious Behavioral Health Conditions

Molina PCPs are contractually required to screen and evaluate members for behavioral health problems and refer them to a behavioral health specialist as appropriate, with the member's/caregiver's consent. Molina provides training and reference materials for specific behavioral health screening services (e.g., ADHD, depression, brief screening tools, etc.). Additionally, the Molina Behavioral Health team is available to assist in referring and engaging members in behavioral health treatment once identified by the PCP screening process. PCP training materials are made available through provider meetings, the Provider Manual and web-based resources (with hard copies available upon request). Links to general professional reference sources are also posted including, for example, the Substance Abuse and Mental Health Services Administration (SAMHSA), the American Psychiatric Association (APA), the American Academy of Pediatrics (AAP), and the American Academy of Child and Adolescent Psychiatry (AACAP). Molina's Case Managers are also equipped with child- and adolescent-specific health risk assessment tools that address physical as well as emotional and mental health symptomology and service needs.

In addition, Molina uses an automated, evidenced-based functional status survey tool for pediatric members called the PedsQL™. The PedsQL™ Measurement Model is a modular approach to measuring health-related quality of life for children and adolescents who are healthy or with acute and chronic health conditions. The PedsQL™ Measurement Model integrates seamlessly both generic core scales and disease-specific modules into one measurement system. The core scales include physical, emotional, social and school functional status with summary scores created for physical and psychosocial health.

Treatment Protocol for Children with Serious Behavioral Health Conditions

Molina understands that children with mental health needs require comprehensive, age and developmentally appropriate care, and that mental disorders in the pediatric population may be accompanied by significant physical disabilities and health issues. To meet these challenges, all of Molina's child members diagnosed with a behavioral health condition are referred to Molina's Care Management Program and, as deemed applicable based on their risk profile and severity of illness, assigned to an Integrated Health Home. These children will also receive Interdisciplinary Care Team meetings that include their comprehensive physical and behavioral health providers such as psychologists, social workers and other specialists to ensure a holistic approach to their care. The team meetings may also include others, such as caregivers, family members, and other supports to address their needs in addition to those of the member.

PCPs may provide clinically appropriate behavioral health services that are within the scope of their practice. PCPs are instructed on how to work with the Molina Behavioral Health team in accessing behavioral health care and in continuing to communicate treatment planning needs between the physical

and behavioral health providers. PCPs also have materials available regarding best practice models and clinical practice guidelines for integrated care delivery.

To better serve children with serious behavioral health conditions, Molina contracts with select vendors to provide a value-added continuum of wrap-around behavioral health services. These agencies provide individualized intervention and ongoing treatment plans that include, as indicated, in-home face-to-face visits, intensive case management (ICM), Assertive Community Treatment services (ACT), mobile crisis intervention, intensive outpatient programs, partial hospitalization, and onsite discharge and aftercare follow-up for inpatient stays. Expected outcomes for this program include enhanced recovery and resiliency; reduced Emergency Room utilization; fewer inpatient admissions or readmissions; shortened lengths of stay; less need for crisis intervention; in-home or out-of-home placement stabilization; and reduced involvement with the criminal justice system.

Collaborating with Community Resources and Local School Systems

Molina Healthcare of Illinois, Molina's sister health plan, serves as an example of how Molina has partnered with community resources, particularly local school systems, to address when a member is in crisis. The Molina Healthcare of Illinois TANF line of business requires all members under the age of 21 to have immediate access to a behavioral health screening wherever the crisis is occurring. Molina Healthcare of Illinois has partnered with community stakeholders, including schools, to establish a screening protocol, which includes a separate crisis line with access to mobile outreach dispatch. For the Iowa High Quality Healthcare Initiative program, Molina will work with community mental health partners to establish screening, assessment and support services and will also collaborate with local school districts to identify solutions to provide these services in the school setting.

Exhibit 3.2.8.8-1 below is an example of Molina's crisis plan, which will be utilized by a crisis worker (a paid provider from a health partner) to document key information when speaking with a Molina member who has experienced a behavioral health crisis at school or other community-based location. The crisis worker then forwards the completed crisis plan to Molina's Care Management team who stores and maintains the plan in the member's electronic medical record for reference during care management processes and interventions and for care planning with the member's Interdisciplinary Care Team.

Exhibit 3.2.8.8-1 Sample Crisis Plan

Wellness & Safety Plan – Questions to Review, Items to Reinforce, Helpful #s to Remember

What are your WELLNESS TOOLS/Skills? (What helps you calm down … get support … feel better?)

Circle all that apply: Listening to music * Journaling * Petting my dog or cat * Hugging a stuffed animal * Reading

Walking * Jogging * Yoga * Bouncing on Ball * Deep Breathing * Singing * Shooting hoops * Talking it out * Play a game

Coloring/drawing * Squeeze Stress Ball * Take a nap * Play a soothing video game * Check in on social media * Others:

_____ _____

_____ _____

What do you do for DAILY MAINTENANCE? For example, saying positive affirmations such as "I am important", making sure to exercise every day, listening to music, taking your medicine or vitamins, getting plenty of sleep. List below:

_____ _____

_____ _____

What are your STRESSORS? For example, being yelled at/teased. What do you do to cope? List your COPING with STRESSORS ACTION PLAN, in other words, what you can do to deal with each one:

When I am being yelled at, I will take deep breaths, ask to take five minutes to calm down, and then I will close my eyes and try to block it out, tell myself "Breathe … it's okay".

STRESSOR	STRESSOR ACTION PLAN

What are your EARLY WARNING SIGNS that you are feeling triggered or stressed? How does your body react and/or what emotions do you feel? Describe your personal responses that you notice first. For example when your head starts to ache, excuse yourself, stretch a little bit, and get a drink of water.

EARLY WARNING SIGNS	EARLY WARNING SIGNS ACTION PLAN

List your SUPPORT PEOPLE and how best to reach them. Consider formal and informal supports, including family, friends, adults at school, pastor or other clergy, peer support system, or the parents of a friend. Whom do you trust?

_____ _____

_____ _____

My ACTION PLAN: I will reach out to a support person when I get stressed, notice my early warning signs or feel unsafe. Specifically, I will call/text/message/talk direct to:

_____ _____

_____ _____

Helpful numbers: Lifeline 1-800-273-TALK * Behavioral Health Crisis Line 1-888-275-8750 * CARES 1-800-345-9049 * 911

Molina's process for member care planning involves the inclusion of information from a variety of resources, including school professionals, as school is an important support system for both children and their families. Such collaboration with multiple resources allows Molina to have a more informed and comprehensive understanding of the member's needs; better identifies areas for gap analysis and

interventions; and provides additional member support that encourages adherence to their plan of care.

9. Describe how you will ensure compliance with the Mental Health Parity and Addiction Equity Act.

Molina has taken steps to ensure that its policies and procedures for the provision of behavioral health and substance use disorder services are in parity with corresponding physical health services and are in compliance with the Mental Health Parity and Addiction Equity Act. Molina annually reviews all policies and procedures and updates the prior authorization guidelines to ensure compliance with state and federal regulations. Additionally, Molina provides training, both employee and provider training, to ensure compliance. Molina also does not require prior authorization for most ambulatory services, which reduces barriers to access. In the last year, Molina has also implemented a thorough review of all Healthcare Services Policies & Procedures and revised them to create integrated policies when possible to ensure parity. Additionally, when services such as transportation are a covered or value-added benefit for physical health needs, Molina ensures these services are also offered for behavioral health needs.

10. Describe how you will provide care that addresses the physical and behavioral health needs of members in an integrated manner.

Molina is committed to person-centered care management that integrates whole-person needs inclusive of physical, mental health and substance use treatments. Molina members who struggle with co-morbidities across physical and behavioral health service needs are among the most vulnerable of all patients. This is especially apparent in the "mortality gap" seen for the severely mentally ill wherein life expectancy runs 25 years shorter than for their counterparts. It is at the intersection of behavioral health and medicine that integrated care management brings the greatest positive change. An individual with behavioral health needs requires support in accessing behavioral health care, but also needs help with understanding their physical health needs and following through on necessary appointments, home-based treatment, medication management and so forth. Similarly, someone with a chronic physical health condition may not seek the medical care they need due to untreated depression that causes them to become isolated and unmotivated in pursuing their medical treatment plan. Molina's Case Managers will assist in identifying these service gaps, and under-diagnosed or undertreated conditions, and ensure cross-communication among disparate providers within members' Interdisciplinary Care Teams (ICT) in the effort to maximize members' health outcomes.

Molina uses a person-centered integrated care management approach based on empirically validated best practices that have demonstrated positive results in numerous Molina managed care markets to ensure that members receive high-quality care. Molina's care management services can make a significant positive impact on members with behavioral health challenges through the identification of under-diagnosed problems; assisting with service access and linkages; and supporting proper follow-through with treatment plans. Molina engages the member and their family/caregivers in the integration of physical health, behavioral health (including substance use disorder treatment), and social supports to eliminate fragmentation of care and to provide a single, highly individualized plan of care that focuses on the abilities and preferences of each member. Members who present with co-morbid physical and behavioral health care needs require coordination and communication among the many providers, agencies and care teams that manage segments of the members' care. Molina Case Managers work with members' PCP and other medical specialists; facility-based services; the mental health center team including the community case manager, psychiatric prescriber and program managers (e.g., day treatment or clubhouse); and other community and rehabilitative supports (e.g., faith-based, educational, job training) to ensure full integration of care. Case Managers act as members' primary point-of-contact to ensure consistent and efficient communication between members and their care delivery teams. Case Managers also help

members to navigate the complex systems of care and different payers that provide the broad array of services needed to support effective care treatments.

Molina identifies members with behavioral health needs through the screening and health assessments performed by Case Managers at enrollment and various times throughout the year. Standard assessment tools are comprehensive in nature and address substance use disorders and mental health conditions. Some members will experience co-occurring mental health and/or substance use disorders. Each condition will need to be addressed in order for the other to be adequately treated. It is during the initial and subsequent contacts with the Case Manager that efforts are made to engage the member in active participation with the Interdisciplinary Care Team and development of the Care Plan. The member's perspective on their care needs and preferences are incorporated into the care planning process.

Once identified and referred for appropriate behavioral health treatment, the members' acute inpatient and outpatient medical care is managed using a whole-health approach that encompasses all aspects of individual care to encourage and promote adherence to both physical and behavioral health treatment plans.

Molina PCPs are contractually required to screen and evaluate members for behavioral health problems and refer them to a behavioral health specialist as appropriate, with the members consent. In addition, PCPs may provide clinically appropriate behavioral health services that are within the scope of their practice. Molina will provide training and reference materials for specific behavioral health screening services (e.g., ADHD, depression, brief screening tools, etc.). Additionally, the Molina Behavioral Health team is available to assist in referring and engaging members in behavioral health treatment once identified by the PCP screening process. PCPs are instructed how to work with the Molina Behavioral Health team in accessing behavioral health care and in continuing to communicate treatment planning needs between the physical health and behavioral health providers. PCPs also have materials available regarding best practice models and clinical practice guidelines for integrated care delivery. PCP training materials are made available through provider meetings, the Provider Manual and web-based resources (with hard copies available upon request). Links to general professional reference sources are also posted including, for example, the Substance Abuse and Mental Health Services Administration (SAMHSA), the American Psychiatric Association (APA), the American Academy of Pediatrics (AAP), and the American Academy of Child and Adolescent Psychiatry (AACAP).

Behavioral health providers are also contractually required to refer members to their PCP for medical care, with member and/or parental or guardian consent, when physical problems are known or suspected. They are also required to send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the PCP, with member and/or parental or legal guardian's consent, as appropriate. These requirements are stated in the Provider Manual. Similarly, the PCP's contract language requires contact initiation with a behavioral health provider when this provider is known to the PCP (by member report) and the behavioral health provider has not already initiated contact.

Molina's integrated, person-centered Care Management program and Transitions of Care program, which assists in transitioning members from one setting to another, such as from inpatient to outpatient settings, are designed to address the fragmented care that often occurs with frequent inpatient admissions and readmissions. Molina's Transitions of Care program focuses on the critical foundational elements adapted from the four pillars of Dr. Eric Coleman's Model of Care Transition Interventions. Molina's care transitions focus is on members admitted with diagnoses that have been shown are at the highest risk for inpatient re-admission, including history of serious psychological impairment (psychosis, schizophrenic, bipolar disorder) or substance use disorders. These programs are designed to provide additional support for Molina's Behavioral Health services to enhance communication between PCPs and behavioral health clinicians. Molina is particularly sensitive to transitions of care for behavioral health services and highly respects the importance of those established relationships. Physical and behavioral health physicians and service providers who qualify but are not part of the Molina Provider Network will be invited to join the

network in an effort to maintain long-term continuity for members and keep them with their preferred providers. Additionally, Molina ensures that members discharged from a psychiatric inpatient care setting are seen by their outpatient provider within 7 days of discharge.

11. Describe your mechanisms for facilitating the reciprocal exchange of health information between physical and behavioral health providers and methods for evaluating the effectiveness of such strategies.

Molina's Interdisciplinary Care Team (ICT) is focused on delivering integrated, whole-person care and serves as a driver for the integration of care by providing a forum for information sharing and supporting interaction between the member, PCP, behavioral health providers, pharmacy staff, and other ICT participants to address the member's unique needs and promote continuity and coordination of care. The ICT consists of the member and/or their designated caregiver, the member's PCP, behavioral health providers, Molina Pharmacy staff, nurses, specialty care providers, Peer Support Specialists and the Molina Care Management team, such as the Case Manager and Community Connector. Behavioral health expertise is woven into the clinical and administrative management of the member's care. The ICT's composition is designed to address all aspects of a member's health care needs and incorporates member preferences. The ICT is the primary driver for Individualized Care Plan development and updates and is shared with all ICT participants.

Assessments are all completed by Molina's Case Managers who are qualified to screen for behavioral health issues through specific behavioral health training, motivational interviewing techniques, and professional qualifications, licensing and/or certification. Services and intensity of care management offered will be driven by the member's unique condition, needs and risk analysis. An outreach call or face-to-face visit is conducted to perform the comprehensive assessment and the results of this assessment drive the need for risk stratification and for additional condition-specific assessments as determined by evidence-based tools. Family participation in the assessment process is encouraged and promoted, with the member's permission.

When appropriate, ICTs will be co-led by physical health and behavioral health experts. Care Plans and evidence-based clinical guidelines will be jointly developed including a clinical workflow, and specific intervention decisions will be made jointly. As opportunities for improvement are identified in this forum, the evidence-based guidelines will be reviewed and updated through a formal committee structure. Because Molina realizes the importance of care management and effective patient navigation for dually diagnosed individuals, Case Managers will help identify physical health, behavioral health, substance use or preventive needs, and ensure care is provided in a seamless process. The Case Manager convenes with the ICT for weekly case conferences that provide the opportunity for ongoing communication between ICT members; reviews difficult cases; identifies practice care or service gaps; plans the following week's appointments; and designates team members to tasks that ensure that all work loops are closed. Additionally, the ICT interacts on a continual basis to ensure that specialist notes are received and captured in a member's health record; laboratory and diagnostic imaging results have been received and reviewed; outstanding member or family requests have been reviewed; and members are sent reminder calls/texts/postcards about upcoming visits. Molina has also developed robust behavioral health training materials to leverage in a clinical setting to support and expand upon the knowledge of PCPs who serve members with behavioral health diagnoses and other comorbidities.

Behavioral Care Management needs are managed by qualified mental health professionals, or by a team consisting of a physical health Case Manager and a qualified mental health professional if a member presents with co-morbid physical health and mental health care needs. If a member presents a primary physical health care need and is not in mental health treatment other than the ongoing prescription of medications, the case will be managed by the physical health Case Manager with consultation of the qualified mental health professional. If, for any reason, a case is managed solely by a physical health Case

Manager and the member is receiving mental health treatment, the Case Manager will meet and document regular case reviews with a qualified mental health professional.

In order to ensure a complete chain of responsibility, when multiple Case Managers participate in coordinating services, each will address their respective areas of physical health and mental health expertise in communicating with providers. To resolve issues for the member, the assigned lead Case Manager will act as the primary point of contact for the member to ensure efficient communications. To maintain clear roles and facilitate easy and immediate case review, information exchange, and task assignments, documentation is shared in a single electronic case file accessible only by involved Case Managers to ensure confidentiality in compliance with HIPAA regulations.

The Individualized Care Plan (ICP) developed for members incorporates family and culturally defined objectives, including religious and spiritual needs of the member, their life experience, natural support systems, and socioeconomic conditions. The ICPs address coordination across the care continuum, as well as other needed social and treatment services (e.g., housing, transportation, education, physical and behavioral health referrals, chronic condition self-care, healthy lifestyles) according to the health beliefs and practices of the member. Essential components of the ICP include members' goals and preferences, and measurable objectives and timeframes to meet physical health, behavioral health, psychosocial and members' self-management objectives with prioritized timeframes for updates based on members' needs as well as federal and state regulations. The ICP also captures behavioral health components based on the results of assessments. Ultimately, the ICP delineates specific interventions based on evidence-based clinical guidelines for specific physical health conditions and behavioral health conditions, such as for depression, anxiety or severe mental illness. These interventions may include referral to outpatient care, intensive outpatient care, partial hospitalization, and inpatient psychiatric care. For hospitalized members, the ICP incorporates discharge and care transition planning. The ICT will periodically reassess the member's need for services and the intensity of these services and will extend or discontinue services as found to be clinically appropriate.

Communication between Molina's Case Manager and physical/behavioral health providers will be compliant with all applicable federal and state regulations and will include:

- Facilitation of consultations amongst those involved in the member's care, including physical/behavioral health providers, family members, and other caregivers;
- Interdisciplinary Care Team meetings;
- Updates to ICPs for review and sharing by ICT members; and
- Notification to ICT participants when a member has a transition in health care settings or significant changes in health care status.

IT Solutions for Behavioral Health Coordination/Information Sharing

Molina will leverage its IT solutions to achieve information integration that is critical to successful Behavioral Health coordination. Molina's IT solutions, particularly the Clinical CareAdvance platform, enable the creation and management of Individualized Care Plans (ICP) where physical health, behavioral health, and wrap-around service needs are all captured, shared and made available in a secure environment to the ICT, the member and his/her family. The ICP will facilitate coordination and optimal scheduling of services.

Case Managers are able to ensure timely communication, share information, track and monitor progress, identify issues and ensure appropriate care planning using a comprehensive integrated care management system, Clinical CareAdvance. Clinical CareAdvance provides a single source for assessments, configurable care planning, consent tracking, task and team management, alerts, progress tracking, communication creation, and ongoing monitoring. The comprehensive view available through Clinical CareAdvance enables the Case Manager to create targeted interventions and ensure appropriate services

based on a member's entire health profile rather than on a single diagnosis or event, resulting in improved health outcomes and increased member satisfaction; better coordination of care between providers, payer and members; and the management of medical costs while ensuring quality of care.

To facilitate communication and align care planning efforts between Case Managers, members, and providers, Molina also offers a secure online provider and member Web Portal available 24 hours a day, 7 days a week that imports and displays information from Molina's claims processing system and Clinical CareAdvance. The Web Portal allows members, caregivers and providers to view and print a member's Care Plan; provide feedback to the Case Manager; view the member's profile; and view a list of the member's Care Team participants and contact information.

Molina's Methods for Evaluating the Effectiveness of its Health Information Sharing Strategies

Molina utilizes audits and reporting to measure the effectiveness of health information sharing strategies. Case Managers and Transition of Care Coaches are regularly audited for case content, completion rates and times, and successful contact rates. Molina runs reports regularly to ensure the completion of timely and positive engagement, assessment and planning. Molina's Care Management leaders also look at successful completion rates for Case Managers to measure the positive impact of Integrated Care Plans.

Current and past treatment plans are reviewed in Interdisciplinary Care Team meetings, so treatment modalities and interventions that were or were not successful in the past are evaluated and accounted for, and an improved plan of care is created. Interdisciplinary Care Team notes are documented in a separate assessment form, so reportable data and outcomes can be measured.

3.2.9 Health Homes

1. Describe your proposed approach for implementing health homes.

Molina currently has experience in several of its health plans across the enterprise coordinating services for members using a Health Homes model. Molina has developed and established a program model that provides intensive community-based Health Home service coordination to ensure integration and communication between physical/behavioral health providers; formal and informal supports; and long-term services and supports providers. In Molina's model, Health Homes serve as a bridge to integrating care within existing care systems. Molina's Case Managers serve as the central point of contact for members receiving services through a Health Home to promote integration of multi-provider, multidisciplinary, patient-centered care when co-management is necessary for members diagnosed with complex chronic conditions or serious and persistent mental illness, or those receiving long-term services and supports.

Molina's Health Homes model is based on CMS guideposts, and has a goal of assembling a team of health care professionals located in one or more sites who provide integrated care for individuals in collaboration with other providers and facilities. The aim is to improve transitions across care settings and decrease poor outcomes and readmission risk during those care transitions and post-discharge. In addition to administering physical health and behavioral health services, Molina's Health Home providers ensure that each individual's physical, functional, social supports and environmental needs are addressed. Molina coordinates long-term services and supports, such as those covered under 1915c waivers, for all members affiliated with Health Homes, as appropriate, to ensure the seamless delivery of care and fiscally sound utilization of resources.

Molina's Case Managers address the individualized needs of adults and children with serious and persistent mental illness within Integrated Health Homes programs utilizing an interdisciplinary care team approach and Integrated Care Plan model.

Adults and children in the Chronic Condition Health Homes program who have two or more chronic conditions or are at risk for developing a second condition receive coaching on self-management techniques in coordination with their Health Home treatment team utilizing their Integrated Care Plan.

Molina proposes the following approach for implementing Health Homes for the Iowa High Quality Healthcare Initiative.

Molina's Health Homes Model

Molina is establishing a growing reputation for its successful operation of Health Homes across the enterprise that serve as Primary Care Providers for members with complex needs that warrant a high-touch approach. The traditional Health Home serves as the central point for directing patient-centered care. Molina's model integrates case management, as appropriate, to ensure that members' needs are addressed and to avoid duplication of services. This integrated approach helps support the following outcomes:

- Reduction in avoidable health care costs, specifically preventable hospital admissions/ readmissions and avoidable Emergency Room visits;
- Timely post-discharge follow-up; and
- Improved member health outcomes and stabilization by coordinating primary medical, specialist, behavioral health, and long-term care services and supports.

Molina's Health Homes provide six specific services beyond the clinical services offered by a typical PCP:

- **Comprehensive care management**, which facilitates improved collaboration and exchange of information among treating providers. Case Managers provide guidance to members and health home providers, ensuring that all pertinent information about complex members is communicated to the treatment team, and members are directed to the appropriate set of providers for their care. Additionally, monitoring of medication lists and pharmacy usage can identify improper pharmaceutical use, which is communicated to the health home provider through the Health Home Care Manager, Molina's Case Manager (when appropriate), pharmacist or other participants of the Interdisciplinary Care Team;
- **Care coordination and health promotion**, which improves the experience of care, quality of life and consumer satisfaction. By ensuring that members receive the right care when they need it, as well as providing education and support for chronic and complex conditions, Molina improves overall health outcomes. Improving overall health outcomes reduces health care costs;
- **Comprehensive transitional care and follow-up**, which facilitates smooth transitions in care. The transitions team is able to coordinate behavioral and general medical follow up in a timely fashion after discharge. They can address member questions or facilitate contact with the health home staff. These actions reduce the use of Emergency Room and readmissions to the inpatient setting. Reducing the use of Emergency Room and hospital admissions reduces health care costs;
- **Patient and family support**, which decreases reliance on long-term care facilities. Additionally, Case Managers are able to provide assistance and direction to members' families when they have concerns about members' health that can increase use of the health home providers and urgent care, while decreasing the use of hospital Emergency Rooms;
- **Referral to community and social support services**, which improves the experience of care, quality of life and member satisfaction; and
- **Use of information technology** to link services, if applicable.

Molina's Health Home Provider Network

A Medical Home can be the facility for a Health Home, or the Health Home may be located in another facility, such as a behavioral health practice or Community Mental Health Center. Health Home services are delivered through an established Health Home provider network, and a dedicated Health Home care coordinator. Molina, as the lead entity, will organize the Health Home network either through direct contracting, or through Memoranda of Understanding, and will contract with Health Home Care Coordination Organizations to deliver Health Home care coordination services. Other additional lead entity responsibilities will include:

- Providing a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Health Home Care Coordination Organization;
- Assigning Health Home members to Health Home Care Coordination Organizations using a smart assignment process, including PRISM whenever possible or other data systems to match the member to the Health Home Care Coordination Organization that provides most of their services and optimizes member choice;
- Collecting and reporting encounters to DHS;
- Ensuring person-centered and integrated health action planning, which will include providing high-touch care management, such as the member-to-care coordinator ratio and documentation of support staff that complements the work of the care coordinator;
- Collecting, analyzing and reporting financial, health status, and performance and outcome measures to objectively determine progress towards meeting Health Home goals; and
- Ensuring hospitals have procedures in place for referring Health Home-eligible members who seek or need treatment in a hospital Emergency Room for Health Home enrollment.

Molina's Health Home provider network will work collaboratively with Molina's Care Management team, local community agencies and providers of long-term services and supports.

Operation of Health Homes

Health Home providers work with members, caregivers, other providers, Molina's Case Managers, and state and non-state entities to ensure that the member's physical and behavioral health needs are met. This includes screening, identification and referral to medically necessary or functionally necessary covered services and assessment and coordination of non-clinical services that impact the member's health. Molina will promote, monitor, document and make best efforts to ensure that PCPs and specialty care providers comply with the use of the Health Homes Model. Health Homes services will include:

- Patient self-management education;
- Provider education;
- Evidence-based models and minimum standards of care;
- Standardized protocols and participation criteria;
- Provider-directed or provider-supervised care;
- A mechanism to incentivize providers for provision of timely and quality care;
- Implementation of interventions that address the continuum of care;
- Mechanisms to modify or change interventions that are not proven effective;
- Mechanisms to monitor the impact of Health Homes over time, including both the clinical and the financial impact;
- Comprehensive care coordination and health promotion;
- Palliative care options in the event of a life-limiting diagnosis;

- Comprehensive traditional care, including appropriate follow-up, from inpatient to other settings;
- Data management focused on improving outcome-based quality of care and improved patient and provider satisfaction;
- Patient and family support (including authorized representatives);
- Referral to community and social support services, if relevant; and
- Use of health information technology to link services, as feasible and appropriate.

Health Homes are intended to serve a targeted group with historically poorer outcomes, sometimes due to disparities in treatment regarding their physical and behavioral health needs. The successful operation of Health Homes in Iowa will improve health outcomes for members, increase member satisfaction and control costs through improved integration, member engagement and better service delivery.

Interactive tools developed by Molina will be available to designated Health Homes for coordination of care and services. Molina's Web Portal serves as a tool for providers to access valuable information regarding members' individual conditions and treatment histories. This information will make providers aware of members' needs; help with coordination of care and services; and enable targeted interventions while effectively utilizing resources. A Molina Case Manager will also be part of the Health Home team and act as the primary contact to expedite information sharing and collaborative decision making.

2. Describe strategies proposed to increase health homes participation.

Molina recognizes that Iowa was one of the first states to implement a Health Home program. As of April 2015, almost 23,000 adults and children are enrolled in Iowa's Integrated Health Home Initiative and over 35 counties have Health Homes available. Molina is excited to continue the success of the Iowa Health Home Program by leveraging the State's progress, implementing strategies that have made Molina Health Homes successful and collaborating with organizations like Iowa Health Plus, University of Iowa Health Alliance, IHH Community Mental Health Centers and other major provider organizations. Molina's strategies to increase Health Homes participation include:

- Working with select provider groups to embed Molina onsite support staff to assist in care coordination efforts within clinics;
- Approaching strategic providers to contract as Health Homes who are committed to the interdisciplinary care team model and collaborate with Molina's Care Management staff for their assigned membership; and
- Ensuring that all eligible members receive information about the availability of Health Home services, including the benefits of this model and how to engage in services through a variety of methods, including telephonic and written communications that take into account a member's cultural, linguistic and literacy needs.

3. Describe your proposed reimbursement structure for health homes.

To further support the Health Homes model, Molina will use its vast experience in managing alternative payment methodologies that are matched to the readiness and capacity of each designated Health Home. Alternative methods of payment could include, with state approval, agreements that move beyond fee-for-service and focus on performance, outcomes and Value Based Reimbursement arrangements, depending on the development and readiness of the specific Health Home. The Health Home would share in a portion of the savings from resulting reductions in key utilization metrics to improve the delivery of quality care, which may include overall medical cost ratio; inpatient admission or readmission rates; and/or Emergency Room utilization. Molina will specifically seek opportunities to offset the

administrative burden of Health Homes by exploring an outcomes-driven payment methodology. Molina recognizes that Health Home savings for Iowa are projected to be between $7 million and $15 million in state dollars over the three-year period from 2013-2015 and we anticipate our programs will continue the trend.

4. Describe how you will ensure non-duplication of payment for similar services.

Molina will ensure non-duplication of payment for similar services by establishing that members can only be enrolled in one Health Home. Molina will assist the member in choosing the appropriate Health Home (ie. Health Homes, Chronic Condition Health Homes, Integrated Health Homes) to be enrolled in based on their health status and circumstances. A member cannot be in more than one health home at the same time. Duplicated services outside of the member's Health Home will not be eligible for payment.

Molina's core claims processing system, QNXT, uses several different edits to identify potential duplicate claims to ensure non-duplication of payment for similar services. Each edit uses a different combination of data to identify a claim as a potential duplicate. A claim is considered a duplicate if it meets a combination of exact match criteria using Member, Rendering Provider, Pay To Provider, Date of Service, Service Code, Form Type, Modifiers, Charges, Units, Bill Type, etc. During the claim validation process, claim lines are compared against historical claims in QXNT. If a duplicate claim is identified, the claim line will have an edit applied and will deny in QNXT. If the claim only partially meets these criteria, claims will be routed for manual review, and a claims examiner will choose the appropriate outcome of payment or denial.

Once the claims are processed through QNXT, they are sent to an external vendor for claims coding validation. Molina has a business arrangement with HealthCare Insight (HCI) for the screening and reviewing of professional and outpatient facility claims for correct coding according to State or Federal coding guidelines. Screening and reviewing of Molina claims by HCI is a daily process. This process also includes a second review for any possible duplicate claims that were not previously identified through standard claims processing activities.

In addition, Molina performs a number of quality audits. Random Audits are conducted on a post-payment sample of mass adjudicated claims and a minimum of two percent of manually adjudicated claims. Focused Audits review specific claims that are pulled to audit for various reasons, such as a request from Claims Management to monitor performance or specially requested audits of a type of provider. Trainee Audits are conducted when requested on a new Claims Examiner or a seasoned Claims Examiner recently trained on a new line of business. High Dollar Audits are performed on 100% of claims billed with a dollar amount above a specific threshold.

3.2.10 Chronic Condition Health Homes

1. Describe how you will fulfill the requirements of this section in addition to the general Health Homes requirements.

Molina will develop a network of Health Homes providers dedicated to providing primary care services to adults and children with a focus on the needs of members who are managing two or more chronic conditions and/or are at high risk for worsening health and additional comorbidities. Molina's Health Home model promotes care coordination services and complex case management to assist the member in navigating the health care system and their own disease management, which can both seem overwhelming and difficult to negotiate.

Care Coordination services include screening and identification of members who are eligible and will benefit from a Health Homes approach to health care, as well as assessment for behavioral, functional and social/caregiver needs that may be impacting the member's ability to adjust to a new diagnosis, worsening

condition, and/or accommodate an expanded treatment plan, such as the addition of insulin to a diabetes regimen or weekly Coumadin testing that require a member's time, resources and support systems. In addition to care coordination, Molina's Case Managers will assess members for waiver service program eligibility and community-based resources, as appropriate. Case Managers also conduct assessments and may provide education related to the awareness of and treatment for behavioral health and substance use disorders; conduct face-to-face meetings; and provide oversight of service plans and care plan development in collaboration with the member that reflects the member's care goals and addresses any barriers or gaps in care. Case Managers also facilitate communication among providers, the member and the member's family/caregiver, as well as coordinate Interdisciplinary Care Team (ICT) meetings to support the member's Care Plan goals.

Substance Use Disorder Chronic Condition Health Home—Potential Partnership with Iowa Behavioral Health Association

Molina is currently in discussions with the Iowa Behavioral Health Association regarding the establishment of a Substance Use Disorder Chronic Condition Health Home staffed with behavioral health providers specializing in treating substance abuse and addiction. Today, these homes do not exist in either Iowa Integrated Health Homes or Chronic Condition Health Homes.

In a Chronic Condition Health Home model, Molina believes a qualified substance use disorder provider would be able to offer highly focused and effective management of a member's condition(s) based on their understanding of the chronicity of substance disorders and coexisting medical conditions. Furthermore, we believe such a person-centered care setting would reduce the potential for exacerbation of medical complications due to substance abuse and decrease the member's potential relapse into addiction.

3.2.11 1915(i) Habilitation Services and 1915(c) Children's Mental Health (CMH) Services

1. Describe your proposed approach for delivering these services.

Molina will deliver 1915(i) Habilitation Services and 1915(c) Children's Mental Health (CMH) Services to eligible members in accordance with Iowa High Quality Healthcare Initiative Contract requirements. Molina understands the services under the CMH waiver include:

- Environmental modifications and adaptive devices;
- Family and community support services;
- In home family therapy; and
- Respite care.

Additionally, Molina recognizes the services associated with the Habilitation Services waiver include:

- Case Management;
- Home-based habilitation;
- Day habilitation;
- Pre-vocational employment; and
- Supported employment.

Molina's Case Managers will utilize a person-centered approach to collaboratively develop a comprehensive plan of care that maximizes the member's health outcomes and promotes living in the least restrictive setting. All Molina Case Managers will follow a strict code of ethics to respect members' rights; provide information for informed decision making; promote member empowerment, so they can

make informed decisions to choose the best service options available; and act as an advocate for members to best serve their needs. Additionally, Molina will ensure the provider network will include geographic and service coverage to meet all the services required by the waivers.

Administering Conflict-free Needs Assessments

Molina will ensure conflict-free needs assessment administration consistent with Balancing Incentive Program (BIP) requirements through several means, including:

- Separation of clinical and direct service provision;
- Robust monitoring and oversight of processes;
- Making grievances and appeals processes available to members, so they can submit concerns about the quality, services and outcomes of care they are being provided; and
- Engaging all stakeholders, including the member, member's family/caregivers, and any applicable advocates in the member's care planning process.

Timeline for Completion of Member Needs Assessments and Molina's Member Assessment Process

Molina will comply with the provisions of Medicaid services as specified in Attachment 1 – Scope of Work, Section 3.2.11.2.2, and will complete all needs assessments (i) upon the member's initial enrollment with Molina; and (ii) when we become aware of a change in the member's circumstances, which necessitates a new assessment. Molina will ensure that it conducts member reassessments at least every 12 months.

Molina will contact members based on the state's determination of eligibility for 1915(i) Habilitation Services and 1915(c) Children's Mental Health (CMH) Services. Molina will conduct an initial face-to-face assessment at the member's place of residence to determine their level of care; review strengths; identify needs and deficits; and develop a plan of care. If a member is unable to participate due to cognitive impairment or other limitations, the Case Manager will contact the member's health care proxy, guardian or caregiver to establish service needs and goal setting. Throughout the process, the Case Manager will clearly communicate information to the member, to the extent that they are able to understand, and/or the member's health care proxy, guardian or caregiver to ensure that all parties are engaged in the process.

Molina's Care Management teams will perform robust biopsychosocial assessments to address members' physical health, behavioral health and functional needs. As part of the Care Management process, Molina's Case Manager will work with the member and the member's Interdisciplinary Care Team to develop a fully integrated care plan that addresses the member's health goals, including self-management of physical health and behavioral health conditions and determining the level of care coordination necessary to enable the member to maintain as much independence as possible. The Case Manager will make certain that care plans build on member strengths and include member-specific, measurable goals; specify a plan of action or intervention to meet those goals; and include measurable timeframes for attaining the desired outcomes.

Molina's Case Managers will consider various information resources when working with the member to develop the plan of care, including the face-to-face discussion with the member and/or member's representative; recommendations from the member's PCP and other service providers; and the comprehensive needs assessment, as appropriate. During the face-to-face discussion with the member, the Case Manager will systematically assess the member's strengths and needs in several key areas, including functional abilities; physical conditions; behavioral health conditions; social/environmental/cultural factors; and existing support systems. The member's 1915(i) Habilitation Services and 1915(c) Children's Mental Health (CMH) Services long-term services and supports that are part of their waiver service plan are reviewed and consented to by the member during the care plan development process. Throughout the

entire Care Management process, Molina's Case Manager supports and encourages members (and members' families/caregivers), to the extent that they are able, to actively participate in identifying strengths and needs, making decisions, and developing the care plan. At each assessment visit, Molina's Case Manager will review care plan goals and document detailed progress and any changes to the plan that may be needed. Molina will ensure that all components of the member care planning process will meet contractual requirements as well as state and federal regulations and policies within contractual timeframes.

If at any time, Molina determines that a member may require a different level of care, a comprehensive reassessment is conducted, and a new care plan is made to ensure the administration of the appropriate level of interventions. If a member experiences a transition in care setting or change in condition, they may have a reassessment sooner than their scheduled follow up. To prevent a gap in critical services, Molina's Case Manager will help the member in completing a back-up plan that identifies designated supports who will assist the member in the event service providers are not available.

Molina will initiate and conduct an annual reassessment of each member receiving 1915(i) Habilitation Services and 1915(c) Children's Mental Health (CMH) Services. The assessment will be conducted within 12 months of the last assessment. If the member experiences a major change in health status prior to the annual reassessment, Molina's Case Manager will conduct a reassessment and work with the member's Interdisciplinary Care Team to review and revise the Individualized Care Plan based on the member's specific needs and preferences.

Monitoring Members' Receipt of Services

Members receiving 1915(i) Habilitation Services and 1915(c) Children's Mental Health (CMH) Services are monitored in Molina's Clinical CareAdvance care management platform to ensure that they are receiving services outlined in their care plan that address identified needs. Molina's Healthcare Services management team reviews the record of each member receiving 1915(i) Habilitation Services and 1915(c) Children's Mental Health (CMH) Services to ensure adherence to timeliness requirements for Level of Care reassessments. Healthcare Services staff ensures that a regular schedule for follow-up, communication, coordination of care and services, and reassessment with the member is established. Healthcare Services staff is notified of a member's change in health status through the following methods: predictive modeling; ongoing care management interventions; and direct member, nursing facility and other provider referrals.

Informing Members of Their Rights

Molina's Case Managers will inform members eligible for 1915(i) Habilitation Services and 1915(c) Children's Mental Health (CMH) Services about their rights, including the right to file a grievance or appeal and the right to self-directed care.

All Molina members have the right to file a grievance or to request an appeal on service determinations that includes their right to a state fair hearing, honoring the provisions of the 1915(c) Waiver requirements and Medicaid regulatory guidelines. If at any time the member disagrees with the assessment, authorization or determination of services, Molina's Case Manager will provide them with a written notice of action that explains their right to file an appeal. The Case Manager will explain the process for appealing the decision and associated timelines, including the process to continue services without change until an appeal determination is reached. The Case Manager will explain that the member will receive a notice in the mail from Molina to notify them of an adverse determination and the process for requests for hearings and appeals, and will provide needed assistance to the member.

As part of the care coordination process, Molina's Case Manager will inform the member that they have the right to self-directed care, including their right to choose services for medically necessary and cost-effective care. The Case Manager will notify the member of any long-term care services that must be prescribed and will coordinate the request with the PCP. The Case Manager will assist the member with

selecting or changing a PCP. The Case Manager will also develop a written service plan that reflects services to be utilized; appropriate coding/modifiers; frequency or quantity of service; and units of measure. Molina's Case Manager will obtain the member's signature on the service plan, and confirm if they agree or disagree with each service authorization.

The Case Manager will then inform the member that upon member agreement of the service plan, the Case Manager will submit the request for authorization. Molina will make a determination regarding the provision of services requested within the contractual timeframes and to support the safety and well-being of the member. Molina's Case Manager will review and update the service plan at each service review, at least annually, when there is a change in the member's functional or health status or needs, or at the request of the member.

2. Describe your experience serving similar populations, if any.

Molina serves members in waiver programs similar to those in the Iowa High Quality Healthcare Initiative in its sister health plans, Molina Healthcare of Illinois, Molina Healthcare of New Mexico and Molina Healthcare of Texas, which includes the following populations: children with serious emotional disturbances, individuals with HIV/AIDS, Traumatic Brain Injuries, the Elderly, Persons with Disabilities, members in Skilled Living Facilities and those residing in Nursing Homes. Molina will leverage the extensive experience of its sister health plans with waiver care coordination to ensure Iowa High Quality Healthcare Initiative members eligible for 1915(i) Habilitation Services and 1915(c) Children's Mental Health (CMH) Services are receiving timely and appropriate services that address their functional needs. Molina's Care Management IT platform, Clinical CareAdvance, used by all Molina Health Plans, allows Case Managers the ability to schedule tasks that ensure the appropriate monitoring and oversight of long-term services and supports administration. Molina also has the capabilities to monitor services members receive to ensure the budgeted service cap is not exceeded.

3.2.13 Iowa Health and Wellness Plan Benefits

1. Describe how your proposed approach will ensure Medically Exempt members will receive State Plan benefits.

Molina will comply with the provision of Medicaid services for Medically Exempt members in accordance with Attachment 1—Scope of Work, Section 3.2.13.1. Molina understands that individuals who are identified as Medically Exempt can choose between the Iowa Wellness Plan and regular Medicaid State Plan benefits, as described in Iowa Admin. Code 441 Chapter 78.

Molina will receive findings from the member survey and attestation and referral form from the state, which identifies Medically Exempt individuals, and will ensure the provision of State Plan benefits for Medically Exempt members instead of Alternative Benefit Plan benefits. Those who qualify as Medically Exempt will be automatically enrolled by the state in the Medicaid State Plan, however, if the individual opts-out of Medicaid State Plan coverage, Molina will be prepared to enroll the individual in Iowa Wellness Plan benefits. For example, a member who is eligible to receive services through the Medicaid State Plan will be placed in an integrated health home to ensure that both physical and behavioral health needs are being addressed. Molina understands that Medically Exempt members will have no premium obligations for the Iowa Wellness Plan.

2. Describe your proposed strategies for implementing retrospective claims analysis to determine if a member is Medically Exempt.

Although DHS has final approval for determining medically exempt beneficiaries, Molina will assist in

identifying members who meet Medically Exempt criteria as described in Attachment 1—Scope of Work, Section 3.2.13.1.1. This includes monitoring retrospective claims to identify members who may meet medical criteria to be declared Medically Exempt as described in 3.2.13.1. At minimum, diagnosis data will be mined, but Molina may also evaluate other claims data such as billing codes. Since not all Medically Exempt criteria is included on a claim, Molina may leverage other data sources, such as authorization, case management and assessment information to identify members who may meet Medically Exempt criteria. Based on its data reviews, Molina will work with authorized representatives as defined in 3.2.13.1 to complete the Medically Exempt attestation and referral forms, so the Agency may make a determination.

3.2.14 Value-Added Services

1. Describe any proposed Value-Added Services. Include in the description:

a. Any limitations, restrictions, or conditions specific to the Value-Added Services;
b. The providers responsible for providing the Value-Added Service;
c. How the Value-added Service will be identified in administrative (encounter) data;
d. How and when providers and members will be notified about the availability of such Value-Added Services while still meeting the federal marketing requirements; and
e. How a member may obtain or access the Value-Added Services.

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

2. Provide any applicable data on improved outcomes linked to Value-Added Services you have implemented in other states.

CONFIDENTIAL

3.3 Continuity of Care

1.Describe your strategies to ensure the continuity of care of members transitioning in and out of the program, and transitioning between Contractors and funding streams.

If an Iowa High Quality Healthcare Initiative member is transitioned from another program or Contractor to Molina, Molina will facilitate the seamless transition of services by assigning a Case Manager to ensure continuity of care defined by the previous care plan until a reassessment can occur. When Molina is notified of Iowa High Quality Healthcare Initiative members who receive acute, specialty or community-based LTSS, Molina will work with the necessary agencies (e.g., DHS, home health, or other Contractor) to ensure that authorizations are in place for all transitioned members for the continuation of services.

Molina's transition planning process includes:

- Review of the existing care plan prepared by the previous plan or entity;
- Preparation of a transition plan that ensures continuity of care by utilizing the member's existing care plan until Molina conducts an assessment, and a new care plan is developed in collaboration with the member;
- Coordination to ensure the member receives Durable Medical Equipment (DME) or supplies that have already been ordered without interruption or delay, or authorization of DME that is otherwise deemed necessary; and
- Facilitation of payment to the current provider of services under the existing authorization.

Molina will receive enrollment files for new members from DHS. When previous authorizations are shared, they will be loaded into QNXT, Molina's core information management system. QNXT data utilized for care management activities will be manually uploaded to Clinical CareAdvance, Molina's web-based integrated care management platform that includes documentation of assessments; development of care plans; information about authorizations; and data regarding all health care providers utilized by the member, including primary care and ongoing specialty needs, for use by Molina's Case Manager. Molina works to ensure continuity of care that is seamless for members while taking into account the primary funding stream to coordinate benefits as applicable.

Once Molina is notified by DHS that a member has transferred to another program or Contractor, and Molina is provided with the receiving program entity/Contractor name, Molina's Case Manager will transition appropriate care plan and authorization information, including utilization data and applicable clinical information, such as Disease Management and Care Management notes, to the other entity upon the member's disenrollment from Molina.

Preserving Patient-Provider Relationships

Care of newly enrolled Iowa High Quality Healthcare Initiative members will not be disrupted or interrupted. Molina's Utilization Management and Provider Services teams will make every effort to preserve patient-provider relationships whenever possible. Utilization Management staff will follow Molina's Continuity of Care policy and procedures to enable members who are in an active course of treatment to continue to receive care from their historic provider and will refer non-participating providers to Provider Contracting staff to be evaluated for future contracting outreach efforts. When the provider-patient relationship is unable to be preserved for some reason, Molina will assist the member with transitioning to a contracted provider who provides the equivalent care as expeditiously as the member's health condition requires.

If covered services are not available within Molina's network, Molina will use single case agreements and network development targeting highly utilized out-of-network providers. The single case agreement

process is used when a member and/or a provider contacts Molina for services; there is no available provider in the network; and an out-of-network qualified provider is willing to provide needed services. Molina contacts the provider and offers to sign a single case agreement for that member to continue to receive services from the specified provider. This ensures continuity of care and provides the opportunity for Molina's Utilization Management team to identify in-network providers for transfer. In addition, Molina's Provider Contracting team works with identified out-of-network providers to pursue contracting opportunities in order to bring them into the Molina network, ensuring the member can continue to see the established provider.

To ensure continuity of care for women who are already receiving prenatal or postpartum care at the time of enrollment, Molina works with treating physicians to develop a transition plan for a specified period of time as deemed necessary to provide the best minimal care according to state-required timeframes. Molina's Provider Contracting team will attempt to contract with out-of-network providers, so members do not need to change providers. Molina will allow newly enrolled pregnant members past the 24th week of pregnancy to remain under the care of her current OB/GYN and continuing through postpartum checkups through the first six weeks post-delivery, even if the provider is out-of-network. If a member wants to change to an in-network OB/GYN, Molina will facilitate the change if the provider agrees to accept her in the last trimester.

If a member moves out of a service area, Molina will pay out-of-network providers in the new service area who provide urgent or emergent medically necessary covered services to members through the end of the period for which Molina received a capitation payment for the member.

3.4 Coordination with Medicare

1. Describe your proposed approach and strategies for coordinating care for duals (members with both Medicare and Medicaid coverage).

Members who qualify for both Medicare and Medicaid often have complex care needs, higher program spending and a greater need for coordination. Molina has extensive experience managing the unique needs of dual eligible members and currently provides quality and cost-effective care for 80,000 dual eligible members. Molina's experience in caring for its dual eligible members includes the administration of Medicare Special Needs Plans (SNP) serving 45,000 dual eligible members in nine states (Molina is the eighth largest D-SNP in the country and the fifth largest D-SNP in our markets). Molina is also currently serving 35,000 dual eligible members in our Medicare-Medicaid Plans (MMP Demonstration plans) in five states.

In all possible coverage scenarios, Molina utilizes Case Managers and information technology to coordinate services for dual eligible members in a systematic manner and ensure members can easily navigate the system and receive primary Medicare benefits and wrap-around Medicaid benefits and services seamlessly. The keys to effectively coordinating care and services for dual eligible members include:

- A complete understanding of all available benefits and community services;
- Managing care and services through the integrated care planning process;
- Regularly communicating with other payer sources, programs and providers to avoid duplication and maximize available resources; and
- Having robust information systems configured to appropriately manage the applicable program benefits.

Accountable for the coordination, delivery of care and member experience, Molina's Case Managers are ready to work with dual eligible members to educate them; maximize the benefits available under each

program; and facilitate the provision of seamless care. Case Managers research all services available to members by assessing available plan benefits and available community-based services based on each unique member's coverage and needs. Case Managers communicate regularly with the member's PCP to jointly develop Care Plans; engage the PCP in the Care Team; monitor progress; and coordinate necessary care. For members with a behavioral health diagnosis, Case Managers also reach out to and coordinate care planning efforts and services with their Behavioral Health providers. Molina's dual eligible members are eligible for all of Molina's Disease Management and Care Management programs and services, including Molina Healthcare Transitions, and will be appropriately referred to these services based on their needs. Other key elements of Molina's integrated care planning process for dual eligible members include assessments; behavioral health screenings; member and family engagement; discharge planning; care teams; health promotion and prevention; medication management; and continuous quality improvement. The Case Manager will also identify the primary Medicare payer and assist members and providers with administrative issues, such as primary and secondary billing.

Molina's claims processing system, QNXT, is configured to coordinate benefits across plans, capturing benefits and financial responsibility under each program, noting any supplemental benefits available; documenting the primary Medicare payer; and identifying the member's PCP and PCP contact information. When Molina has responsibility for both Medicare and Medicaid claims, Molina will process both payments from a single claim submission. When Molina is the secondary payer, Molina will process all crossover claims timely and accurately and coordinate wrap-around services to ensure members receive the full set of benefits available to them. To help coordinate care and services, Molina will work with other payers and providers to gain electronic access to utilization data for those benefits and services for which Molina is not financially responsible. This may include access to a Web Portal, electronic files and/or electronic data feeds. Where this information is not readily available, Molina will reach out to these providers and payers by phone and e-mail on a case-by-case basis to align and coordinate care planning activities and participation on care teams. Particularly important to the effective management of dual eligible members will be Molina's access to hospital census data and pharmacy data.

Medicaid and Medicare plans include shared and uniquely separate benefits. To provide dual eligible members with the best possible coordination of benefits and services, Molina's experience has allowed it to gain a thorough understanding of the benefits offered to these members, such as:

- Medicaid covers financial responsibility for Medicare's out-of-pocket costs, such as deductibles;
- Medicaid also provides coverage and coordination for community based long-term care including waiver services where applicable;
- Medicare Part A has limits on inpatient days, SNF days, and home health, after which Medicaid becomes responsible; and
- Special Needs Plans provide supplemental benefits, such as non-emergency transportation, vision and dental services. The supplemental transportation benefit will be utilized prior to Medicaid benefits, therefore decreasing the need for the Medicaid transportation benefit.

Molina's Network Development department also targets high-volume Medicare providers to be included in its Medicaid network to facilitate better provider communication and coordination, and support continuity of care for members transitioning into Medicare.

2. Explain how your staff will be trained to assist dual-eligible members with questions about benefits, appeals, grievances, and other topics where Medicare and Medicaid policies may differ.

Molina employees who interact with dual eligible members receive training to enable them to assist members with questions they may have about benefits; the appeals and grievances process; and other areas where Medicare and Medicaid policies may differ. Member Services is members' first point of

contact and strives to answer any questions and/or resolve any concerns during the initial call. If necessary, Member Services will internally warm transfer members to the appropriate party for assistance per established protocols.

Member Services Staff Training

Molina conducts training for its Member Services Representatives upon hire and on an ongoing basis. New Member Services Representatives receive 14 days of classroom training and on-the-job training, which consists of three days off-the-phone and two days on-the-phone training with an experienced staff member to ensure sufficient exposure to all Medicaid and Medicare information. Supervisors monitor calls to ensure optimum member services support is consistently provided. This is reinforced by periodic training sessions on an individual or group basis as needed, for example, when new benefits or lines of business are added. Member Services Representatives participate in peer-to-peer training and support to ensure consistent performance among staff. New Hire Training curriculum includes wrap-around services for dual eligible members and other relevant topics, such as:

- Operations, policies and procedures;
- Regulatory and contractual requirements;
- Role of the PCP;
- Benefits and unique services for members, including wrap-around services for dual eligible members;
- Health care access and delivery;
- Disease Management programs, Care Management, screening and preventive services, and wellness promotion services;
- Claims and Coordination of Benefits (COB);
- Provider network practices and capacity (open or closed panels);
- How to change PCPs, and enroll and disenroll from the health plan;
- Guidelines to document and address member grievances and appeals and how the process differs between Medicaid and Medicare;
- Fraud and Abuse;
- Use of oral interpreter services from local resources and CyraCom;
- How to quickly identify, process and resolve quality of care issues;
- Potential barriers to access;
- Coordination with other state health and human services programs;
- Value-added Services;
- Emergency Prescription Process; and
- DME process for obtaining services.

Member Services Representatives all participate in mandatory company cultural diversity training and can direct members to appropriate resources to address their cultural and linguistic needs. Molina staff is trained on policies and procedures pertaining to the privacy and security of Protected Health Information (PHI) under HIPAA within 30 days of hire and additional training based upon job roles. All employees receive annual Fraud and Abuse training to make them aware of the detection, prevention and reporting of illegal activity affecting the health plan and state.

Care Management Staff Training

Molina provides classroom training to all Care Management staff regarding benefits and services for dual eligible members. Training includes discussion of the coordination of services critical to effective care management of dual eligible members and focuses on:

- Dual Eligibility;
- Medicaid Benefits;
- Medicare Benefits;
- Coordination of Benefits; and
- System Application.

Care Management staff have a thorough understanding of the complex benefits provided to dual eligible members and ensure that the services provided through Medicaid are not duplicated through Medicare. Additionally, Care Management staff is trained and understand how other services relate and interact with the primary Medicare benefit. Case Managers are prepared to answer questions asked by dual eligible members and can assist them in navigating the health care system.

Molina's MLTSS programs honor self-direction, and independent and community living to achieve improved outcomes by engaging the member, community resources, providers and stakeholders to develop person-centered solutions that extend beyond the traditional boundaries of Medicaid covered services.

SECTION 4 – LONG TERM SERVICES AND SUPPORTS

Please explain how you propose to execute Section 4 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience. Provide any relevant data regarding member or provider satisfaction with MLTSS programs you operate in other states.

Molina understands, agrees and will comply with all Long Term Services and Supports requirements set forth in accordance with Section 4 of Attachment 1 – Scope of Work. Molina ensures that we will coordinate and provide services for our member in a manner that facilitates maximum community placement and participation for members that require Long-term Services and Supports (LTSS).

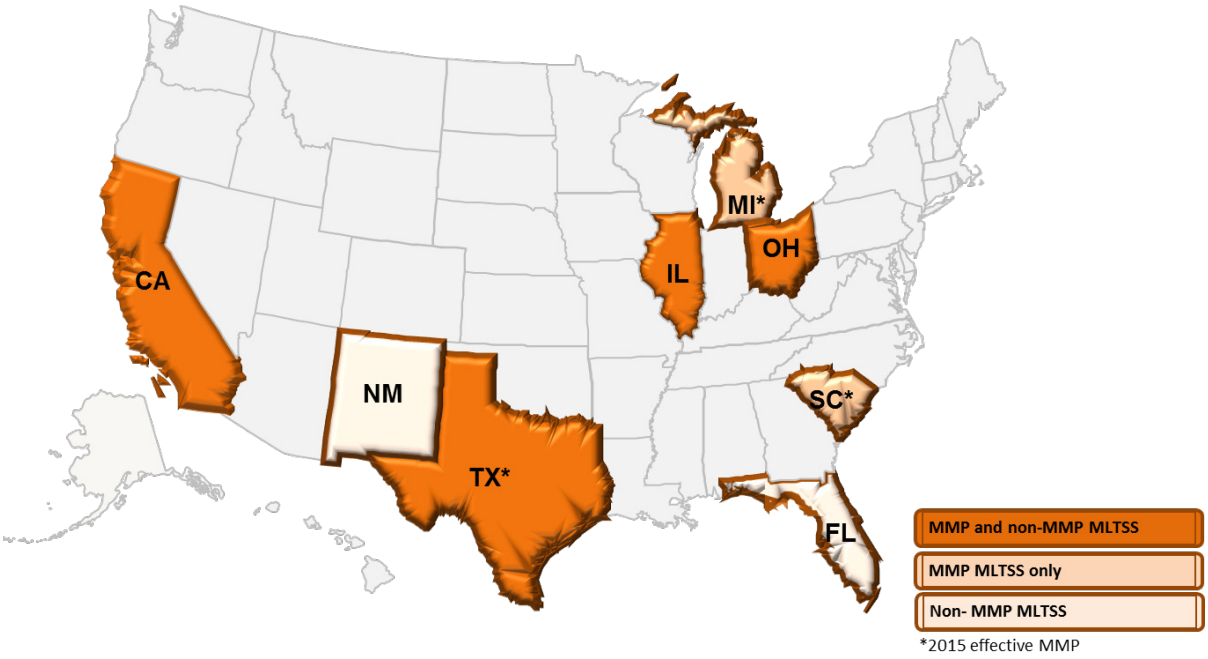
As shown in Exhibit 4-1, Molina has successfully implemented and currently operates Managed Long-term Services and Supports (MLTSS) programs in our subsidiary health plans.

Molina's Managed Long-term Services and Supports (MLTSS) programs are person-centered vs. health plan imposed

Molina's MLTSS focus and strategy:

- Honor existing care plans and continue care;
- Pay providers accurately and timely from day one;
- Understand the program, care and administration, through the eyes of the member, providers, and stakeholders. and
- Collaborate to gain outcomes and efficiencies.

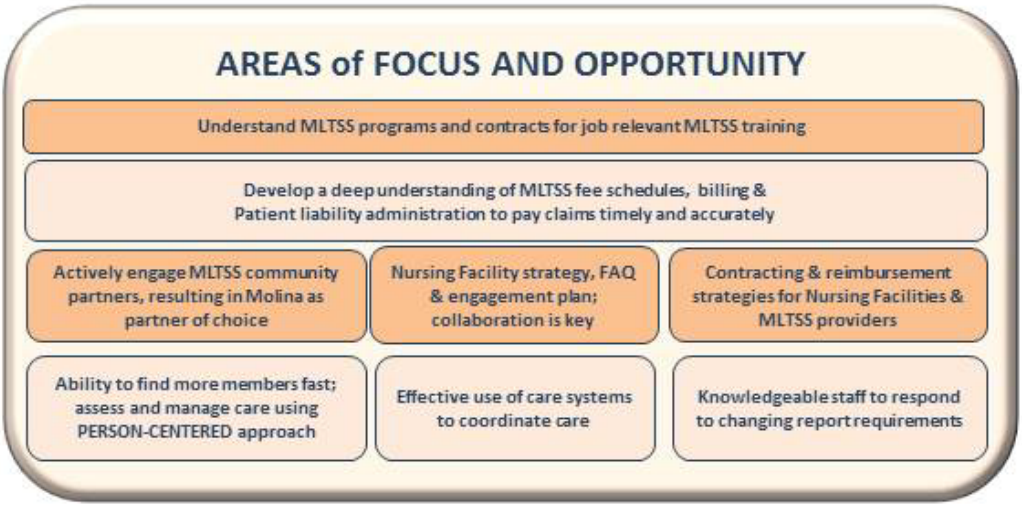
Exhibit 4-1 Molina's Medicare-Medicaid Plans (MMP) Including Managed Long-term Services and Supports (MLTSS)



As part of the Iowa High Quality Healthcare Initiative, every Molina member requiring LTSS will receive comprehensive case management services, which will include development of individualized care plans. Members will be enrolled in appropriate disease management and other care management services. Members and their families will be encouraged to participate in the member's own health management to maximize health outcomes and encourage independence. The member will be at the center of care planning. Molina will respond to each member's unique healthcare delivery challenges with cultural expertise that provides a better understanding of individuals' social, cultural and linguistic needs. Central to Molina's success will be well-run managed care programs that produce:

- Comprehensive access to care for its members;
- Reductions in inappropriate Emergency Room and other utilization;
- Appropriate reporting for claims, healthcare costs and financial information;
- Efficient communications between different provider types;
- Effective member outreach programs to increase preventive care; and
- Outstanding case management, disease management, utilization management, and 24-hour access to medical personnel.

In examining our extensive experience with MLTSS programs in our other state plans, Molina has developed the following Areas of Focus and Opportunity for the Iowa High Quality Healthcare Initiative:



Molina's Approach to Long-Term Care Services and Supports

To ensure members can maintain the highest level of functioning possible in the least restrictive setting, Molina's LTSS needs identification process includes a comprehensive assessment of the member's functional needs followed by the development of an Individualized Care Plan. The plan may include housing assistance; medication management and administration; post-hospital discharge planning; institutional care; transitional assistance services; personal care services; consumer-directed personal care services; private duty nursing; minor home modifications; Durable Medical Equipment (DME); rehabilitation services (residential and day); crisis intervention; behavior intervention services; nutritional consultation; home delivered meals; environmental accessibility adaptations; personal emergency response system; vehicle adaptation; communication aids; and referral to Early Childhood Intervention or school-based programs. To meet the distinct needs of members under the age of 21 and requiring LTSS, Molina will continue to recruit nurses, social workers and paraprofessional staff with experience working with pediatric populations presenting with complex care challenges.

To ensure the needs of our members are being met, Molina has a fully integrated Interdisciplinary Care Team composed of a Molina Medical Director, Case Manager, Utilization Management nurse, and pharmacy, behavioral health and long-term care staff. This team meets biweekly and as needed to develop strategies for care management. Additionally, the Interdisciplinary Care Team includes the member's PCP and specialists (if applicable) in care planning discussions and in the development of effective care management and integration strategies. Molina's Integrated Care Management Team includes medical and behavioral health clinicians, along with ancillary agencies and community agencies actively coordinating the member's care, based on the individualized member needs and preferences. The Interdisciplinary Care Team model provides the following coordinated care benefits for members who are receiving LTSS:

- Creation of a team-oriented, multidisciplinary comprehensive care coordination model for the member, which has been demonstrated to produce better outcomes when compared to the fragmented care coordination services delivered under FFS or less comprehensive models;
- Promotion of the development, implementation and maintenance of Individualized Care Plans, and the establishment of a point-of-contact that facilitates the coordination of care between providers and other stakeholders, resulting in prioritized delivery of necessary services;
- Improvement of programmatic evaluation capabilities from all stakeholders' perspectives;
- Improvement of access to care by leveraging the contracted network of providers, including those specializing in services for children; and
- Alignment with managed care organization and regulatory incentives by preventing unnecessary and/or long-term admissions to nursing facilities and promoting increased utilization of Home and Community-Based Services (HCBS), thus accomplishing the objectives of reducing costs while providing care in the least restrictive setting.

Molina will include children on SSI-related language in all of its contracts with home and community-based long-term care services, child care providers, and residential care facility providers requiring these providers to notify Molina in the following instances: change in a member's medical condition; member Emergency Room visit and/or hospitalization; or the member missing two or more appointments.

MLTSS Successes in Other States

Molina has experience in providing care through MLTSS across eight states including California, New Mexico, Michigan, South Carolina, Texas, Florida, Ohio and Illinois. We have had successes in many program areas. Over time, we have experienced reductions in avoidable Emergency Room visits and a downward trend in inpatient readmissions. Additionally, we have had success with member driven care plans that are designed to move people from institutional care into the community.

Enterprise-wide, Molina routinely measures and evaluates all available sources of satisfaction data, including member complaints and satisfaction surveys administered to members who have participated in one or more of Molina's programs covering Disease Management, Case Management or the 24-hour Nurse Advice Line.

While Molina routinely administers and evaluates satisfaction surveys by program, the results are not isolated to specific services or populations (e.g., members receiving LTSS). For example, Molina Healthcare of Texas administers annual CAHPS surveys to members enrolled in Molina health plans that serve Medicaid, Medicare, Dual Eligible Special Needs Plan (D-SNP), and CHIP populations. While Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey participants include members who have their LTSS/waivers managed by Molina, the results of these satisfaction surveys are not reported or evaluated exclusively for members who receive LTSS.

Highlights of satisfaction survey results for Molina Healthcare of Texas, which includes satisfaction results from Molina members receiving LTSS, include the following:

- **2014 Case Management Satisfaction Survey** –
  - 91% indicated their Case Manager spent enough time with them and listened when the member spoke;
  - 90% indicated that they were happy with the services they received from the Case Manager; and
  - 93% indicated that they would recommend the program to someone else.
- **2013 Disease Management Satisfaction Survey (2014 Survey in Progress)** –
  - 95% indicated that their Care Manager treated them with respect;
  - 92% indicated that the Care Manager spent enough time with them; and
  - 90% indicated that materials sent to them were useful.
- **Nurse Advice Line** – Survey results for 2012 through mid-2014 related to Molina Healthcare of Texas's Nurse Advice Line indicated members' increasing satisfaction from 98.4% in 2012 to 99.2% in 2014.
- **CAHPS Survey Improvements –** Molina Healthcare of Texas conducts the annual CAHPS survey to determine satisfaction with Molina services for CHIP, Medicaid, Medicare, D-SNP and program beneficiaries. The CAHPS survey results are compared to the NCQA Quality Compass 2013 national mean to assess how Molina member satisfaction scores compare with other Medicaid plans. Molina's 2014 scores indicate that member satisfaction with the health plan overall, health care overall, customer service and coordination of care – four components which Molina considers essential in providing quality care – rated higher than the NCQA Quality Compass Medicaid average in all applicable categories.

In addition to administering CAHPS surveys, Molina is supportive of qualitative information about LTSS such as the National Core Indicators-Aging and Disabilities (NCI-AD) initiative to support states' interest in assessing the performance of their programs and delivery systems and improving services for older adults, individuals with physical disabilities, and caregivers, such as the Developmental Disability (DD) service system's National Core Indicators (NCI). The NCI-AD's primary aim is to collect and maintain valid and reliable data that give states a broad view of how publicly-funded services impact the quality of life and outcomes of service recipients. The three-state pilot of this survey tool included an LTSS market in which Molina is contracted. Molina welcomes the opportunity to explore if this survey tool would be among the appropriate measures of success for the Iowa program.

Molina has had tremendous success in operating MLTSS programs in its other state health plans. For example, Molina currently coordinates and provides LTSS for dual eligible members in our Ohio health plan.

Molina Healthcare of Ohio Managed LTSS Program

Molina's Dual Options members (i.e., members covered by both Medicare and Medicaid) in Ohio have access to a variety of Long-term Services and Supports (LTSS) to help them meet daily needs for assistance and improve quality of life. LTSS benefits are provided over an extended period of time, primarily in member homes and communities, but also in facility-based settings such as nursing facilities as specified in the member's Individualized Care Plan. Overall, Molina's integrated care model promotes improved utilization of home and community-based services to avoid hospitalization and nursing facility care and includes a full array of services from nursing care to transportation and services in the community.

LTSS includes all of the following:

- Nursing;
- Physical, Occupational, Speech, Respiratory or Intravenous Therapy;

- Social Services;
- Dialysis;
- Personal Assistance Services;
- Nutritional Counseling;
- Terminal and Palliative Care (through hospice agencies);
- Home Modification, Maintenance and Repair;
- Out-of-Home Respite;
- Pest Control;
- Alternative Meals Service;
- Emergency Response Services;
- Transportation; and
- Respite Care.

LTSS Waiver Programs

Molina has extensive experience in serving members through the Medicaid waiver programs offered through the Ohio Department of Medicaid. Each waiver provides different types of services. In order to be eligible for Waiver services the following criteria must be met:

- **Assisted Living Waiver Program** – Medicaid-eligible individuals age 21 and older who require at least an intermediate level of care, are in a nursing facility, and are enrolled in PASSPORT, Choices, Ohio Home Care Waiver, or Transition Carve-Out Waivers.
- **Choices Program Waiver** – Medicaid-eligible individuals who are age 60 and older who require at least an intermediate level of care and live in an approved service area.
- **Home and Community-Based Services Waivers** – Medicaid-eligible individuals who would otherwise need to be in a nursing home, hospital, or facility for the mentally retarded and/or developmentally disabled.
- **Home Choice** – Medicaid-eligible individuals living in a facility-based care setting for at least 90 days and moving into qualified housing.
- **Transitions II Aging Carve-Out** – Waivers-eligible individuals age 60 or older with either intermediate level of care or skilled per OAC.
- **Ohio Home Care Waiver Program** – Medicaid-eligible individuals who are younger than age 59 who require an intermediate or skilled level of care.
- **PASSPORT Waiver Program** – Medicaid-eligible individuals who are age 60 or older, and require at least an intermediate level of care.

LTSS Waivers – Transition of Care Period

When a member enrolls with Molina and they are eligible under a waiver program, the member is able to continue receiving services under the umbrella of that waiver's benefit through a Transition of Care period. Once the transition is complete and the member has been assessed by Molina's Case Management Team, the member may be eligible for other waiver services due to functional assessment and medical need, which are based on Nursing Facility Level of Care Determinations or other regulatory assessments that are often part of waiver eligibility requirements. These new waiver services become a combined Waiver (i.e., the traditional or original waiver benefits are combined into one benefit) that is coordinated by a Molina Service Coordinator.

Benefits of Managed Long Term Services and Supports covered through 1915(c) Waivers may include a variety of long term services and supports to meet the member's individualized needs:

Self-directed Services

Members eligible for self-directed care or services, or their designated caretakers and/or representatives, have decision-making authority over certain services and manage their services with supports. Self-directed care or services often allow members and their families more flexibility, control and responsibility for managing all aspects of the individual's care. Under Self-directed Care, a member becomes the "employer" and can be empowered to hire and/or fire a provider within the provisions of their contract and agreement with their designated personal care attendant.

A waiver Case Manager provides oversight to assist the consumer with self-directed personal care. The member also may choose an authorized representative to help with the day-to-day supervision of their service provider and to assist with employer-related tasks. A Financial Management Services (FMS) vendor, also known as a fiscal intermediary, is often available to work with members to handle the complexities associated with being the employer of record, such as taxes, payroll and other associated responsibilities.

In some states where self-directed services are options for members who meet eligibility criteria for Long Term Services and Supports, personal care providers must be an approved provider. Federal law prohibits spouses, parents or legal guardians from being paid caregivers. When a consumer is already participating in self-directed care through a Medicaid waiver prior to enrolling in a Managed Long Term Services and Supports program, authorized services will continue throughout the transition period.

Telehealth

Additionally, in New Mexico, Molina Healthcare has successfully leveraged telehealth to serve elderly and disabled members in rural communities. This has been achieved through partnerships with primary care clinics and Emergency Rooms to provide telehealth access to behavioral health specialists. This technology has significantly expanded access to behavioral health crisis services in very rural areas of the state and created the opportunity for Spanish speaking and culturally competent behavioral health providers to be readily available to those populations. Additionally, this model could be expanded to other needed specialty services by creating telehealth stations in critical access hospitals or PCP offices to connect members to a variety of specialty providers.

4.1 General

1.Explain how you will ensure that individuals are served in the community of their choice and that funding decisions take into account member choice and community-based resources.

Molina agrees, understands and will comply with the provisions of Medicaid services as specified in Attachment 1 – Scope of Work, Section 4 – Long Term Services and Support, subsection 4.1 – General. Molina shares the Department of Human Services' dedication to serving individuals in the communities of their choice within the resources available and to implementing the provisions of the United States Supreme Court's mandate in Olmstead v. L.C. Funding decisions. Molina's will provide additional care coordination and quality oversight for members requiring LTSS, to ensure the member's health needs are continually met in the appropriate setting.

We believe that self-directed care is a critical component of a community-based LTSS program that enhances freedom of choice and fosters member independence to remain in the community longer with higher levels of satisfaction. As part of its integrated case management approach for members requiring LTSS, Molina considers individual member choice and community-based alternatives within available resources. Self-directed care allows each member to determine for themselves what mix of personal care services and supports work best for them and which caregiver will provide those services. Self-directed

care enhances a member's opportunity to utilize existing members of their support system, such as a family member or a close friend with whom they may already feel safe and supported.

Molina's LTSS Case Management programs will be tailored to encompass a broad spectrum of services designed to provide DHS members with the highest level of care in the least restrictive setting. Case Managers will work closely with Molina staff and Primary Care Physicians (PCPs) in a Medical Home environment to proactively identify members who may be at additional risk based on current health status, chronic disease states, disabilities and the likelihood of hospitalization. The Case Manager will utilize the collective information to work with members and their families to proactively address issues in order to have the greatest impact on the member's health and well-being. Case Managers will promote choice, dignity, independence, individuality, privacy and self-determination.

Funding Decisions based upon Member Choice and Community-based Resources

Molina Case Managers will fulfill DHS placement goals to maintain members in the most integrated, least restrictive setting (based primarily on the member's choice of options) and meet cost effectiveness standards. The Case Manager will discuss the availability of needed services with the member and/or member's representative after the needs assessment is completed. The Case Manager will discuss the most appropriate service placement with the member and/or member's representative. Topics of discussion will include member's choice, necessary HCBS services, HCB settings, availability, cost effectiveness, covered services associated with care in a nursing facility compared to services provided in the member's home or HCB setting, member's Share of Cost, and room and board cost responsibility. If the member chooses to be admitted to an assisted living center, the Case Manager will ensure that the member exercises their choice for single occupancy by completing the Single Occupancy Form. The Case Manager will inform the member that if the member chooses to live in their own home, they cannot be required to enter into an alternative residential placement setting that is more cost effective than the HCBS as long as the cost of the HCBS is cost effective.

Compliance with the Olmstead Decisions

Molina's Care Management program and Model of Care philosophies include the multifaceted goals of preventing unnecessary institutionalization; assisting members who are currently residing in nursing facilities to move back into their preferred setting within communities when they express a desire and feasibility to transition; respecting a members choice to self-direct their care; and ensuring Long-term Services and Supports (LTSS) are provided in the least restrictive setting to help prevent unnecessary placement in a long-term care setting. Molina's Care Management model emphasizes a high-touch, person-centered approach to care, engaging and empowering its members to make informed decisions about their care through coaching and education, at every opportunity. The Molina Care Management model builds on the member's desire to engage in activities that promote self-directed care and autonomy that honors the member's preferences, choices and abilities that takes into account their safety and well-being. This includes assigning resources based on specific member needs, promoting self-care and self-determination, and keeping members safe and in their preferred setting within the community by ongoing needs assessment, referrals to LTSS coordinators for determination of need/consideration of increase in services, identification of natural supports and home safety evaluation and facilitation of modification referrals and services, where needed. Members who reside in nursing facilities are assessed using the Nursing Facility Level of Care Determination (NFLOCD) tool and through ongoing care coordination and follow up, including review of their Minimum Data Set (MDS) assessment to determine their desire and feasibility to return to a community-based setting. The Case Manager enlists the member's medical treatment team in transition planning activities based on their expressed preferences and identified needs. If the member indicates a desire to return to the community, the Case Manager works closely with the member and/or designated heath care proxies and supports to ensure that all planning and assessment for planning, pre-transition, at time of transition and post-transition within the community take place. This

includes coordinating and obtaining any necessary authorizations and the coordination of long-term services and supports, back up planning and environmental/ home modifications, according to the member's needs and preference.

4.2 Level of Care Assessments

1.Describe your ability and process for conducting level of care reassessments and tracking and determining when a reassessment is required.

Molina agrees, understands will comply with the provisions of Medicaid services as specified in Attachment 1 – Scope of Work, Section 4.2 – Level of Care and Support Assessments, and will develop and implement policies and procedure for ongoing identification and reassessment of members who may be eligible for Long Term Services and Supports (LTSS). Accordingly, Molina will comply with the provisions of subsection 4.2.2.2 – Initial Assessment and Annual Support Assessment, and will conduct annual level of care reassessments using DHS designated tools by population and when we become aware that a member's functional or medical status has changed in a way that may affect level of care eligibility.

Members identified as Level of Care (LOC) eligible and residing in a nursing facility or Intermediate Care Facilities for the Intellectually Disabled (ICF/ID) will be monitored in Molina's Clinical CareAdvance (CCA) software platform to identify changes in condition or needs; tracked for annual reassessment via software task capabilities; and monitored by the Healthcare Services management team for adherence to timeliness requirements for Level of Care reassessments. A regular schedule for follow-up, communication, coordination of care and services, and reassessment with the member is established by the Case Manager. System-generated reminders (tasks) may be set in accordance with the agreed-upon schedule and plan of care to assist the Case Manager in conducting timely member contact. A change in health status and notification of a member becoming high risk is identified through ongoing campaigns, predictive modeling, and direct member, nursing facility and other provider referrals.

If a member reports a change in health status or desire to change their health setting, the Molina Case Manager will conduct a level of care reassessment within five (5) days based their individualized needs to address their change in condition. The Case Manager follows up at scheduled intervals appropriate to the member's care needs and monitors for potential change in health status. At a minimum, the face-to-face level of care determination assessment is conducted annually.

Members residing in a nursing facility will receive an annual LOC reassessment that will be a face-to-face assessment. Members who reside in a nursing facility will also have their Minimum Data Set (MDS) assessment findings incorporated into their integrated Individualized Care Plan (ICP). These members will receive a follow-up assessment as necessary and upon any change in status or care setting, or routinely as defined by the member's risk level.

2.Propose the approach by which needs assessments will be administered in a conflict-free manner consistent with BIP requirements.

In accordance with the provisions of Medicaid services specified in Attachment 1 – Scope of Work, Section 4.2.2 – Level of Care Assessments and Annual Support Assessments, Molina will administer assessments and reassessments for LTSS in a conflict-free manner consistent with the Iowa Balance Incentive Program (BIP) requirements identified in subsection 4.2.2.2.

Molina's Integrated Care Management model starts with its new member assessment process. If Molina receives claims data on members prior to the enrollment date, the new member assessment process begins with a risk stratification process through predictive modeling software to assist Molina staff in prioritizing outreach to identify any gaps in member care needs and ensuring a smooth transition. Members receiving

waiver services and members residing in nursing facilities are also identified during this process and are stratified to a high risk.

Shortly after a new member's enrollment, a Molina team member conducts an initial Health Risk Assessment of the new member addressing medical, behavioral health, Long-term Services and Supports (LTSS) needs, and any gaps in care. The member is then assigned to a level of care according to their identified needs and complexity of care. A Molina Case Manager is assigned to more complex members for further assessment, follow-up, and Individualized Service Plan (ISP) development, which addresses gaps in care and coordination of services (e.g., medical, behavioral, social and LTSS). Molina Case Managers also utilize the Interdisciplinary Care Team to ensure the integrated Individualized Care Plan is a collaborative effort addressing all identified member care needs and preferences.

Administering Health Assessment in a Conflict-free Manner

Molina Case Managers utilize a person-centered approach to collaboratively develop a comprehensive plan of care that promotes living in the least restrictive setting. All Molina Case Managers follow a strict code of ethics to respect members' rights, provide information for informed decision making, promote empowerment to choose the best service options available and act as an advocate for members to best serve their needs.

Molina ensures and promotes conflict free assessment administration by deploying the following through several means:

- Integration of clinical and service coordination needs to help avoid fragmentation of care including physical, functional and behavioral health/ intellectual and or related condition needs and authorized services;
- Robust monitoring and oversight of the processes to ensure interviewers do not have a vested interest in a particular outcome of the assessment;
- Member satisfaction outreach, findings are shared with stakeholders and process improvements are made based on results of member surveys;
- Complaints, grievances and appeals are reviewed and processes are formally in place to address individual concerns about the quality, services and outcomes of the care they are being provided; and
- Engagement of all identified participants of the member's Interdisciplinary Care Team, including the member, their family primary care physician, specialty care providers, home and community-based service providers, behavioral health providers, intellectual/developmental and related disorder treatment team members and any other applicable advocates.

Molina's Care Management teams perform a robust bio-psychosocial assessment to address members' medical, behavioral health and functional needs. The Molina fully integrated care plan addresses the member's goals for self-management of their medical, functional, social and behavioral health conditions in addition to any service coordination necessary to maintain the highest level of independence. The Case Manager will make certain that care plans include member-specific, measurable goals, specify a plan of action or intervention to meet their individualized goals, and include a time frame for attaining the desired outcome. At each assessment visit, the Case Manager will review the goals and document detailed progress and changes that may be needed.

The member's long-term services and supports that are part of their waiver service plan are reviewed and consented to by the member during the care plan development process. Throughout the entire Case Management process, the Case Manager supports and encourages members, to the extent that they are able, and members' families to actively participate in identifying strengths and needs, making decisions, and developing a plan. Building on members' strengths, Case Managers will assist members to develop goals that address the issues identified in the care planning process and outline specific steps for the member to achieve each goal. Molina Case Managers will consider various information resources,

including the face-to-face discussion with the member and/or member's representative, recommendations from the member's PCP and other service providers, and the Preadmission Screening (PAS), if appropriate, to develop a plan of care. During the face-to-face discussion with the member, the Case Manager will systematically assess the member's strengths and needs in several areas, including functional abilities, medical conditions, behavioral health, social/environmental/cultural factors and existing support system.

Molina has extensive experience with waiver service coordination to ensure members are receiving timely and appropriate services to address their functional needs. The Molina care management platform allows for Case Managers to schedule tasks to ensure appropriate monitoring and oversight of long-term services and supports. Molina also has capabilities to monitor services received to ensure the budgeted service cap is not exceeded.

All Molina members have the right to file a grievance with their concerns or to request an appeal on service determinations that includes their right to a state fair hearing, honoring the provisions of the 1915(c) Waiver requirements and Medicaid regulatory guidelines. If at any time the member disagrees with the assessment, authorization or determination of services, the Case Manager will give them with a written notice of action that explains their right to file an appeal. The Case Manager will explain the process for appealing the decision and associated timelines, including the process to continue services without change until an appeal determination is reached. The Case Manager will explain that the member will receive a notice in the mail from Molina to notify them of an adverse determination and the process for requests for hearings and appeals, and will provide needed assistance.

Molina will contact members based on the state's determination of nursing facility level of care to validate eligibility for long-term services and supports. An initial face-to-face assessment, at the member's place of residence, is conducted to determine their level of care, to review strengths, identify needs and deficits, develop a service plan and create a plan of care. If a member is unable to participate due to cognitive impairment or other limitations, the Case Manager will contact the member's health care proxy, guardian or health care giver to establish service needs and goal setting.

Throughout the process, the Case Manager will clearly communicate information to the member, to the extent that they are able to understand, and/or the member's health care proxy, guardian or health care giver to ensure that all parties are engaged in the process.

As part of the service coordination process, the Case Manager will inform the member that they have the right to self-directed care, including their right to choose services for medically necessary and cost effective care. The Case Manager will notify the member of any long-term care services that must be prescribed and will coordinate the request with the PCP. The Case Manager will assist the member select or change a PCP. The Case Manager will develop a written service plan that reflects services to be utilized, appropriate coding/modifiers, frequency or quantity of service, and units of measure. The Case Manager will obtain the member's signature on the service plan and if they agree or disagree with each service authorization.

The Case Manager will inform the member that, upon agreement to the service plan, the Case Manager will submit the request for authorization. Molina will make a determination regarding the provision of services requested within the contractual time frames, and to support the safety and wellbeing of the member. The Case Manager will review and update the service plan at each service review, at least annually, when there is a change in the member's functional or health status, or needs, or at the request of the member.

To prevent a gap in critical services, the Case Manager will assist the member to complete a back-up plan that identifies designated supports to assist members in the event service providers are not available.

3. Propose a timeline in which all assessments shall be completed:

Molina will comply with the provisions of Medicaid services as specified in Attachment 1 – Scope of Work, subsection 4.2.2.2 – Initial Assessment and Annual Support Assessment, and will complete all needs assessments (i) within the first 60 days of the member's initial enrollment with Molina; and (ii) within five (5) days of notification of a change in the member's health, functional status or social/caregiver support or other circumstances which necessitate the need for a reassessment. At a minimum, Molina conducts reassessments at least every twelve (12) months

Molina understands that the timeline for needs assessments is subject to DHS review and approval, and we will adhere to the DHS-approved timeline when performing needs assessments. Molina confirms that it will obtain DHS approval prior to making any changes to the needs assessment timelines.

a. Upon initial enrollment with the Bidder

Molina's Case Management service planning and coordination process begins with a comprehensive assessment of the member's biopsychosocial needs, including an evaluation of their physical, behavioral health and other psychosocial domains. The assigned Case Manager will contact the member to schedule an initial assessment no later than 60 days of enrollment for new members. Case Managers will prioritize outreach based on historical data analysis, risk identification and pre-call review findings that necessitate a more timely intervention including those members transitioning to Molina who are currently receiving HCBS. A subsequent face-to-face visit is conducted by a Case Manager to assess the following areas:

- Current health status, including condition-specific issues;
- Documentation of pertinent clinical history and current medications;
- Measure of assistance needed with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) including unmet needs;
- Identification of behavioral health conditions including intellectual and developmental and related disorders, cognitive functioning and substance use disorder;
- Identification of palliative care and life planning needs;
- Cultural and linguistic needs, preferences or barriers to care;
- Needs for caregiver resources and identification of informal supports; and
- Knowledge of available benefits and community resources.

To develop a comprehensive plan of care for the member, the Case Manager will use the initial assessment results, including input from participants of the Interdisciplinary Care Team (ICT) established by the member, and may include the member's healthcare proxy or designee, informal supports identified by the member, the primary care physician, behavioral health providers, mental health and disability service providers, specialty care providers, LTSS, nursing facility treatment team, as appropriate, and other community-based supports and services. The initial assessment and the member-directed formation of the ICT is the platform upon which the Case Manager develops an integrated service plan and Individualized Care Plan (ICP).

The ICP, including service coordination needs, is developed by the Case Manger within 90 days of the member's effective enrollment. The Case Manager honors the continuity of care period for existing service plans to ensure continuity of provider services and the least disruptive transition to Molina. Molina has experience establishing permanent relationships with existing HCBS providers identified during continuity of care periods in current LTSS lines of business across the enterprise.

b. When the Bidder becomes aware of a change in the member's circumstances which necessitates a new assessment

If at any time a member requires a different level of care, a comprehensive reassessment is conducted no later than five (5) days from the time Molina receives notification of a member's change in health, functional or support/caregiver status or needs. A new Individualized Care Plan and service plan is developed for the administration of the appropriate level of interventions, coordination of services and continuity of care. If a member experiences a transition in care setting or change in condition, they may have a reassessment sooner than their scheduled follow up.

Members receiving LTSS services are monitored in Molina's Clinical CareAdvance (CCA) software platform to identify changes in condition or needs. Molina's Healthcare Services management team reviews each member receiving LTSS services for adherence to timeliness requirements for Level of Care reassessments. A regular schedule for follow-up, communication, coordination of care and services, and reassessment with the member is established by the Healthcare Services staff. A change in health status and notification of a member becoming high risk is identified through ongoing campaigns, predictive modeling, and direct member, nursing facility and other provider referrals.

c. At least every twelve (12) months

Molina will initiate and conduct an annual reassessment of each member receiving LTSS services. The assessment will be conducted within 12 months of the last assessment. If the member experiences a major change in health status prior to the annual reassessment, the Molina Case Manager will conduct a reassessment and work with the Integrated Care Team (ICT) to review and revise the member's Individualized Care Plan based on the member's specific needs and preferences.

4. Describe your plan to track and report level of care reassessments.

In compliance with the provisions specified in Attachment 1 – Scope of Work, Section 4.2 Level of Care and Support Assessments, subsection 4.2.2.2 – Initial Assessment and Annual Support Assessment, Molina will conduct level of care reassessments, using DHS designated tools by population, at least annually. Accordingly, Molina will also reassess members when we become aware that the member's functional or medical status has changed in a way that may affect level of care eligibility. In accordance with the provisions of subsection 4.2.2.3 – Documentation Requirements, Molina will submit the required and specified documentation to the state, in the timeframes specified and in the format determined by DHS, for all reassessments which indicate change in a member's level of care. Molina understands and confirms that we currently have and will maintain the ability to track and report on level of care reassessment data.

Members identified as meeting the Level of Care determination will be monitored by their assigned Molina Case Manager who will provide Service coordination and assessment of needs to identify changes in condition or functional status that may warrant a level of care redetermination. Molina Case Managers are also monitored by the Case Management leadership team for adherence to timeliness requirements for Level of Care reassessments. A regular schedule for follow up, communication, coordination of care and services, and reassessment with the member is established by the Case Manager based on members individualized needs and preferences. System-generated reminders (i.e., tasks) may be set in accordance with the agreed-upon schedule and plan of care. A change in health status and notification of a member becoming high risk may be identified through campaigns, predictive modeling, and direct member, primary care physicians and other community-based services or specialty provider referrals. Molina will report nursing facility level of care determination outcomes in accordance with the State of Iowa regulatory guideposts as outlined in the final Molina contract with the state partner, to ensure timely health information exchange and coordination of members needs and services.

5. Vendors must work with the State or its designee responsible for implementing the PASRR process. Propose strategies to ensure members receive the specialized services and supports indicated by the PASRR level 2 screening.

Molina will comply with the provisions of Medicaid services as specified in Attachment 1 – Scope of Work, Section 4.2.2 – Level of Care Assessments and Annual Support Assessments, subpart 4.2.2.4 – Preadmission Screening and Resident Review. Molina confirms that we will work with the State or its designee responsible for implementing the PASRR process and for oversight to ensure screenings are conducted prior to admission or when there is a significant change in the member's health status. We understand that the Preadmission Screening and Resident Review (PASRR) is a critical and important way of identifying and addressing behavioral health/intellectual/developmental and related conditions that require specialized treatment, intervention and services.

In the course of Molina's comprehensive face-to-face level of care assessment, we will probe for the presence of behavioral health treatment needs and/or members that exhibit an active or specialized condition that warrants interventions typically evaluated through the PASRR Level 2 Assessment. The Case Manager will verify that the PASRR has been conducted and work with the State or its designee responsible for implementing the PASRR-process to complete the assessment as appropriate. The PASRR program is a program mandated by the Centers for Medicare and Medicaid Services (CMS) to ensure that nursing facility applicants and residents with behavioral health/intellectual/developmental and related conditions have access to the services, interventions and treatment necessary for their wellbeing. This will ensure the member is placed appropriately and that the member receives the services they require to meet their individualized needs.

To address the member's health needs, the Molina Case Manager will develop a fully-integrated care plan through collaboration with the member, nursing facility treatment team, behavioral health providers, mental health and disability service providers, legal guardian and healthcare proxy as appropriate and all other individuals that the member designates as part of their Interdisciplinary Care Team. The Molina Case Manager will also help coordinate Interdisciplinary Care Team meetings, as appropriate, to address changes in the member's health status, complexity of needs, and per member/guardian request to ensure member receives the specialized services and supports appropriate to their identified needs.

4.3 Community-Based Case Management Requirements

1. Describe your proposed model for delivering LTSS care coordination services.

Molina agrees, understands and will comply with the provisions of Medicaid services as specified in Attachment 1 – Scope of Work, Section 4.3 – Community-Based Case Management Requirements. Molina's care coordination model for Long-term Services and Supports (LTSS) will incorporate community-based case management for qualified members enrolled in the Iowa DHS High Quality Healthcare Initiative as defined in the Statement of Work and in compliance with state and federal regulations.

Molina's Care Management model emphasizes a high-touch, person-centered approach to care, engaging and empowering its members to make informed decisions about their care through coaching and education, at every opportunity. The Molina Care Management model builds on the member's desire to engage in activities that promote community life and honors the member's preferences, choices and abilities. This includes assigning resources based on specific member needs, promoting self-care and self-determination, and keeping members safe and in their preferred setting within the community by ongoing needs assessment, referrals to LTSS coordinators for determination of need/consideration of increase in services, identification of natural supports and home safety evaluation and facilitation of modification

referrals and services, where needed.

A face-to-face comprehensive assessment will be conducted in the member's home or the setting of their choice. Utilizing Molina's comprehensive screening tool, Molina's Case Managers will conduct a comprehensive face to face assessment in the members home or the setting of their choice to identify areas of risk, assess for unmet needs such as; physical, social, behavioral health and functional areas that may require a variety of medical, behavioral health and Long Term Services and Supports (LTSS) as possible interventions.

A referral for LTSS and long-term care (LTC) assessment may be made based on assessment findings or at any time due to change in health status or generate directly from a member, family/or legal representative/ designee, regulatory agency, Home and Community Based Service (HCBS) providers and all other providers.

Based on results of the assessment and level of care screening, the member will be enrolled in the waiver program. A Case Manager will work with the member to develop a care plan and authorize waiver services for integration into the overall plan of care.

Members who transition into a long-term nursing facility after implementation will be monitored by Molina staff to evaluate any change to their condition or member desire and appropriateness to transition back into the community with LTSS services. Members desiring to return to the community will be assessed utilizing the required Long Term Care Assessment to determine appropriate level of services and eligibility.

Long Term Care (LTC) assessment for level of care determination results will be shared in the Molina Interdisciplinary Care Team meetings based on the member's needs and preferences. The Molina Case Manager will complete an Integrated and Individualized Care Plan that will include LTSS and integration of all waiver assessment findings.

Molina has experience developing broad-reaching provider networks where we provide medical, behavioral and LTSS services statewide to our members in Washington, California, Michigan, Texas, New Mexico, Wisconsin and Utah, in urban and rural settings. Molina will contract with LTSS providers in Iowa to ensure that members receive the necessary services and interventions for self-determination and care in the least restrictive environment. Molina will develop relationships with existing HCBS providers in order to establish an adequate provider network. The following are some of the types of providers that may be included in Molina's LTSS program:

- **Adult Day Health Care (ADHC)** – Medically supervised care and services provided at a licensed day care center. Transportation to and from the home is provided within 15 miles of the center.
- **Adult Day Health Care (ADHC) Transportation** – Transportation to and from the Adult Day Health Care program.
- **Companion Care (In-home Respite for Caregiver Relief)** – As part of the services offered in the waiver, this service is defined as short-term caregiver relief. This may be provided by an agency or as member-directed care.
- **Environmental Modification** – Pest control services and physical adaptations to the home that may include ramps or repair/minor home modifications to allow wheelchair access, bathroom safety supplies, and other safety and access related modifications.
- **Home Delivered Meals** – Regular or special diet meals delivered to the member's home.
- **Incontinence Supplies** – Limited supply of diapers and underpads.
- **Nursing Facility (Long Term Custodial Care)** – Once admitted to a nursing facility, Molina's case management team will continue to provide care coordination to avoid unnecessary medical costs such as hospitalizations and prescription drugs (utilizing clinical pharmacy consults as necessary). Ongoing

care coordination will also be used to determine if the nursing facility resident can appropriately be transitioned back to the community and need for MFP referrals.

- **Palliative Care Program** – This program and its interventions focus on pain management and comfort care. Palliative care providers help optimize quality of life for Molina members who have a serious, chronic or life-limited illness who may not meet the hospice criteria of a terminal illness with a six month or less life expectancy. This program may assist members with their transition to a formal hospice program when appropriate along the care continuum.
- **Personal Care I (Light Homemaking Services)** – A service that provides assistance with general household activities.
- **Personal Care II (Personal Care and Light Homemaking Services)** – A service that helps with activities of daily living such as bathing, dressing, preparing meals, housekeeping, and observing health signs.
- **Personal Emergency Response System (PERS)** – This service provides an electronic device which enables high-risk individuals to secure help in the event of an emergency.
- **Respite Care (Facility-Setting)** – Temporary relief for the member's caregiver by admission to an in-patient facility (nursing home or hospital) or community residential care facility (CRCF).
- **Telemonitoring** – Web-based monitoring of vital signs, such as blood pressure, blood sugar and weight loss. RNs communicate results with physicians as appropriate.

Community-based LTSS are based on the member medical and functional needs and will be subject to specific eligibility requirements, limitations and exclusions.

Department-wide support and training is provided to Case Managers embedded in their communities. This are conducted via twice weekly WebEx meetings where managers and clinical trainers are available for answering questions, providing direction and keeping Case Managers informed of departmental updates, policy changes and other important information. Rural Case Managers are provided internet access via portable internet cards and Blackberry devises to facilitate 24/7 contact with their supervisors and peers for support.

2. Propose the required qualifications, experience and training requirements for community-based case managers.

Molina will comply with the provisions of Medicaid services as specified in Attachment 1 – Scope of Work, Section 4.3 – Community-Based Case Management Requirements, Subpart 4.3.1 – Community-Based Case Manager Qualifications, and will submit for DHS review and approval, the required qualifications, experience and training of community-based Case Managers. Molina will ensure that all of our Community-Based Case Managers (Case Managers) will meet our established qualification and experience guidelines. We understand that Community-based Case Manager qualifications are subject to DHS review and approval, and we will implement and adhere to the DHS-approved qualifications following execution of the Contract. Molina confirms that it will obtain DHS approval prior to making any changes to these qualifications.

Qualifications and Experience

Molina Case Managers are required, at a minimum, to hold a Bachelor's Degree in Social Work, Health Education or other mental/social health discipline or a combined equivalence of experience and education, including experience in dealing with the special needs of the long-term care population. Consistent with Molina's interdisciplinary care management approach, Case Managers may also hold a state license as a Registered Nurse (RN) or Licensed Vocational Nurse (LVN) with experience in case management and long-term support services. Molina Case Managers are also required to have the

appropriate experience and background, which is three or more years of clinical experience and two years or more of Case Management experience. Additionally, Molina will adhere to the qualifications set forth by Iowa High Quality Healthcare Initiative.

LTSS Support Training

Maintaining consistency in the assessment of HCBS member needs and the service authorization process begins with effective and comprehensive Case Management training followed by ongoing oversight and re-evaluation. All Case Managers will utilize Molina's proven Case Management process in which there is a consistent approach to member assessment and service coordination. Molina will train Case Managers on the specific requirements of the Iowa High Quality Healthcare Initiative.

Comprehensive Training

All community-based case management staff will receive uniform classroom training for in-home and community-based long-term care services specific to the Iowa LTSS program. Training focuses on accurate assessment of needs and the coordination of LTSS services and authorizations to maximize members' success in achieving the greatest degree of independence possible. Performance standards and expectations are included in the training of Case Managers. Supervisory resources are available at all times to ensure an ongoing understanding of Case Management roles and responsibilities. The initial orientation consists of 80 hours of classroom training.

Molina uses a mentoring program that partners new hires with seasoned Case Managers during the first three months of employment. This ensures the new Case Manager receives individualized guidance and support to review cases and situations. Mentors also provide regular constructive feedback to help new Case Managers develop necessary skills. Ongoing Case Management training is provided in regularly scheduled sessions on at least a quarterly basis. In these sessions, Case Manager's review updated and new policies and procedures, become familiar with new programmatic features, and review case studies. Case Management staff meetings provide the opportunity to review challenging cases and reinforce consistency in the assessment and authorization process.

Some key areas of Case Management Training focus include:

Training Topics	Outcome Objectives
HCBS Services	Ability to explain and offer options to members
Assessment of Need Process and Timelines	Ability to accurately assess and observe functional status of members to produce accurate and consistent determination of needs
Pre-Admission Screening and Resident Review (PASRR)	Understanding the PASSR purpose and process
Nursing Facility Level of Care (NFLOC) Determination	Ability to conduct a Nursing Facility level of Care assessment and synthesize findings to approve long term services and supports to support care needs of NFLOC members
Molina's Fully Integrated Care Management Model	Staff will be able to teach back core competencies of Molina's Integrated Care Management model: • Assessment; • Care Planning; • Interdisciplinary Care Team; and • Integrated Care Plan, including Service coordination.

Training Topics	Outcome Objectives
Systems Training	Ability to enter accurate and complete data in: Clinical CareAdvance -Clinical documentation QNXT- Authorizations Client Assessment and Tracking System (CATS)
Government Programs and Terminology	Ability to explain Medicaid, Medicare, Dual Eligibility, DHS
Coordination of Benefits	Ability to explain the COB process to members and research member status in the IT systems
Cultural Sensitivity	Understanding diverse cultural and linguistic characteristics of member and specific impact needs. Connection to community partners
Community Resource Assistance	Ability to assist members to access auxiliary resources and expectations around partnership with community-based providers
Dual Eligibility Coordination	Ability to coordinate Medicaid and Medicare benefits and help members to access care

Ongoing Oversight Focused on Consistency
To ensure consistency in Case Manager's assessment of needs and service authorizations for members receiving HCBS, Molina Case Managers will use evidence-based practices, practical experience, industry standards, and internal benchmarks.

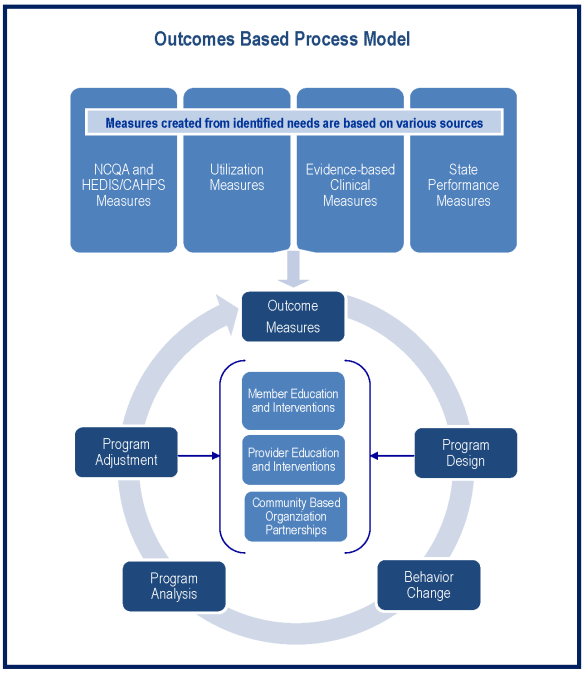
Molina's Case Managers will receive ongoing supervision to ensure consistent, quality case management activities are conducted with the objective to improve members' health and quality of life. Ongoing supervision consists of quality performance reviews that include caseload monitoring, quarterly case file audits, and checks for member assessment and service coordination authorization consistency. Case Managers will meet with their supervisors monthly to review progress, discuss issues, and set goals and objectives. Case Managers will receive feedback during these sessions and have access to supervisors on a daily basis.

Re-Evaluation
Molina's Case Management will use its inter-rater reliability tool and outcomes based process model to re-evaluate consistency among Case Managers with regard to the assessment of HCBS member needs and service authorizations. The objective of the re-evaluation process is to evaluate consistency in applying appropriate criteria (inter-rater reliability), identify areas for training or retraining, identify barriers and opportunities for improvement, and monitor employee performance.

Molina will use an inter-rater reliability process to measure the consistency of the Case Management decision making process, including the application of related policies and procedures. The inter-rater reliability process includes evaluating critical areas such as respecting the member's rights, utilizing observation and interviewing techniques, application of the Uniform Assessment Tool (UAT), providing explanation and knowledge of all HCBS services, completion of the Cost Effectiveness Study (CES), completion and documentation of the care plan including distribution of a copy to the member, authorization of services in QNXT within designated established timeframes and follow-up contact with the member to ensure member satisfaction with services.

The inter-rater reliability process includes:

- Regular staff meetings to review and discuss case files, outcomes, discrepancies and opportunities.
- Quality Review Audits (Non-Physician) where Case Managers review 10 case files every three months to analyze the information for consistency in application of criteria.
- The Case Management Administrator will calculate individual and overall department performance and prepare a summary report for each Case Manager. The individual performance score will be included in the Case Manager's performance review.
- Meetings to provide forums for discussion of outcomes and implementation of modifications to processes.



Molina Healthcare's Quality Oversight Committee will monitor and track specific Case Management activities on a quarterly and annual basis to ensure consistency is met across all functions, to help identify areas of concern and make recommendations to improve Case Management systems and processes.

Molina will also apply an Outcomes-based Process model to analyze specific conditions, diagnoses, operational processes, services or populations for which measurable outcomes are desired. The process continues as a cycle of ongoing monitoring as outcomes are re-measured and the specific programs are enhanced with each cycle. Once approved for implementation, various departments and subcommittees continuously monitor the implemented activities and track the performance measures that have been defined.

The Outcomes-based Process Model includes the following steps:

- Establish standards and benchmarks;
- Collect data;
- Analyze data and determine performance levels;
- Identify opportunities for improvement;
- Prioritize opportunities;
- Design and implement interventions, including corrective actions; and
- Measure effectiveness and adjust program design as necessary to achieve desired behavioral change.

Molina's improvement methodology is designed to address gaps in performance. Approaches to improve quality and performance include the following activities:

- Develop, modify or update organizational policy and procedures;
- Address gaps in staffing patterns, personnel or training needs;
- Deploy new, or modify existing systems, operations and tools; and
- Communicate results, changes and updates internally and externally.

Any problems detected with the intervention, or significant variation from performance standards, are reported for further review and action. Case Management administrator staff review and monitor

information on a quarterly basis. Results and change in processes to positively impact outcomes are shared with the Case Management Team on an at least an annual basis.

3. Describe your proposed staffing ratio for community-based case managers to members.

Molina is committed to maintaining an adequate staffing ratio to meet the unique needs of members requiring LTSS services. In accordance with subpart 4.3.1 of the Scope of Work, Molina acknowledges and understands that the state will not be designating specific community-based case manager to member ratios that must be maintained. Molina also understands that the State reserves the right to require us to hire additional community-based case managers if it is determined by DHS that we have insufficient care coordination staff to meet the needs of the population. Molina will maintain an adequate staffing ratio to meet the needs of members requiring LTSS and enrolled in the High Quality Healthcare Initiative. As such, to meet the needs of the LTSS population, Molina tentatively proposes the following community-based case managers-to-members ratio.

Community-based case manager positions will be assigned to all four member levels. These staff maintains an assignment of 1-600 members depending upon the mix of levels. If the case mix is primarily Level I members, the case load would be 1-600 cases; if primarily Level II members, the case load would be 1-350 cases. For a case mix consisting of primarily Level III members, the case load would be 1-85. For a case mix consisting of primarily Level IV members, the case load would be 1-60.

4. Describe how care coordination services will include ongoing communications with community and natural supports.

In compliance with the provisions of services specified in the Scope of Work, section 4.3.2, Molina will maintain ongoing communications with a member's community and natural supports to monitor and support their ongoing participation in the member's care. Stringent record keeping and ongoing communication allows the Care Management staff to keep all providers aware of the member's needs, ensures cost effective use of resources and a coordinated approach to improve the member's health outcomes and prolong their ability to stay safe in the community setting of their choice.

The Case Manager shares Individualized Care Plans with the member's PCP and communicates regularly with the PCP office. Case Managers collaborate with Molina paraprofessional care coordinators in our Community Connectors program, which is designed to extend care management to the communities where our members live with a culturally and linguistically sensitive approach to member engagement and education. Because of their community ties, Community Connectors are well positioned to identify natural support systems in member's community, including churches, tribal and cultural social centers, parks and recreation programs and other community-based organizations and to address barriers to care with cultural sensitivity.

Molina works proactively with providers, recipients and other stakeholders to maintain a comprehensive and successful communication program focused on soliciting input; providing timely, accurate and useful information; and communicating significant program changes that may impact the recipient, the provider or other stakeholders. In the event that the member transitions from Molina to another managed care organization, we will provide adequate and timely communication to ensure that there is no interruption or delay in member's service delivery.

Ongoing Communications Methodology

Molina will establish the appropriate process and procedures to communicate and explain to its network providers the standards for the Iowa High Quality Healthcare Initiative through formal training and written materials. These materials will include LTSS requirements; changes in regulatory requirements, as appropriate; and changes in subcontract requirements. Through frequent and effective communications

with providers, Molina will keep providers up-to-date on program standards and regulatory changes to reduce their administrative burden, improve operational efficiencies, reduce unnecessary calls to Provider Services and minimize claims rework. Molina will keep providers informed of all changes following the timing specified in Molina provider agreements and Iowa High Quality Healthcare Initiative contract requirements. Updates to DHS Subcontract Provisions, as amendments to the contract, will be distributed via direct mail.

General information and updates on health plan operations will be delivered using multiple methods, as listed below, to ensure providers are receiving information as it is available.

Provider Manual – The Molina Provider Manual will contain all DHS program information and regulatory requirements necessary for participation in the Molina provider network. Molina will distribute the Provider Manual to all new practitioners when they enter into a network provider contract and will use the Provider Manual as the primary source of provider training. The Provider Manual is available in hard copy, on CD and on Molina's provider Web Portal. Updates to the Molina Provider Manual are distributed throughout the year via direct mailing, facsimile distribution, electronic mail, and on the Web Portal.

Provider Web Portal – The Molina Provider Web Portal is another venue Molina utilizes to communicate with providers when program changes or laws and regulations take effect. Molina will post program changes on the Provider Web Portal to alert providers of changes that impact services or requirements; these postings will also include copies of recently distributed documents.

Direct Mail Communications – Molina will mail notifications to providers to inform them of regulatory, subcontract or program changes at least 30 days in advance of changes taking effect, unless regulatory or DHS' timing requires shorter timeframes.

Facsimile Communications – Molina will establish a database of secure provider facsimile telephone numbers to facilitate transmission of general updates and will use "Just the Fax" software to facilitate automated facsimile distribution. This is a very cost effective means of communication within the network.

Electronic Mail – Molina will establish a database of provider electronic mail addresses to facilitate electronic submission of real-time information to its provider network.

Provider Newsletters – Molina will publish and mail a Provider Newsletter on a routine basis. The newsletter will note recent changes impacting providers, general information regarding the plan and updates on quality and compliance initiatives.

Remittance Advices – Molina will create special messaging on Remittance Advices when changes will be made that will affect provider reimbursement. Additionally, we may insert notices within Remittance Advice envelopes to provide additional information.

Provider Meetings – Molina will update providers on the latest changes that affect the provider network during Molina provider meetings. During these routine training sessions Molina will include reminders to providers to access the Molina Web Portal on a regular basis for access to current information.

Physician Advisory Committee Meetings – Molina will establish Physician Advisory Committee meetings in each assigned Geographic Service Area that will meet no less than biannually. The intent of these meetings is to facilitate a two-way communications venue with key physicians in each community. These meetings keep Molina aware of emerging issues within the network specific to a given Geographic Service Area. These meetings also give network providers a voice in the operation of the plan and a mechanism for continuous operational improvement.

Provider Service Representative Interaction – Molina Provider Service Representatives conduct routine face-to-face visits with providers. Molina emphasizes the importance of routine meetings with

providers when hiring and training Provider Service Representatives. Provider Service Representatives annual evaluation criteria is heavily weighted by frequency of provider meetings and timeliness of new provider in-person orientations.

5. Describe how internal operations support communication among departments to ensure community-based case managers are aware of issues related to their assigned membership.

In compliance with the provisions specified in the Scope of Work, subpart 4.3.3 – Internal Contractor Communication, Molina has internal communication systems and processes in place to insure community-based case managers are made aware of issues relevant to the members on the assigned caseloads. Molina has detailed procedural practices and procedures in place to ensure Case Managers adequately utilize internal operational support communication mechanisms and participate in inter-departmental coordination to ensure that they are meeting the needs of their assigned membership.

Central to Care Management data sharing is Molina's electronic data management platform, Clinical CareAdvance (CCA). Clinical CareAdvance provides care management leadership the ability to audit Care Management performance and compliance, and also provides reporting to internal and external stakeholders. Case Managers also have access to Emergency Room use and hospitalization through the utilization management system (QNXT), which Case Managers can access through an interdepartmental dashboard.

Internal Case Management Operational Support and Departmental Communication

Molina's Case Management team works in close collaboration with other departments in order to communicate and utilize all information that is available to maximize access to quality care with good health outcomes while controlling costs and achieving high member satisfaction. Inter-departmental coordination occurs within clinical operations as well as through ongoing communications with other departments and access to other shared information. The following examples describe some of the key inter-departmental coordination efforts between case management and other areas of the organization to improve member health and service outcomes.

Clinical Operations Inter-departmental Coordination

Molina's care management services include Case Management, Disease Management interventions and initiatives and Utilization Management functions. These services will be supported by Molina's Nurse Advice Line, available 24 hours a day, 365 days a year to answer members' or members' representatives' questions. Case Managers receive daily reports describing Nurse Advice Line activity to communicate new information and ensure appropriate follow-up occurs. Case Management team members will share with other team members their knowledge and expertise as licensed nurses, social workers, qualified behavioral health professionals, pharmacists and medical directors through participation in formal Interdisciplinary Care Team (ICT) meetings and informal ICT collaborations that are conducted via telephone, WebEx, and telepresence. Interdepartmental team meetings, both formal and informal, ensure that all aspects of a member's care needs are considered. Particular attention is paid to the integration and coordination of behavioral health and medical service management across interdepartmental functions. For example, members identified for Disease Management services are screened for depression and when appropriate receive an additional depression assessment. Case Managers then contact the member's PCP to coordinate appropriate referrals and enroll the member into specific Disease Management programs. The Case Manager facilitates communication and coordination among cross functional inter-departmental teams and the PCP to efficiently integrate behavioral and physical health services in a culturally sensitive manner.

Data Analytics Inter-departmental Coordination
Molina's Case Management team collaborates with data analytics staff to identify service delivery issues and members in need of additional Case Management interventions. Examples of Case Management's inter-departmental collaboration with data analytics staff include:

- Claims data identification of frequent Emergency Room use for services that could be more appropriately provided through outpatient facilities or community behavioral health resources.
- Claims data identification of high-risk pharmacy utilization such as failure to fill psychiatric medications, narcotic misuse, poly-pharmacy and off-label prescribing patterns.
- Claims data identification of potentially misaligned treatments with diagnoses, such as in the prescription of an antidepressant without a mood disorder diagnosis. This may indicate that the PCP, or other non-psychiatric prescriber, may be focused on other physical treatment needs and prescribed the antidepressant as a secondary treatment. Such a case would require further investigation, assessment and follow-up.
- Data analysis of Case Manager's performance, such as review of case activity, timeliness of contacts and interventions, progress in achieving goals noted in the care plan and inter-rater reliability of service authorizations.

Provider Services Inter-departmental Coordination
Case Managers will work closely with Provider Services and participate in the Member Provider Satisfaction Committee, a multi-departmental standing committee dedicated to overseeing provider network strategies and ensuring that general network access, service availability and appointment timeliness scheduling requirements are met. Case Managers will share with Provider Services information about their assigned members' experiences accessing services, such as customer service in the provider's office, patient satisfaction, facility conditions and handicap access issues. The Molina Provider Services representative will then work with the provider office to address the issues raised and will communicate the results with the Case Manager who will share the information with the member. Case Managers working directly with provider offices can also relay changes in office information to Molina Provider Services staff, such as provider contact numbers, locations and office hours. If a network need is identified and a provider is identified to fill that need, Case Management staff relays this information to Network Development to work on contracting with that provider. Updated information is included in the Molina Provider Directory used inter-departmentally by Case Management, Member Services and other teams.

Quality Assurance/Quality Improvement Inter-departmental Coordination
The Case Management team regularly communicates with the Quality Assurance/Quality Improvement departments regarding service delivery to members. Inter-departmental communications include data analyses of:

- Provider under- and over-utilization of services;
- Established use of best practice models; and
- Provider satisfaction surveys results.

Case Management staff work with the Quality Assurance/Quality Improvement departments to develop and implement performance improvement plans. Results of data collection and the assessment of performance improvement plan success are also shared with Provider Services staff who engages the provider in related discussions.

Information Technology (IT) Inter-departmental Coordination
The Case Management team relies upon the expertise of the IT department to support customized reporting of member information and demographics, authorization and claims data, provider performance and access issues, and Case Management assignments and performance, etc. Inter-departmental

communications between Case Management and IT staff ensures appropriate data is analyzed to meet specific state contract requirements and improve the Case Management services provided to members.

Information Systems that Support Inter-departmental Coordination
Inter-departmental coordination will be supported by use of the fully integrated electronic care management documentation system, Clinical CareAdvance, and the authorization/claims system, QNXT. Clinical CareAdvance facilitates inter-departmental communications through functional applications that manage assessments, screening tools, care plans, memos, schedules, tasks, forms, and progress notes. Clinical CareAdvance has the capability to track time sensitive actions with a full range of alert options and notifications that keep Case Managers and cross-functional teams apprised of the whole picture that comprises members' status and care needs. QNXT allows for sharing of member eligibility status, benefits, service authorizations, utilization and service provider information. These system functions enable expedient exchange of information among all inter-departmental staff in support of effective and efficient administration of case management activities.

6. Describe strategies to minimize community-based case manager changes and processes to transition care when a member has a change in community-based case managers.

Molina will comply with the provisions of Medicaid services as specified in the Statement of Work, Section 4.3.4 – Changes in Community-based Case Mangers. Molina has developed a highly successful member-centric programmatic approach to care management by which members are assigned a single point-of-contact to provide service and care coordination. Molina will explore opportunities to partner with existing vendors during transition periods to ensure high-touch, seamless delivery to members to minimize service interruption or issues related to HCBS.

We understand that our strategy and plan are subject to DHS review and approval, and we will implement and adhere to the DHS-approved plan following the execution of the Contract. Molina confirms that it will obtain DHS approval prior to making any changes to our strategy and plan. Molina's has provided our strategy and approach to minimizing changes in Community-based Case Managers and our process to efficiently transition care below.

Changes in Community-based Case Managers

In an instance where Molina must change a member's Community-based Case Manager, the assigned Case Manager will introduce the new Case Manager to member to provide the least disruptive transition for member. Molina's Healthcare Services Management team makes every effort to resolve any member concerns related to their Case Manager to preserve the continuity of service, but if a member requests a change in their Case Manager, the leadership team will honor a member's request to ensure that the member's needs, preference and wellbeing are taken into account.

If a High Quality Healthcare Initiative member is transitioned from another MCO or health plan to Molina, Molina will facilitate the seamless transition of services by assigning a Service Coordination Team to ensure continuity of care defined by the previous service plan until a reassessment can occur. When Molina is notified of members who receive acute, specialty or community-based LTSS, Molina will work with the necessary agencies (e.g., DHS, home health, or other MCO) to ensure that authorizations are in place for all transitioned members for the continuation of services. For newly enrolled and transitioning members with existing authorizations and a service plan, Molina will honor those authorizations and service plan until an assessment and service plan is completed by the Molina Service Coordinator.

Upon completion of the initial Health Risk Assessment (HRA) and stratification into levels, members are contacted directly by the Case Manager to welcome the member to Molina and introduce themselves as the member's personal Case Manager. The role of the Case Manager, the frequency of communication, and general expectations are established up front, and the member is provided with all necessary contact

information. Members are provided with a pre-printed magnet with important phone numbers and are also provided with the Case Manager's contact information. Members are informed of their right to change Case Managers at any time. The process for requesting such a change is fully explained by the Case Manager upon introduction and included in the Member Handbook provided with the New Member packet. During the initial contact with the member, a PCMH or Health Home option for care management will be discussed. The Molina Case Manager will coordinate referrals to the external agencies providing care coordination activities.

If a member requests a change in Case Manager or if a Case Manager change is required due to caseload reassignment, provider request, or special need, the member is notified of the new assignment immediately, both verbally and in writing to ensure the member is fully satisfied with the change and they have the new contact information.

If a Case Manager's attempt to introduce themselves or notify members of a change via telephone, visit or letter, or through information from the member's family, neighbors or providers is unsuccessful, another letter requesting that the member contact the Case Manager is left at, or sent to, the member's last known residence and community resources are utilized to pursue contact. Community resources include regional Assertive Community Treatment teams; Income Support Division (ISD) offices when the member applies or recertifies for Medicaid; and Community Connectors.

Monitoring and Balancing Caseloads

Case Manager caseloads are overseen by the Director of Case Management or their designee with support from the Manager of Case Management and Case Manager Supervisors.

To support caseload monitoring efforts, Molina has written protocols and tools designed to closely track, monitor, evaluate, and balance workloads. Molina's Case Management staff use TriZetto's Clinical CareAdvance system, a web-based, member-centric health management solution, to manage, track and document the activities and progress of members in Molina's Case Management program. Case Manager case assignments and caseloads are entered into Clinical CareAdvance and reviewed monthly to account for new and terminated enrollments. In addition to tracking Case Manager assignments, Clinical CareAdvance tracks Case Manager initial contact; comprehensive, in-person assessments; and Integrated Care Plan development and provides alerts to the Case Manager to ensure timeliness in compliance with state contract requirements

Case Manager ratios and performance metrics, including timeliness, quality of Individualized Care Plans, and compliance with member outreach standards, is monitored on a weekly basis through analytic reports from information stored in Clinical CareAdvance, retrievable and reportable on demand. Audit results are used to adjust staffing ratios and caseloads, and improve training and education. Case Managers have access to supervisors on a daily basis to get support and voice concerns and meet monthly to review caseloads, report progress, discuss issues, and set goals and objectives.

Molina will also monitor the Case Manager caseloads of contracted entities such as PCMHs and Health Homes. Monitoring will be conducted using reports from Clinical CareAdvance captured at the member, practitioner, PCMH, and Health Home level, including the assigned care coordination and risk levels. The reports will be reviewed on a weekly basis by the Case Management staff to determine the need to adjust staffing levels. The information will be communicated to the appropriate external entities to make the appropriate adjustments.

In addition to ensuring that numerical caseload ratios are balanced to comply with contract-required ratios, Molina uses standard assessments and evidenced-based predictive modeling tools to group members into one of three levels of risk. This stratification is used to appropriately match resources with each member's unique physical, behavioral, social, and environmental needs and maximize member health outcomes. Molina's risk stratification process is run on a monthly basis to ensure members are assigned to the appropriate risk level based on their resource needs, level of risk and acuity, and current

health status. This information is immediately loaded into Clinical CareAdvance to effectively and accurately monitor the Case Manager assignments and caseloads and make adjustments as necessary.

Adjusting Caseload

Caseload reassignments are processed by the Case Manager Supervisor immediately upon a triggering event as directed by the Director of Healthcare Services or their designee. The changing of a Case Manager due to caseload adjustments is managed closely to prevent or minimize member disruption, identifying members who can be most easily reassigned. For example, Molina will not reassign a member during an active course of treatment, unless specifically requested or warranted by their condition. Circumstances that trigger caseload adjustments and Case Manager reassignments include member, caregiver or provider requests; changes in member status that require care and services outside of the Case Manager's expertise; or imbalances in Case Manager caseload. Imbalanced caseloads are identified through Case Manager testimony or system-generated reports indicating a Case Manager's assignment has exceeded the caseload ratio; documentation inaccuracies or non-compliance with care management standards; or fluctuations in membership or changes in risk level.

Minimizing Staff Turnover

Molina minimizes staff turnover through selective hiring to ensure staff possess the proper skill set for their positions; supplying team members with ongoing training and growth opportunities; providing one-on-one monthly coaching sessions with management; and offering flexible work schedules. In addition, Molina rewards and incentivizes employees with competitive compensation, incentive bonus and merit programs, healthcare benefits, and encourages work-life balance.

7. Describe your proposed discharge planning process.

Molina will comply with the provisions of Medicaid services specified in the Scope of Work, Section 4.3 – Community-Based Case Management Requirements, subpart 4.3.5 – Discharge Planning. Molina has developed a robust Transitions of Care Program (ToC), based on principles of the Coleman model and other best practices that take into account the interrelated biopsychosocial conditions and needs of the member that impact health, safety and quality of life. Policies and Procedures for the Molina Transitions of Care Program are available for the review and approval of DHS.

Member ToC outreach begins at the time Molina is notified by member or facility of a planned procedure or an unplanned admission. In the case of planned procedures, the member is contacted before the procedure, if unplanned, or emergent, support is provided to the member, family and/or caregiver throughout the inpatient or outpatient facility stay and post-discharge processes for 30 days after discharge home, to ensure that Community-based Case Managers (Case Managers) are actively involved in discharge planning.

Discharge Planning

Care Review Clinicians collaborate with hospital staff to create an appropriate discharge plan for the patient. They review the medical necessity and appropriateness for selected post-discharge services that may include home health care services, infusion therapy, durable medical equipment, skilled nursing facility placement, rehabilitative services, behavioral health intensive community case management or substance abuse treatment. If a member experiences a hospitalization and resulting significant change in health status, it might be necessary for an in-person visit from their assigned Case Manager to do an updated needs assessment, and update the plan of care as appropriate.

At the time of discharge the hospitalist will communicate with the Molina Interdisciplinary Care Team, the member, the Primary Care Physician, and Molina's Transition Coach to discuss any new or changed medications, and any other new orders for diet, therapy or follow-up care. The Transition Coach will follow the member for approximately 30 days of post-acute discharge focusing on the following:

- Confirm necessary follow-up appointments have been scheduled;
- Necessary prescriptions are filled;
- Assessment for the need of home health care or medical equipment is made; and
- Transportation and behavioral medicine referrals, as appropriate.

8. Describe your process for monitoring the effectiveness of the community-based case management process. Provide outcomes from similar contracts in other states, if available.

Molina will comply with the provisions of Medicaid services as specified in the Scope of Work, Section 4.3.8 – Community-Based Case Management Monitoring, and will develop a comprehensive program for the ongoing monitoring of our community-based case management process.

Molina's process for monitoring the effectiveness and appropriateness and effectiveness of home and community-based services (HCBS) provided to its members is encompassed in Molina's integrated care management, auditing and reporting processes. The goal is to keep members in the community and ensure the right services from the right provider at the right time, effectively coordinating with the State and other qualifying programs to avoid duplication. Molina's methodology for monitoring the effectiveness and appropriateness of HCBS is as follows:

- Molina will assign each member with HCBS needs, as determined by the Health Risk Assessment (HRA) or as previously determined by DHS, a Case Manager who shall monitor the quality and appropriateness of service delivery and the health, safety and welfare of members.
- For members with HCBS needs, Molina's Case Manager will conduct a complete and comprehensive in-person review and assessment at least annually and as necessary, to identify services needed and resources available to keep the member safe and healthy in the community. This assessment shall include long-term care needs such as environmental safety identifying items such as smoke detectors, pests/infestation, and trip and fall dangers; social supports; cultural sensitivities; and nursing home level of care as indicated.
- With input from the Care Team, including the member, the Case Manager will develop a care plan that reflects member preferences and needs identified in the comprehensive needs assessment and reassessment process, including appropriate provision of HCBS services.
- The Molina Case Manager shall monitor the Care plan, engage the member in self-care, maintain regular member contact through monthly to quarterly phone calls and quarterly to semi-annual in-person visits based on member need and level of care, and update the Care Plan as needed. Care Plan updates will be communicated to with all Care Team members.
- As part of the care planning process, for members participating in the Self-Directed Community Benefit, the Case Manager will coordinate and collaborate with the support broker and the Financial Management Services Broker (FMS) to ensure member needs are being met and members are receiving appropriate services.
- At least annually, Molina will develop and conduct reviews of the budgets for HCBS to ensure financially appropriate administration of such services to its members.
- Additional mechanisms for monitoring HCBS quality include but are not limited to:
  - Quality of care concerns;
  - Data review, including mortality, frequent Emergency Room or hospital use;
  - Member satisfaction surveys;
  - Care coordination feedback regarding HCBS services; and
  - Monitor compliance with drug therapy and efficacy.

Monitoring HCBS on the Individual Level and Program Level

Molina will establish specific criteria to determine appropriate HCBS services on both an individual and program level.

To determine appropriate HCBS care and services on an individual level, Molina's Case Manager will conduct a comprehensive assessment, including a nursing facility level of care evaluation as indicated. This assessment is used to identify risks, understand needs, and assign appropriate services and resources to keep the member safe and healthy in the community. Approval of HCBS is based on the scoring of the assessment of Activities of Daily Living (ADLs), Instrumental Activities of Daily Living scale (IADLs), and other environment and clinical factors. Case Managers also rely on criteria in the Minimum Data Set (MDS) 3.0 data specified by CMS for determining if a consumer meets criteria for medical necessity. Examples of other benefit criteria that Molina's Case Managers will employ to approve appropriate HCBS and personal care services include:

- Minor home modifications are approved only if documentation supports the requested item(s) as being necessary and related to the individual's disability or medical condition; and
- Adaptive aids and medical supplies are approved only if it provides a safe alternative to nursing facility placement. Items that are not of direct remedial or medical benefit to the individual are not approved.

To determine the appropriateness of HCBS services at the program level, Molina relies on the Utilization Management (UM) and Quality Improvement (QI) staff. Designated UM staff is responsible for monthly audits of HCBS authorizations for appropriateness and compliance with standard review criteria using the member care record which stores all authorization and care plan information. Utilization Management audits look for inappropriate authorizations by Case Managers and are used for future targeted training efforts, individual Case Manager interventions, or corrective action plans to ensure appropriateness of services going forward.

Quality Improvement staff will be involved in reviewing quality performance indicators at the program level. The quality performance indicators include but are not limited to:

- Enhanced member satisfaction surveys (i.e.; quality of life survey);
- Percentage of visits initiated on time (Electronic Visit Verification system);
- Number of days to start of care;
- Frequency of service interruptions or missed visits;
- Number of member complaints;
- Members requesting transfer to another agency;
- Total HCBS spending per member;
- Reduction in authorized hours; and
- Reduced member dependency.

Trends in HCBS service delivery identified by the UM or QI staff, indications of fraud and abuse, and other quality and service measures in the provision of HCBS are brought to the Quality Improvement Committee monthly for review and intervention as indicated.

Molina will use these individual and program criteria to determine and establish an appropriate HCBS service delivery model so that all members requiring long-term care services in the state are able to obtain the particular services that are appropriate to their health needs. Criteria will address all domains necessary to provide effective and appropriate HCBS services to keep members safe and healthy in the least restrictive setting.

Measuring Successful Outcomes

For individual level HCBS services, outcome measures will be based on member functioning and member experience. For example:

- Member functioning
  - Utilization
    - Decrease in hospital admission and readmission
    - Decrease in ER visits
  - Transitions in Care
    - Decrease in nursing home placements
    - Successful SNF to home-based transitions
  - Direct measures of current and past functioning
    - Maintain ADLs
    - Maintain IADLs
  - Social functioning
    - Increased or maintained participation in social and recreational activities
  - Adherence to care plan
    - Goals met
    - No missed appointments
- Member experience
  - Member Satisfaction Surveys

The Case Manager is responsible for oversight, monitoring, and intervention for individual level HCBS services, using the Care Plan as a gauge to set expectations, goals and established desired outcome measures.

For program level HCBS services, outcome measures will be based on overall program performance in the following areas:

- Member satisfaction (CAHPS);
- Percentage of services delivered (i.e., hours delivered/authorized hours);
- Serious health and safety service incidents (critical incidents);
- Nursing home placement per thousand;
- Change in health condition reports per thousand;
- Emergency Room visits per thousand;
- Initial hospitalizations per thousand;
- Hospital readmission rate;
- De-institutionalization success rate; and
- Regularity of PCP visits.

The Quality Improvement Committee is responsible for oversight of the program level HCBS measures.

Examples of Outcome in Other States

To ensure that members receive high quality care, Molina uses an integrated care management approach based on empirically validated best practices that have demonstrated positive results in numerous Molina managed care markets. Research and experience show that a higher-touch, member-centric care

environment for at-risk members supports better health outcomes and reduces the need for institutional care.

Molina strives for full integration of physical health, behavioral health, long-term services and support (LTSS); and social support services to eliminate fragmentation of care and provide a single, individualized plan of care for members. Molina has proven experience in operationalizing programs that administer Long Term Services and Supports (LTSS), Home and Community Based Services (HCBS) and coordinated Long Term Care in a nursing facility. These programs have assisted members in achieving health goals and have resulted in Molina members returning to community-based settings.

Molina is committed to promoting person-centered care and providing individualized assistance to our members to see them thrive at the highest level of independence possible while addressing their special needs. This commitment extends to all Molina health plans, regardless of if the health plan is responsible for providing Long Term Services and Supports (LTSS), by connecting members to the needed services within the community and informally partnering with home- and community-based programs within the areas we serve.

Molina has specific experience with Managed Long Term Services and Supports (MLTSS) in California, Florida, Illinois and Ohio. Molina's programmatic approach to integrated care management is applied to MLTSS to support a high-touch, member-centric approach that is strength-based and collaborative and to utilize formal and informal supports to promote health, wellness and stability.

In the MLTSS case management and service coordination process, a care team is established that includes a community-based Case Manager who coordinates services to meet a member's physical and behavioral health needs, including the coordination of long-term supports and home and community-based services. Communication and collaboration between a member's care team participants, which may include doctors, behavioral health providers, LTSS providers, agency social workers, caregivers and family, are facilitated by the Case Manager.

To assess for a member's biopsychosocial status, risk potential and level of care, the Case Manager reviews a member's diagnostic and utilization history, and conducts a comprehensive in-person assessments. A member's identified health needs and stated goals are used to develop the member's Individualized Care Plan, which includes a plan for waiver or LTSS services, and referrals to community resources. Case Manager support and assistance to our members continues in-person and by telephone as needed, and Case Managers work with the member on achieving their identified health goals and needs outlined in their care plan. The in-person assessment enables the Case Managers to observe a member's physical environment, functional status and emotional affect, and provides an opportunity to establish a trusting relationship between Case Manager and member, which is critical to helping the member achieve his or her health goals.

Case Managers conduct in-person assessments at a member's residence, or another agreed-upon location, at the time of enrollment to establish and report to the State the member's current level of care needs. Reassessment is conducted at least annually, or as required by the State for members receiving LTSS services, and when a change in health or functional status is identified, which might result in an increased or decreased need in support services or transition to a higher or lower level of care. If a member is unable to communicate their own wishes without the assistance of a proxy, the Case Manager will work with the member's parent, guardian, or other appointed healthcare proxy to design a care plan that provides services and supports that meet the medical, physical and emotional needs of the member.

In addition to the comprehensive assessment tool, Case Managers have a Risk Assessment Survey tool they can use to better serve members with complex needs, chronic conditions, frailty and higher risk for utilization. The Risk Assessment Survey tool focuses on possible harm or negative consequences that may result from environmental hazards, durable medical equipment deficit or disrepair, unmet caregiver or transportation needs, or member behavior that puts their health and wellbeing at risk. Through these

assessment findings and the conversation started with the member on the identified concerns, the Case Manager can educate the member on intervention options and coordinate care with providers as necessary. Care plans progress toward members meeting their goals and serve as an effective tool for Case Managers to ensure that members have access to education, resources and services to address their biopsychosocial needs.

Molina evaluates ongoing care management program metrics and the outcomes of care management interventions including LTSS and HCBS through a Healthcare Services Committee structure and member satisfaction surveys.

9. Provide proposed strategies for ensuring a seamless transition of LTSS services during program implementation. Include a proposed strategy and timeline within which all members receiving LTSS will receive an in-person visit, an updated needs assessment and service plan. Describe how you will ensure services are not reduced, modified, or terminated in the absence of an up-to-date assessment.

As part of the implementation of the High Quality Healthcare Initiative, Molina will establish a Conversion Plan for newly enrolled members that comply with state requirements and the process outlined in Attachment 1 – Scope of Work, subpart 4.3.11 – Implementation. Molina ensures that Case Managers will meet with members in person and with their providers over the phone to ensure no disruption of service and maintain current required service levels and member needs are being met. Molina ensures that services being provided to members will not be reduced, modified or terminated in the absence of an up-to-date health risk assessment that supports the reduction, modification or termination.

Molina understands that our strategy/timeline for the effective delivery of LTSS is subject to DHS review and approval, and we will adhere to the DHS-approved strategy/ timeline following the Execution of the Contract. Molina confirms that it will obtain DHS approval prior to making any changes to our strategy/timeline.

Addressing the health needs of members receiving LTSS is critical during the implementation process and ensuring a seamless transition of LTSS services during program implementation takes time. Based on our experience, Molina has detailed processes and procedures in place to help ensure a streamlined and timely LTSS transition process and quality health care and support to our members receiving LTSS. An overview of our process and timeline is shown in Exhibit 4.3.9-1.

Exhibit 4.3.9-1 Strategy and Timeline for Effective LTSS Delivery

Molina's policies and procedures ensure newly enrolled members in an active course of treatment or those who actively receive physical, Long-term Services and Supports (LTSS) and/or behavioral health care services, do not experience a disruption or interruption of care upon transition or throughout the transition phase. Molina's written policies cover continuity of care for those whose health could be jeopardized if medically necessary covered services were to be disrupted or interrupted.

Molina understands the importance of new members receiving uninterrupted, appropriate physical/behavioral health care services and LTSS from a physician or other providers, including LTSS providers, and its strategies and resultant experience have proven successful in transitioning members into a managed care structure. For new members who currently receive or require specialized care, service coordination and case management services, a Molina Service Coordinator works directly with the member, their family or caregiver, community case coordinators and transitioning service providers to engage them in the Integrated Care Management process. As part of our new member outreach call and clinical assessments process, any special needs that require additional assistance are identified, and Molina coordinates required services to maintain continuity of established care needs.

If a High Quality Healthcare Initiative member is transitioned from another MCO or health plan to Molina, Molina will facilitate the seamless transition of services by assigning a Case Manager to ensure continuity of care defined by the previous service plan until a reassessment can occur. When Molina is notified of members who receive acute, specialty or community-based LTSS, Molina will work with the necessary agencies (e.g., DHS, home health, or other MCO) to ensure that authorizations are in place for all transitioned members for the continuation of services. For newly enrolled and transitioning members with existing authorizations and a service plan, Molina will honor those authorizations and service plan until an assessment and service plan is completed by the Molina Case Manager.

Molina's transition planning process includes:

- Review of the existing service plan prepared by the previous plan or entity;
- Preparation of a transition plan that ensures continuity of care by utilizing the member's existing service plan until Molina conducts an assessment, and a new service plan is developed in collaboration with the member;
- Coordination to ensure the member receives Durable Medical Equipment (DME) or supplies that have already been ordered without interruption or delay, or authorization of DME that is otherwise deemed necessary; and
- Facilitation of payment to the current provider of services under the existing authorization.

Molina will retrieve enrollment files for new members from DHS, and when previous authorizations are shared, they are loaded into QNXT, Molina's core information management system. QNXT data utilized for service coordination activities is manually uploaded to Clinical CareAdvance, Molina's web-based integrated care management platform that includes documentation of assessments, development of service plans, information about authorizations and data regarding all health care providers utilized by the member, including primary care and ongoing specialty needs, for use by Molina's Care Management Team.

Comprehensive Strategy and Timeline to Ensure Seamless and Effective Care

Molina will assign all members receiving LTSS a community-based Case Manager who will serve as the member's designated point of contact. The Case Manager will conduct an in-person visit upon enrollment at the member's place of residence. The Case Manager will also conduct additional visits to reassess the member and address any change in member's health, functional or social/caregiver status within five (5) days of receiving notification of a change in status. The Case Manager will conduct timely and appropriate follow up to the initial assessment based on member acuity to ensure that the member is receiving service and supports as specified in the care plan; that the member's health needs are being met;

and that the member is satisfied. If during this process the Case Manager identifies gaps or access to care issues that require urgent intervention, the Case Manager will assign the issue the highest priority with action taken in less than five (5) days.

Molina's Case Manager will conduct a complete and comprehensive in-person review and assessment at least annually and as necessary, to identify services needed and resources available to keep the member receiving LTSS safe and healthy. This assessment shall include long-term care needs, such as environmental safety identifying items such as smoke detectors, pests/infestation, and injury and fall dangers; social supports; cultural sensitivities; and nursing home level of care as indicated. In-person visits provide Molina Case Managers the opportunity to observe a member's physical appearance and mood; assess any changes in functional status or injury; and provide personalized coaching and assistance with concerns.

The Molina Case Manager will develop an Individualized Care Plan with the member that reflects both the member's LTSS needs and healthcare goals. The Molina Case Manager will strive to engage the member in self-directed care by maintaining regular member contact through monthly to quarterly phone calls and quarterly to semi-annual in-person visits based on member need and level of care and by updating the Care Plan as needed. Updates to the member's Care Plan are communicated to all participants of member's Care Team.

4.3.12 Nursing Facilities and ICF/IDs

1. Describe proposed strategies for providing care coordination services for residents of nursing facilities and ICF/IDs, including the timelines and frequency of in-person visits.

Molina agrees, understands, and will comply with the provisions of Medicaid services as specified in Attachment 1 – Scope of Work, subpart 4.3.12 – Nursing Facilities & ICF/IDS, and will provide care coordination services for residence of nursing facilities and ICF/IDs in compliance with the provisions of subpart 4.3.12.1. Accordingly, Molina will evaluate the nursing facility and ICF/ID care plans to determine adequacy and ensure timely discharge planning is addressed and implement.

Molina understands that our strategy and timeline is subject to DHS review and approval, and we will adhere to the DHS-approved strategy and timeline following the Execution of the Contract. Molina confirms that it will obtain DHS approval prior to making any changes to our strategy and timeline.

A Molina Case Manager will be assigned as the designated point of contact for individuals residing in a nursing facility or an ICF/ID. The Case Manager will conduct a face-to-face visit upon enrollment at the member's residence within 60 days of effective enrollment and will also conduct additional visits to address any significant change in members functional and health status within five days of notification of change.

The Case Manager will work in conjunction with the member's PCP to coordinate all covered services and will coordinate services provided through their state program with any applicable case workers. All members who receive services through designated programs (e.g., ICF/IID, Nursing Facility, etc.) or through HCBS Waiver programs receive care through the Care Management Team that includes both Molina and state resources as well as providers serving the member's needs.

Molina works with parents, guardians, friends of the member, or child advocates who participate as part of the member's care team to identify and document care planning needs, and to develop goals and establish expected outcomes. Goals are identified and established in the care plan of the member. The Molina Case Manager facilitates and attends Interdisciplinary Care Team meetings to review transition plans, care plans, goals and to reevaluate the service plan no less than quarterly.

2. Describe processes for working with nursing facilities and ICF/IDs to coordinate care.

Establishing and maintaining a network of quality providers is central to ensuring quality care to residents of Nursing Facilities, ICF/ID facilities. Molina contracts with hospitalists and SNFists to provide comprehensive coordination of services for members residing in a nursing facility or ICF/ID facility. These providers ensure members receive quality care to avoid complications that result in hospital admission, re-admission and Emergency Room visits. Molina believes the use of hospitalists and SNFists to care for Nursing Facility or ICF/DD facility members will increase their quality of life and could potentially allow members to return to the community.

Molina created the innovative Keep In Touch (KIT) Program to provide chronically ill members living in the community with a dependable and consistent method of communication to ensure the success of their care plans. The KIT program involves identifying members at high-risk who cannot afford dependable phone service. Molina's Care Management staff locates these members and performs face-to-face visits to distribute Molina cell phones. The phones are used to ensure that members are reminded about important appointments, to arrange appropriate methods of transportation and to help Case Managers check-in with the member on a regular basis. The phone is programmed with a limited set of specific numbers that allows the member to contact 911, Nurse Advice Line, the member's PCP, their Molina Case Manager and other stakeholders in the community that contribute to or provide care for the member such as the member's family member or key support person. KIT gives members the ability to reach out as they need care (instead of going to the emergency room) and allows care management staff to reach members to ensure they are receiving the necessary care.

3. Describe strategies for coordinating physical health, behavioral health and long-term care needs for residents and improving the health, functional and quality of life outcomes of members.

Molina uses a patient-centered integrated care management approach based on empirically validated best practices that have demonstrated positive results in numerous Molina managed care markets to ensure that members receive high-quality care. Molina engages the member and their family/caregivers in the integration of physical health, behavioral health (including substance use disorder treatment), Long Term Services and Supports (LTSS) and social supports to eliminate fragmentation of care and to provide a single, highly individualized plan of care that focuses on the abilities and preferences of each member.

Molina's Care Management model uses interdisciplinary care teams to provide individualized coordinated care, which includes the coordination of physical health, behavioral health and LTSS. Molina's Service Coordination Team approach to providing services to members with special health care needs ensures that the needs of the member are coordinated with members of the care team including the PCP, specialty providers and ancillary providers.

The Service Coordination Team provides holistic care to members to address all member needs. The team communicates those needs to all appropriate providers of care to ensure continuity of care through a broad array of services that includes the coordination of medical, behavioral, long-term care services and social services, and assisting members with special health care needs to navigate the health care system. With a thorough understanding of the member's needs, the Service Coordinator creates an Individualized Service Plan. The ultimate goal is to keep the member safe, satisfied and healthy in the least restrictive setting.

Features of Molina's person-centered model of care include general and specialized pediatric assessment tools; predictive modeling; and interdisciplinary care teams who develop and adhere to an evolving Individualized Service Plan to meet the needs of a high-cost, high-risk, complex population. Molina's person-centered managed care model is specifically designed to drive comprehensive care while allowing flexible tailored care for each member's specific needs based on the following goals:

- Preserve the member's dignity and promote the member's autonomy;
- Improve the member's functional independence and quality of life;
- Ensure quality of care by utilizing best practice guidelines with providers;
- Prevent hospitalization, Emergency Room visits and nursing facility placement;
- Coordinate palliative care and hospice; and
- Support caregivers with disease management tools, appropriate respite care and education about special needs.

Molina's person-centered approach to care engages and empowers the member at every opportunity, assigning resources based on specific member needs, promoting self-care and keeping members safely in the community.

Key features of Molina's person-centered model of care are as follows:

- In-home assessments;
- Shared service plan;
- Interdisciplinary Care Team conferences;
- Personal Experience Outcomes model (captures member satisfaction and assists members in achieving their desired individual quality of life outcomes, such as, I decide where and with whom I live; I make decisions regarding my supports and services; I feel safe; and I am free from abuse and neglect);
- Medication management;
- Care transitions;
- Intensive behavioral health integration;
- De-institutionalization; and
- End-of-life care.

Service Coordinators are licensed nurses or social workers assigned to each member to advocate on their behalf, work to remove barriers, and support them in participating in and directing their own care. Molina's Service Coordinators are bilingual and culturally astute paraprofessionals specially trained to serve as member navigators and promote health within the members' communities, helping members access community-based services, pursue personal interests and become personally involved in their local communities.

The Service Coordinator conducts assessments and creates and updates the Individualized Service Plan (ISP) with input from the member, PCP, and other members of the Interdisciplinary Care Team (ICT). Molina acknowledges and supports the concept that the Service Coordinator is primarily responsible for coordinating all aspects of the member's care, including primary and specialty medical care; mental health and substance abuse services; pharmacy; rehabilitation; long-term care; and Home and Community-based Services.

Service Coordinators make home visits no less than quarterly and telephone contact no less than monthly, or more frequently as determined by the member's needs, which may fluctuate. They also assist in arranging provider appointments and, for homebound members, coordinate with other payors for in-home primary care.

Assessments

Molina uses standardized assessments and evidenced-based predictive modeling tools to identify risks, understand needs and assign appropriate resources to meet the unique needs of each individual. To ensure a member's needs and services are well-communicated and well-coordinated, Service Coordinators rely

on the ISP to reflect the expressed needs and desires of members and their families; incorporate input from the PCP and all Interdisciplinary Care Team participants; align care planning and interventions with program goals and keeping members safely in the community; effectively communicate and coordinate with other health plans and agencies; outline member and provider expectations; and engage members in their care.

Development of the ISP begins with a comprehensive assessment to: 1) rapidly identify high-risk members; and 2) engage members and solicit input to help assess needs, identify barriers and assign appropriate resources to ensure that members receive necessary services in a timely, efficient and cost-effective manner.

Member Input for Flexible Allowances

Member (and/or family and caregiver) input is central to ISP development and modification. The Service Coordinator will discuss the member's goals, preferences, barriers, strengths and needs during the comprehensive assessment when identifying and arranging appropriate services and throughout the ongoing ISP process. Molina's Service Coordinator applies this input and the results of the comprehensive health assessment to the drafting and updating of the member-specific ISP. Flexible allowances based on individual needs are considered to meet the needs of the member.

For select members, the Service Coordinator will schedule an Interdisciplinary Care Team (ICT) conference, which includes the member/caregiver and other health plan representatives as applicable, to present a draft ISP for review, improvement and approval. The team discusses steps toward success; clear assignment of roles and responsibilities; milestones; timelines; commitment by all parties; and goals, interventions, and outcomes that are aligned with the individual member's needs, valued as important, fully understood, achievable and measurable. Service Coordinators, with input from ICT participants, will have knowledge of all of the options available to members and, during the development of the ISP, will supply the member with a list of providers available for the chosen services. Members review the plan choices and provide the Case Manager with input to ensure the member's decisions and choices are implemented.

Finally, Molina employs a Personal Experience Outcome model, developed by the University of Wisconsin, to capture member satisfaction and assist members in achieving their desired individual quality of life outcomes, such as, I decide where and with whom I live; I make decisions regarding my supports and services; I feel safe; and I am free from abuse and neglect. The Service Coordinator finalizes the ISP based on this input and enters the plan into Clinical CareAdvance for easy monitoring and tracking.

4. Propose institutional diversion strategies and describe successes in other states.

Molina will propose and implement a comprehensive institutional diversion program designed to meet the specific needs of members enrolled in the High Quality Healthcare Initiative, subject to DHS review and approval, in accordance with the provisions of Medicaid services specified in Attachment 1 – Statement of Work, Section 4.3.12.4 – Diversion Strategies. Molina will adhere to the DHS-approved strategy and timeline following the execution of the Contract. Molina confirms that it will obtain DHS approval prior to making any changes to our strategy and timeline.

We have substantial experience in implementing innovative strategies and developing successful diversion programs in our sister health plans, and will utilize this experience to develop and implement a diversion program tailored to meet the specific needs of the Initiative's population.

Molina's institutional diversion strategies will include education on disease, symptom and medication management for the appropriate level of care; appropriate use of PCP and hours of operation, Urgent Care, and/or Emergency Room; and/or assisting enrollee with establishing a medical home and/or

redirecting to their PCP. Institutional diversion programs that have proven to be successful in other states include the following:

Molina will implement a comprehensive institutional diversion program subject to DHS review and approval. Molina's diversion program will target and address the needs of the following:

- Members awaiting placement in a nursing home, ICF/ID or other institutional setting, including members who may be on an HCBS waiver waitlist;
- Members who have a change in circumstance or deterioration in health or functioning and request nursing facility of ICF/ID services;
- Waiver enrollees admitted to a hospital or inpatient rehabilitation program; and
- Individuals in a nursing facility for a short-term stay.

Molina Healthcare of Florida Nursing Home Diversion Program provides an example of Molina's success in developing and implementing diversion strategies.

Molina Healthcare of Florida Nursing Home Diversion Program
Molina participates in the Nursing Home Diversion (NHD) program to provide home- and community-based services in lieu of nursing home placement for beneficiaries who are eligible for both Medicare and Medicaid in Pinellas and Hillsborough, Florida. The Molina model helps keep individuals in their own home and functioning at the highest level possible. A key part of this new program is leveraging our partnerships with community organizations and agencies. Molina Healthcare of Iowa will leverage this rich collection of experience in managing high risk, vulnerable populations in order to improve program performance and to implement initiatives that align with DHS's strategic objectives for the High Quality Healthcare Initiative program.

5. Propose strategies to identify members who have the ability or desire to transition from a nursing facility or ICF/ID setting to the community. Propose assessment tools, provide a sample transition plan and describe post-transition monitoring processes.

Molina will comply with the provisions of Medicaid services as specified in Attachment 1 – Scope of Work, Section 4.3.12 – Nursing Facilities & ICF/IDs, subpart 4.3.12.5 – Community Transition Activities, and will leverage our extensive experience to create a robust Care Transitions ("Transitions") program for Iowa High Quality Health Initiative program members who desire to transition from a nursing facility of ICF/ID setting to a community integrated setting. Molina will monitor all aspects of the transition process and take immediate action to address any issues that arise in accordance with the provisions of Medicaid services specified in subpart 4.3.12.6 – Post Transition Monitoring.

Molina understands that our strategy and timeline is subject to DHS review and approval, and we will adhere to the DHS-approved strategy and timeline. Molina confirms that it will obtain DHS approval prior to making any changes to the strategy or timeline.

See Attachment 4.3.12.5-1 Face-to-Face Comprehensive Needs Assessment (FCNA) Tool and Attachment 4.3.12.5-2 Sample Integrated Transition and HCBS Plan.

Molina's care management teams have experience assisting members who have the desire to transition back to the community from Nursing Facilities, ICF/ID, or supported living facilities, to community-based settings in many of our plans throughout the organization. This process is initiated by the Molina Case Manager while conducting a face-to-face comprehensive assessment with the member. The Case Manager utilizes the Face-to-Face Comprehensive Needs Assessment (FCNA) tool to determine the member's ability to safely transition back to the community and to determine what supports are needed to facilitate a successful transition for them. Molina proposes that the FCNA tool is utilized to identify

members enrolled in the Iowa High Quality Healthcare Initiative who have the ability or desire to transition from a nursing facility or ICF/ID setting to the community.

The Case Manager will work with the member to develop a transition plan that is member-centric, taking into account the member's individualized needs and preferences. As part of the development of the plan, the Case Manager will evaluate available resources within their community, and assesses necessary and covered medical and home and community-based services and supports, taking into account the safety, well-being and cost effectiveness of the approach to support successful reintegration for the member.

Molina's Care Management model builds on the member's desire to engage in activities that promote community life and honors the member's preferences, choices and abilities. The Case Manager will locate resources, based on specific member needs, that promote self-care and self-determination, and that supports a safe environment in the member's preferred setting within the community. Through the review of the service plan and ongoing comprehensive needs assessments, the Case Manager will determine if there is a need for service changes, identification of natural supports, a home safety evaluation and facilitation of modification referrals and services, as appropriate.

As part of this process the Molina Case Manager:

- Conducts a face-to-face comprehensive needs assessment utilizing the FCNA tool;
- Identifies physical and LTSS short-/long-term interventions needed for safe and successful community reintegration based on members individualized goals and preferences;
- Develops and integrates the transition plan into the member's Individualized Care Plan (ICP);
- Sets a goal for date of transition with the member, taking into account their strengths, desires, resources and needs;
- Follows up at appropriate intervals to monitor progress towards transition plan;
- Establishes an HCBS service plan that includes a contingency plan; assistance is also provided to ensure the member is able to self-direct services, including education on hiring providers and enlisting the help of a fiscal intermediary where appropriate
- Provides ongoing medical treatment planning, including empowerment and self-management techniques to address member's conditions, scheduling necessary outpatient appointments, transportation and other services as part of a fully-integrated care plan; and
- Schedules Home Visits for pre/post transition for monitoring and evaluation, and to ensure safe and successful transition.

Case Managers continue to coordinate services and supports as needed to support members in tandem with the Interdisciplinary Care Team (ICT) to develop and adhere to an evolving ICP. Molina Case Managers are committed to meeting the needs of a high-cost, high-risk, complex population, which includes members requiring LTSS, and to ensure that members receive the right care, at the right time, and in the right setting. This integrated care philosophy has assisted members to move to lower levels of care and helped ensure that Molina supports the member's right to self-determination when there is a desire and feasibility to move to a community based setting.

6. Describe processes for interacting with the State's MFP designee and strategies to prevent duplication and fragmentation of care.

In compliance with Attachment 1 – Scope of Work, Section 4.3.12 – Nursing Facilities & ICF/IDs, subpart 4.3.12.5 – Community Transition Activities, Molina will coordinate with the State's Money Follows the Person (MFP) designee to implement an MFP program and to develop effective transition plans for members.

To ensure members can maintain the highest level of functioning possible in the least restrictive setting, Molina's Case Manager will serve as a member of the MFP planning team and will maintain responsibility for the coordination, authorization and deliver of Medicaid covered services. As appropriate, the Case Manager will propose and implement strategies to prevent duplication and fragmentation of care and provides a single, highly individualized integrated plan of care for members focusing on the abilities and preferences of each member.

Molina's integrated person-centered care management program and Transitions of Care program (ToC), which assists in transitioning members from one setting to another, such as from inpatient to outpatient, are designed to address the fragmented care that often occurs with frequent inpatient admissions and readmissions. Molina's Healthcare Services staff includes nurses, social workers, and other trained professionals, as necessary, to provide enhanced care management, assessment, and coordination of physical and behavioral health needs. Molina utilizes available clinical data sources for case identification. Case Manager's apply information aggregated from multiple and comprehensive evidence-based assessment tools and guidelines based on each member's circumstance and needs to maximize their physical, psychosocial, cognitive and functional outcomes in the least restrictive environment possible.

Upon assessment, care planning, and identification of member's expressed preference, the member is given the option to receive physical and behavioral health in the least restrictive setting. Molina's Integrated Care Management program is a result of the dynamic relationship of assessment, review of acuity and intensity of needs, intervention with reassessment and outcomes evaluation. To ensure effective coordination of services and reduce duplication and fragmentation of care, Molina Case Management staff coordinates the process, which includes involving the member, the member's family and/or caregivers, treating physicians, therapists, counselors, social workers and other practitioners in the Interdisciplinary Care Team (ICT) providing member's care.

Molina Case Management staff utilizes the ICT platform as a tool to help arrange for necessary specialty care, community-based services, and behavioral health needs. The staff ensures and establishes an adequate provider network to accommodate this care to help achieve the balance between resource utilization, communication and functional needs to achieve member-centered goals.

Molina Case Management staff maintains the responsibility of coordinating physical and behavioral health services throughout the member's continuum of care. The staff incorporates the member's preferences while effectively reducing costs during all ongoing communications.

The Case Manager also assists in the development and implementation of a sustainability plan, which will be subject to the approval of DHS.

Molina has experience working with state MFP designees with unique Money Follows the Person programs. For example, Molina Healthcare of Texas has successfully transitioned more than 100 members in 12 months. Molina will work with the MFP designee to provide transition assistance, including housing relocation, and needed equipment and supplies to assist the member in becoming an active member of the community.

4.4 1915(c) HCBS Waivers

1. Describe in detail how service plans meeting contractual requirements, state and federal regulations, and all applicable policies, will be developed for each member enrolled in a 1915(c) HCBS waiver.

Molina will comply with the provisions of Medicaid services as specified in Attachment 1 – Scope of Work, Section 4.4 – 1915(c) HCBS Waivers and Exhibit D, and will develop comprehensive service plans to meet the requirements of member who are enrolled in and/or eligible for 1915(c) waivers. Molina

understands that there are seven (7) Home and Community-Based 1915c waiver services programs and is prepared to support these waiver programs as deemed necessary by the state. Molina ensures that service plans will comply with all state and federal regulations, including 42 CFR 441.301 and the Iowa Administrative Code 441-90.5(1)b and 441-83, and all applicable policies.

Molina's Comprehensive, Person-centered Care Planning Process

To develop a comprehensive, person-centered Care Plan (i.e., Service Plan), Molina involves the member, their families, caregivers and providers, as well as Molina staff as part of an Interdisciplinary Care Team to ensure the delivery of quality services that respect the member's preferences, choices, and abilities. The care planning process includes the identification of member goals and necessary services, and also the back-up plan to ensure that these life-sustaining services remain in place. Case Managers address and outline in the Care Plan specific services regarding the coordination of all covered Medicaid services, including long-term care, attendant care, home and community-based services authorized under HCBS waivers and alternative caregivers and providers. Identification of care needs promotes providing services that allow the member to safely remain in the least restrictive setting while meeting the member's goals. It is critical that the member fully participates in the development and decision-making process.

As part of the care planning process, The Case Manager utilizes and reviews assessment results and other available information, such as documentation from the physician offices, ongoing care plans, facility medical records, and discharge plans. Thorough review of all available information helps the development of a comprehensive plan that addresses all of the member's needs. The Case Management team works with the member and their family, the PCP and other providers as necessary to develop a seamless care plan to meet the member's primary, specialty and acute care service needs; hospital admissions and discharge planning, as well as needs for non-covered community-based services. All Personal Attendant Care and Adult Day Health Services, as well as, HCBS waiver services are authorized following completion of the applicable assessment forms. During the development of the plan of care, the Case Manager will assist the member and/or member's family with their back up plan to keep the member in the community. The member is essential to determining the back-up plan and must be fully aware of their responsibility.

One of Molina's key program goals is to keep members as independent as possible in the community. To this end, continuity of HCBS services is an integral component of our transitions of care policy. For HCBS supports, the Case Manager does the initial review and outreach to HCBS providers and case coordinators and works directly with the service providers, case coordinators, and members or caregivers to engage them in Molina's integrated care management process. During these discussions, the Case Manager will review any existing Care Plans and ensure appropriate integration into Molina's Care Plan development, fully engaging the member and their existing Care Team in the process. In instances where the existing HCBS providers are unwilling to contract with Molina, the Case Manager will continue to work with the transitional team until a mutually agreeable alternative can be identified and implemented. Contracted HCBS providers are invited to participate in the Care Team on a permanent basis as appropriate based on member needs and desires. To the extent available, Case Managers will review state provided information including previously developed Care Plans in advance as part of the needs assessment and network development process.

Molina ensures that the member has a comprehensive care plan by providing extensive training for the Case Manager in the care plan development process. This process is detailed and required extensive documentation of the specific providers and alternative arrangements. For those members living in the community at home, the back-up plan is critical and usually requires identification of more than one back-up alternative. Depending on the severity and complexity of the member's situation the back-up providers will be responsible for potentially life-saving interventions. The plan must include details, such as if provider "A" does not call by a certain time from the member's home, then provider "B" is now on call to immediately go to the member's home and provide services. As the plan is developed, an alternate is

identified for each service. Additionally, the Case Manager's contact information is provided as well as the point of contact. After hours contact is identified as well, potentially utilizing home health agencies that provides 24 hour care or family representative.

All of the contact information and scheduling will be outlined in the plan. All providers listed will be given a copy of the member's signed plan. Additionally, the care plan is a living document and modifications to any part of the plan are made as needed, but updated no less than annually.

Ensuring the Member is at the Center of the Process

Molina supports a self-directed, member-centric health care approach and encourages members to play an active role in their treatment and therapies for recovery. Molina's Care Management team promotes member input and participation to empower members to succeed in accomplishing their goals to live full and productive lives. To support the member-centric process, Molina Case Managers will work with internal/external extenders, such as community connectors, community-based agencies and state designees or Ombudsman, who will assist members with navigating the Molina system and participate in immediate conflict resolution should the need arise.

Molina will contract with qualified vendors to perform the support broker functions. Training will be conducted to ensure the support brokers are educated about the program and philosophy of self-direction. The support broker will assess the member's individual situation and work with the member to establish a budget that incorporates the member's wants and needs in conjunction with the available benefits. Support brokers will emphasize member collaboration to promote person-centered care at all levels, including direct communication with the member's Care Management team, individual treatment planning, as well as participation on advisory boards for review of program success and ongoing program development. Members will be empowered to take as active a role in decision making as they are capable. The Case Manager and support broker will work together to provide support to the member by clarifying the services included under the self-directed benefit; identifying community resources, needed providers, and natural supports that can provide additional member support; providing ongoing education to the member as new issues or challenges arise; helping the member and member's representative to brainstorm solutions and align priorities; and evaluating provider performance.

Members and/or caregivers will be immediately engaged in the process through the screening and comprehensive health assessments. This initial engagement will include an education on the integrated care process and member preferences around communication and provider participants. The member's preferences, including cultural and religious, will always be considered when developing the budget. The support broker will evaluate the member's readiness to change and implement strategies to promote healthy lifestyle choices. Behavioral health needs will be considered in implementing the budget, and behavioral health goals are stated in the member's own words. Support brokers, in collaboration with Molina Case Managers, will be responsible for describing and offering choices to the member regarding least restrictive home and community based services.

Members will always have access to their budget through Molina's secure Web Portal, which is accessible to members, providers, and caregivers with appropriate member consent. Members will also have direct access to their Case Manager and may request a Care Team meeting at any time. The Case Manager will coordinate, facilitate, and monitor the budget; the PCP, support broker and other Care Team participants will provide input, guidance, and adhere to the budget; but the member will be the driver and primary decision maker of the plan.

Molina Case Managers will work in conjunction with the member to provide necessary oversight and management of services that are self-selected and directed. The role of the Case Manager will continue to serve as the conduit for communication and oversight of the coordination of services and communication with the Interdisciplinary Care Team. For members selecting services, the Case Manager will provide

support and empowerment of the member to self-direct the elements of the Care Plan services they have chosen to manage for themselves.

The assigned Case Manager for members who choose the Self-Directed Community Benefit will have specific experience with self-direction and additional training regarding self-direction.

2. Submit a sample service plan.

See Attachment 4.4.2-1 Sample Individualized Care Plan for a sample service plan detailing how Molina will develop individualized plans of care for each member enrolled in a 1915(c) HCBS waiver.

Molina's comprehensive, integrated case management system, Clinical CareAdvance, provides a single source for assessments, configurable care planning, consent tracking, task and team management, alerts, progress tracking, communication creation, and ongoing monitoring. This custom-developed application is designed to interoperate and receive data via export feeds from QNXT. Molina's Case Managers can view a member's missed EPSDT services in the Clinical CareAdvance application and use this information to create targeted interventions and ensure appropriate services are delivered based on a member's entire health profile. Case Managers utilize Clinical CareAdvance to ensure timely communication, share information, track and monitor progress, identify issues and ensure appropriate care planning.

Molina is dedicated to the security and privacy of our members' Protected Health Information (PHI) and has developed stringent measures to ensure all internal Information Technology systems comply with HIPAA regulations. Molina has never experienced a broad spectrum security breach from an external source that has compromised the integrity of our members' personal data.

3. Describe how member's expenditures are tracked against any aggregate monthly cost caps.

Molina will comply with the provisions of Medicaid services as specified in Attachment 1 – Scope of Work, Section 4.4 – 1915(c) HCBS Waivers.

Molina's data platform has the capability to track waiver service expenditures and the ability to report based on specified timeframes. Upon receiving the member's aggregate monthly cap from DHS, the Case Manager will monitor service expenses to ensure the expenses are within the monthly cost caps.

4. Describe proposed methods for monitoring the provision of services identified on a member's service plan.

Molina will comply with the provisions of Medicaid services as specified in Attachment 1 – Scope of Work, Section 4.4 – 1915(c) HCBS Waivers, subpart 4.4.7 – Monitoring Receipt of Services, and will implement strategies to monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the member's Care Plan.

Our process for monitoring the appropriateness and effectiveness of home and community-based services (HCBS) provided to its members is encompassed in Molina's integrated care management process. The goal is to keep members in the community and ensure the right services from the right provider at the right time, effectively coordinating with the State and other qualifying programs to avoid duplication. Molina's methodology for monitoring the appropriateness of HCBS is as follows:

- Molina will assign each member with HCBS needs, as determined by the Health Risk Assessment (HRA) or as previously determined by DHS, a Case Manager who shall monitor the quality and appropriateness of service delivery and the health, safety and welfare of members

- For members with 1915(c) HCBS waiver needs, Molina's Case Manager will contact the member within 5 business days of scheduled service initiation to confirm services are being provided on schedule. Molina's Case Manager will collaborate with the member to determine a back-up plan to resolve any service gaps. Molina's Case Manager will also coach the member to contact them with any problems or concerns. Molina's Case Manager will also complete a comprehensive in-person review and assessment at least annually and as necessary, to identify services needed and resources available to keep the member safe and healthy in the community. This assessment shall include long-term care needs such as environmental safety identifying items such as smoke detectors, pests/infestation, and trip and fall dangers; social supports; cultural sensitivities; and nursing home level of care as indicated.
- With input from the Care Team, including the member, the Case Manager will develop a care plan that reflects member preferences and needs identified in the comprehensive needs assessment and reassessment process, including appropriate provision of HCBS services.
- The Molina Case Manager shall monitor the Care plan, engage the member in self-care, maintain regular member contact through monthly to quarterly phone calls and quarterly to semi-annual in-person visits based on member need and level of care, and update the Care Plan as needed. Care Plan updates will be communicated to with all Care Team members.
- As part of the care planning process, for members participating in the Self-Directed Community Benefit, the Case Manager will coordinate and collaborate with the support broker and the Financial Management Services (FMS) vendor to ensure member needs are being met and members are receiving appropriate services.
- At least annually, Molina will develop and conduct reviews of the budgets for HCBS to ensure financially appropriate administration of such services to its members.
- Additional mechanisms for monitoring HCBS quality include but are not limited to:
  - Quality of care concerns;
  - Data review, including mortality, frequent Emergency Room or hospital use;
  - Member satisfaction surveys;
  - Care coordination feedback regarding HCBS services; and
  - Monitor compliance with drug therapy and efficacy.

5. Describe in detail your proposed strategy for implementing the Consumer Choices Option, including how Support Broker and financial management services (FMS) will be implemented.

Molina agrees, understands, and will comply with the provisions of Medicaid services as specified in Attachment 1 – Scope of Work, section 4.4 – 1915(c) HCBS Waivers, subpart 4.4.8 – Self-Direction. Molina will offer 1915(c) HCBS waiver enrollees the option to self-direct waiver services, in accordance with the Consumer Choices Option consistent with all applicable rules and regulations. Additionally, Molina will comply with subpart 4.4.8.5 – Support Brokers and 4.4.8.6, Financial Management Services. Molina's has provided our draft strategy and approach for implementing the Consumer Choices Option below.

We understand that our strategy and plan are subject to DHS review and approval, and we will implement and adhere to the DHS-approved plan following the execution of the Contract. Molina confirms that it will obtain DHS approval prior to making any changes to our strategy and plan.

Molina embraces the concept of recipients self-directing aspects of their care. A recipient may have a perception of services required that may not align with medical necessity but does allow for optimum outcomes. Molina respects recipients' views of their health needs, and recognizes its responsibility to

collaborate with the recipient, recipient's family and other ancillary providers to assist the recipient in obtaining services in the most cost-effective manner with the goal of optimizing their health outcomes.

Molina's Self-Direction Oversight Process

Molina's strategy for overseeing the self-direction process is multi-pronged and involves Molina staff, contracted vendors and state contracted entities. A Case Manager will be assigned to members who meet nursing facility level of care and are determined through a comprehensive needs assessment/reassessment to qualify for the Self-Directed Community Benefit. The Case Manager will oversee the self-direction process to ensure the member has choice and control over how services are provided, who provides them, any benefit limitations and how much providers are paid.

Molina ensures each member receives the information required to enable them to make the best choice regarding the care, goods, and services they need and/or desire. In the initial contact with the member, the Molina Case Manager determines whether the member will work independently or with an authorized representative to assist them with their self-directed benefit decision-making and gives the member a self-assessment form to help evaluate the member's needs. The Case Manager documents the member's choices, including whether to be their own employer of record (EOR) or if they prefer to designate an authorized EOR. Once the choices are made, Molina obtains the appropriate documentation, such as the Power of Attorney, documentation of authorized representative, or documentation of a designated EOR if chosen. The Case Manager and member or member's representative will then engage the services of a contracted support broker, over which the Case Manager, in conjunction with the Director of Long-term Services, will maintain oversight.

Members, their chosen representatives, or others authorized by the member will participate in required training conducted by Molina. The content of the initial training is essentially a "Self-Directed Community Benefit 101," and includes areas and topics such as the following:

- Understanding the roles of all involved (e.g., member; designated EOR, if applicable; Case Manager; Support Broker; Financial Management Services (FMS) vendor; etc.);
- Consideration in selecting providers;
- Hiring direct-support caregivers;
- Employer (i.e., EOR) responsibilities;
- Information regarding a non-medical model of services and goods;
- Fraud/abuse/neglect prevention and Critical Incident reporting; and
- Development of back-up/emergency plans.

Throughout the process of working with a self-directed member, the Case Manager must remain alert to any observations or reports of poor quality services leading to a consequence for the member and reported as a quality of care issue or requiring a provider corrective action plan. This includes the recognition and reporting to appropriate authorities of Critical Incident (for example, physical/emotional/financial abuse or neglect, law enforcement, emergency services, dangerous situations/hazards, etc.).

Molina will oversee the self-direction process, including the monitoring of the following functions:

- **Molina's Case Manager** – Molina's training team will conduct the initial and annual training for support brokers, the FMS, new Molina staff, and members involved in the self-direction process. Case Managers will ensure the member's self-assessment is completed in a timely manner; ensure a complete and timely implementation of the budget and back-up plan; work with support brokers to ensure they implement solutions to overcome member barriers; and monitor participation in the program to determine the successes and challenges of the service delivery model for members. The Case Manager will document patterns that warrant interventions, and submit critical incident reports.

- **Support Broker** – Molina will train support broker staff annually and more frequently, if needed, to ensure support brokers use a member-centered approach; use People First Language; understand the self-direction budget process, covered benefits and philosophy of a non-medical model of services and goods; monitor the submission of budgets in an accurate and timely manner; conduct quality audits to monitor service delivery and the health, safety and welfare of members; and reinforce team concepts and accurate information with members. Molina will assist the support broker in developing an appropriate back-up plan to ensure the member is not without services and has contact information for secondary caregivers, and will review the plan to verify that it is complete. Molina will also annually monitor the back-up plan and documentation to ensure changes made are appropriate. Molina Care Management staff will conduct scheduled and unscheduled field visits with the member's permission to ensure the member's needs and goals are being addressed by the support broker, and will conduct regular scheduled meetings with the support broker to discuss cases, issues, barriers and solutions.
- **Financial Management Services (FMS)** – Molina will provide initial and ongoing training to the FMS provider (i.e., Veridian) and its staff regarding key requirements of the Self-directed Community Benefit. Additionally, Molina will collaborate with the FMS regarding documentation required for employer of record information and authorized agent information, and facilitate tri-agency meetings with the FMS, support brokers and Molina regarding payment processing and oversight.

Molina will monitor the number of support brokers and their member census on a daily basis; turnaround timeframes to process budget requests; outstanding documents reports (e.g., self-assessment, budget, back-up plan, fraud and abuse reports); and conduct weekly case discussions to identify member barriers and potential solutions. Program oversight and reporting is the responsibility of the Quality Improvement Committee.

Molina's Special Populations Ombudsman
The Special Populations Ombudsman will act as an advocate for members, the FMS and support brokers. Duties of the Ombudsman will include assisting members with navigating Molina's internal processes; serving as the primary liaison to address non-routine concerns and resolve reported issues; and participating in case discussion, as applicable. The Ombudsman will also facilitate any necessary conflict resolution between members, support brokers, the FMS and Molina's Case Managers to avoid interruptions of service.

Collaborating with Program Recipients
Molina provides the recipient with DHS-approved informational materials, which explain the LOC process and the program process, which the recipient needs in order to help him/her make informed decisions and comply with Care Plan and budget requirements. These informational materials include written materials, website information and video presentations.

Molina will collaborate with program consultants to assist with the management of services received by recipients, including self-directed services, and works with recipients during the transition to or from this waiver. Molina is knowledgeable about how the self-directed waivers determine services and co-manages applicable recipients with program consultants to ensure that the recipient receives all of the services to which he/she is entitled and that the services are delivered without duplication.

Implementation of Support Brokers

The member with assistance from the support broker will develop a budget that effectively addresses the member's needs identified as a result of the comprehensive needs assessment. The support broker will review and monitor the appropriateness of the budget, validate that it meets the member's needs and ensure compliance with program regulations and guidelines. The budget may include:

- Necessary environmental modifications;
- Transportation needs,
- Personal care, home health, and nursing needs;

- DME/goods;
- Acute and/or maintenance therapies;
- Homemaker services;
- Dietary/nutritional needs;
- Counseling or other support needs; and
- Other specific requests or desires identified by the member.

The budget is a living document that is subject to adjustments depending on changes in the member's health status or circumstances, such as changes in natural supports. For the duration of the member's participation in the self-directed benefit, the support broker continues to assist the member/member's representative with revising the budget to ensure it aligns with the member's current needs.

Molina's Case Manager oversees the budget to ensure the timely implementation of the member's care and support. The Case Manager addresses and resolves issues or delays in service delivery as quickly as possible, locating resources or seeking assistance as necessary. The Case Manager and the support broker communicate timely and accurate information to the member. They educate the member/member's representative about how to ensure that the goods and care they obtain are of high quality and what to do/who to contact if they are not.

In addition, the Case Manager is responsible for monitoring the budget and in partnership with the support broker, ensures that the budget is tailored to meet the member's needs. Monitoring will be based on a review of monthly reports; case discussions with support brokers and Case Managers; reported complaints; and a review of budgets on an individual member level. The budget review will include a review of the identified back-up plan and the member self-assessment. Ongoing training for Case Managers and support brokers will be provided by Molina's training staff to ensure that review decisions for the requested goods and services are not based entirely on a medical model of care.

Implementation of Financial Management Services (FMS)

Molina currently has an effective and cooperative relationship with a Financial Management Services (FMS) vendor, Veridian. This helps to ensure that members participating in the self-directed benefit (i.e., the Consumer Choices Option (CCO)) receive their care and services in a timely manner and in accordance with their budget plan. Molina works with the FMS to ensure that changes to a member's service delivery routine will be seamless to the member. To comply with requirements for the Self-Directed Community Benefit, Molina will ensure that Molina staff and the FMS are educated about each entity's roles and responsibilities and are fully prepared to work in coordination with each other.

Molina will educate the FMS about Molina's mission and its commitment to members, and will review with them the roles and responsibilities to be performed by Molina's Case Managers, such as assessment/reassessment, Individualized Care Plan development and implementation (including emergency and back-up plans), budget assistance, member/Care Plan monitoring, and provider monitoring. Molina will clearly explain its expectations to the FMS regarding the types and frequency of communications to occur between both parties, and the requirements and timelines for processing referrals, authorizations, and claims submissions. Molina will ensure that our staff and the FMS understand responsibilities regarding HIPAA compliance, data exchanges, reporting requirements and quality requirements. Member materials, such as a member handbook and documentation templates, will be available to the FMS via electronic means or hard copy, if requested.

Molina will also collaborate with the FMS to develop effective processes regarding the review of self-directed members' funding requests and communication between all involved parties in the integrated care model. Molina and the FMS communicate frequently by telephone, in person and/or e-mail to meet the needs of self-directed members. Molina staff carefully reviews proposed budget information upon

receipt, and enters complete and accurate data into the FMS interface system to ensure the timely payment of approved goods and services. Molina works closely with the FMS and support brokers to make certain that the Employer (i.e., the member), Employee (i.e., individuals providing basic services), and Vendor packets are efficiently and thoroughly completed. Packets are reviewed to ensure that all background and criminal records screenings are completed for prospective employees prior to the delivery and payment for services.

For the Iowa High Quality Healthcare Initiative, Molina has collaborated with our FMS, Veridian, to determine and evaluate some potential ideas to improve the services for HCBS waiver enrollees who choose the Consumer Choices Option. Potential ideas that may be implemented include the following:

- **Background Check Process** – Currently this process can take up to six weeks and impact the timeliness of services rendered. We will work together to have a thorough but efficient background check for Employees to ensure that they are qualified to provide services and support, and that the Employees criminal background history has been investigated. This will help ensure services are rendered appropriately as well as decreases safety risks to the Employer.
- **Recruiting Independent Support Brokers (ISBs)** – Beneficial for Case Managers and members enrolled in the Consumer Choices Option, especially in the rural Iowa communities. These ISBs will help ensure the effective budgets are established and that necessary services are provided to the Employer.
- **Connecting Employees and Employers** – The establishment of a method or mechanism to more effectively connect Employees requiring services and connect them with Employers providing those services. This would help ensure the service needs of Employers are addressed, and provide well-performing Employees with the opportunity to provide service for other Employers who are having a difficult time finding qualified Employees.
- **Case Management Training** – Training of Case Managers on the Consumer Choices Option program. This training will be conducted with a concentration on some of the technical aspects of starting a member on the program, which will allow Molina's Case Managers to work more effectively with members.

Ensuring Effective and Collaborative Communication

Molina's contracted support broker vendors will work collaboratively with Molina's Case Managers to provide assistance to members selecting the Self-Directed Community Benefit. Molina will develop comprehensive policies and procedures that clearly define roles and responsibilities of support brokers and Molina's Case Managers to ensure tasks and activities effectively assist the member and are not duplicative. In initial contacts with members, the support broker will focus on educating them about how to work within the benefit's services and supports structure.

The support broker will meet with the member in person and telephonically as often as necessary to help the member. The support broker will assist the member with the development of a comprehensive member-centered budget plan and will submit budget plan information and requests for goods and services to Molina for processing and review. Molina's Case Manager will ensure the support broker completes these activities in an accurate and timely manner.

To assist members who are transitioning into the self-directed Consumer Choices Option, the Case Manager and support broker will collaborate on the development of timelines related to the member's transition and determine the status of any existing budget. The support broker, along with Molina's Case Manager and/or any pertinent external entities, facilitates budget development tasks or budget revisions when necessary. Molina will ensure that the transition process is seamless to the member with no gaps in the delivery of approved services.

Once the budget plan has been developed, the support broker will work directly with the member to ensure that the plan is implemented, including:

- Helping the member with hiring, training, and supervising providers and direct supports;
- Ensuring accurate completion of paperwork related to the member's employees (including employment screenings, timecards, etc.);
- Helping the member conduct research for goods and services and finding cost-efficient sellers and providers; and
- Assisting the member with payment issues and budget discrepancies.

Molina's Case Manager monitors all requests submitted by the member and support broker for appropriateness to ensure they comply with the benefit. For example, the Case Manager will review requested budget revisions to determine if the changes will meet the member's current needs, and considers the member's health and safety. The Case Manager will also work closely with members and support brokers to ensure that requests for budget revisions are submitted to Molina with clear explanations of the adjustments.

Molina's Case Manager will enter all documentation, including communications, prior authorization requests, and demographics into Molina's medical management system. Additionally, the Case Manager will be responsible for the timeliness and accuracy of notification letters and other correspondence to the member.

Molina's Case Managers and support brokers will remain current on self-directed Consumer Choices Option regulations and standards. The Case Manager will be the knowledge resource for the member regarding updates and revisions to covered benefits; rate information for budget development; and other information related to quality planning, and will ensure that the Case Manager and/or the support broker accurately communicate up-to-date information to the member.

6. Provide a sample of the following tools and forms related to the Consumer Choices Option:

a. Self-assessment tool for members seeking to self-direct service;

See Attachment 4.4.6.a-1 Sample Self-Assessment Form.

b. Informed consent contract; and

See Attachment 4.4.6.b-1 Sample Informed Consent Contract.

c. Risk agreement.

See Attachment 4.4.6.c-1 Sample Risk Agreement Form.

7. Describe your approach for monitoring the quality of service delivery and the health, safety and welfare of members participating in the Consumer Choices Option.

Molina will comply with the provisions of Medicaid services as specified in Attachment 1 – Scope of Work, section 4.4 – 1915(c) HCBS Waivers, subpart 4.4.8.13 – Monitoring. Molina will monitor the quality of service delivery and the health, safety and welfare of members participating in the Consumer Choices Option. Additionally, we will monitor the implementation of the back-up plan. If any problems are identified as part of the monitoring process, the member will be given a self-assessment to determine what additional supports, if any, could be made available to assist them. At a minimum, the Care Coordinator will contact a 1915(c) HCBS waiver member within five (5) business days of scheduled initiation of services to confirm that the services are being provided and that the member's needs are being met.

Monitoring Self-direction/Consumer Choices Option

Molina's process for monitoring the appropriateness and effectiveness of home and community-based services (HCBS) provided to its members is encompassed in Molina's integrated care management process. The goal is to keep members in the community and ensure the right services from the right provider at the right time, effectively coordinating with the State and other qualifying programs to avoid duplication. Molina's methodology for monitoring the appropriateness of HCBS is as follows:

- Molina will assign each member with HCBS needs, as determined by the Health Risk Assessment (HRA) or as previously determined by DHS, a Case Manager who shall monitor the quality and appropriateness of service delivery and the health, safety and welfare of members
- For members with HCBS needs, Molina's Case Manager will conduct a complete and comprehensive in-person review and assessment at least annually and as necessary, to identify services needed and resources available to keep the member safe and healthy in the community. This assessment shall include long-term care needs such as environmental safety identifying items such as smoke detectors, pests/infestation, and trip and fall dangers; social supports; cultural sensitivities; and nursing home level of care as indicated.
- With input from the Care Team, including the member, the Case Manager will develop a care plan that reflects member preferences and needs identified in the comprehensive needs assessment and reassessment process, including appropriate provision of HCBS services.
- The Molina Case Manager shall monitor the Care plan, engage the member in self-care, maintain regular member contact through monthly to quarterly phone calls and quarterly to semi-annual in-person visits based on member need and level of care, and update the Care Plan as needed. Care Plan updates will be communicated to with all Care Team members.
- As part of the care planning process, for members participating in the Self-Directed Community Benefit, the Case Manager will coordinate and collaborate with the support broker and the Financial Management Services (FMS) vendor to ensure member needs are being met and members are receiving appropriate services.
- At least annually, Molina will develop and conduct reviews of the budgets for HCBS to ensure financially appropriate administration of such services to its members.
- Additional mechanisms for monitoring HCBS quality include but are not limited to:
  - Quality of care concerns;
  - Data review, including mortality, frequent Emergency Room or hospital use;
  - Member satisfaction surveys;
  - Care coordination feedback regarding HCBS services; and
  - Monitor compliance with drug therapy and efficacy.

Molina will establish specific criteria to determine appropriate HCBS services on both an individual and program level.

Ensuring the Health, Safety and Welfare of Members

To determine appropriate HCBS care and services on an individual level, Molina's Case Manager will conduct a comprehensive assessment, including a nursing facility level of care evaluation as indicated. This assessment is used to identify risks, understand needs, and assign appropriate services and resources to keep the member safe and healthy in the community. Approval of HCBS is based on the scoring of the assessment of Activities of Daily Living (ADLs), Instrumental Activities of Daily Living scale (IADLs), and other environment and clinical factors. Case Managers also rely on criteria in the Minimum Data Set (MDS) 3.0 data specified by CMS for determining if a consumer meets criteria for medical necessity. Examples of other benefit criteria that Molina's Case Managers will employ to approve appropriate

HCBS and personal care services include:

- Minor home modifications are approved only if documentation supports the requested item(s) as being necessary and related to the individual's disability or medical condition; and
- Adaptive aids and medical supplies are approved only if it provides a safe alternative to nursing facility placement. Items that are not of direct remedial or medical benefit to the individual are not approved.

To determine the appropriateness of HCBS services at the program level, Molina relies on the Utilization Management (UM) and Quality Improvement (QI) staff. Designated UM staff is responsible for monthly audits of HCBS authorizations for appropriateness and compliance with standard review criteria using the member care record which stores all authorization and care plan information. Utilization Management audits look for inappropriate authorizations by Case Managers and are used for future targeted training efforts, individual Case Manager interventions, or corrective action plans to ensure appropriateness of services going forward. Audits related to notification to Molina of a member's change in condition, the member's adherence to the care plan and critical incident reporting will be conducted monthly to identify trends for opportunities for improvement interventions.

Quality Improvement staff will be involved in reviewing quality performance indicators at the program level. The quality performance indicators include but are not limited to:

- Enhanced member satisfaction surveys (i.e., quality of life survey);
- Percentage of visits initiated on time (Electronic Visit Verification system);
- Number of days to start of care;
- Frequency of service interruptions or missed visits;
- Number of member complaints;
- Members requesting transfer to another agency;
- Total HCBS spending per member;
- Reduction in authorized hours; and
- Reduced member dependency.

Trends in HCBS service delivery identified by the UM or QI staff, indications of fraud and abuse, and other quality and service measures in the provision of HCBS are brought to the Quality Improvement Committee monthly for review and intervention as indicated.

Molina will use these individual and program criteria to determine and establish an appropriate HCBS service delivery model so that all members requiring long-term care services in the state are able to obtain the particular services that are appropriate to their health needs. Criteria will address all domains necessary to provide effective and appropriate HCBS services to keep members safe and healthy in the least restrictive setting.

Defining Successful Outcomes

For individual level HCBS services, outcome measures will be based on member functioning and member experience. For example:

- Member functioning
  - Utilization
    - Decrease in hospital admission and readmission
    - Decrease in Emergency Room visits
  - Transitions in Care
    - Decrease in nursing home placements

  - Successful SNF to home-based transitions
  - Direct measures of current and past functioning
    - Maintain ADLs
    - Maintain IADLs
  - Social functioning
    - Increased or maintained participation in social and recreational activities
  - Adherence to care plan
    - Goals met
    - No missed appointments
- Member experience
  - Member Satisfaction surveys.

The Case Manager is responsible for oversight, monitoring, and intervention for individual level HCBS services, using the Care Plan as a gauge to set expectations, goals and established desired outcome measures.

For program level HCBS services, outcome measures will be based on overall program performance in the following areas:

- Member satisfaction (CAHPS);
- Percentage of services delivered (i.e., hours delivered/authorized hours);
- Serious health and safety service incidents (critical incidents);
- Nursing home placement per thousand;
- Change in health condition reports per thousand;
- Emergency Room visits per thousand;
- Initial hospitalizations per thousand;
- Hospital readmission rate;
- De-institutionalization success rate; and
- Regularity of PCP visits.

The Quality Improvement Committee is responsible for oversight of the program level HCBS measures.

MOLINA HEALTHCARE

Face to Face Comprehensive Needs Assessment (FCNA)

Member Name: **Responder's Name:** **Relationship to Member:** **Member Healthcare ID:** **DOB:** **State:**	**Home Phone: ( )** **Cell Phone: ( )** **Other: ( )** **Date: / /**

QUESTION		RESPONSE
Hello this is _____ with Molina. I am hoping to talk with you today about your health and see how you are doing. Do you have a few minutes that we could talk?		
COMMUNICATION/ CULTURAL NEEDS/ GENERAL		
1.	Do you or a covered family member have a language need other than English?	☐Yes ☐No
1A.	If yes, choose language:	☐Arabic ☐Russian ☐Mandarin ☐Somali ☐Spanish ☐Vietnamese ☐Other Other:
2.	Do you have a healthcare power of attorney or legal guardian? If yes, specify name and phone number:	☐Yes ☐No
3.	Do you have any hearing, vision, cultural, religious or language needs that medical community providers need to be aware of to provide appropriate care and information to you? If other, describe:	☐ Hearing ☐ Language ☐ Religion/spiritual ☐ Vision ☐ None ☐ Other
4.	Are you able to understand instructions from and communicate needs to your provider or caregiver?	☐Yes ☐No
5.	Do you have a living will or an advanced directive in place? **(If no, provide explanation on what an advanced directive is and how to obtain.)**	Living will ☐ Yes ☐No Advanced directive ☐Yes ☐No If no, enter the date when you provided explanation on what an advanced directive is and how to obtain: DATE ☐Request further information ☐Declined discussion
6.	Other than yourself, would you like your caregiver or any other individual involved in discussions about your care? If yes, who?	☐Yes ☐No

PROVIDERS

Provider Name	Specialty	Phone Number	Date of Last Appointment	Date of Upcoming Appointment

ADDITIONAL PROVIDER INFO and COGNITIVE SCREENING		
7.	Which physician(s) do you see most?	

MOLINA HEALTHCARE

Face to Face Comprehensive Needs Assessment (FCNA)

	frequently? (indicate name and specialty and/or PCP)?	
7A.	When was the date of your last visit?	
8.	Can you get a ride to the doctor's office or clinic if needed?	☐Yes ☐No ☐Not Sure
9.	Do you have any trouble with your memory?	☐Yes ☐No
10.	Now I'm going to ask you a few basic questions about your memory. What is the year? What is the month? What is the day of the week?	 Correct: ☐Yes ☐No Correct: ☐Yes ☐No Correct: ☐Yes ☐No
11.	I am going to name 3 objects. Please wait until I say all 3 words, then you repeat them back to me. Please remember what the 3 objects are because I am going to ask you to name them again later. Apple Table Car	 Recall: ☐Yes ☐No Recall: ☐Yes ☐No Recall: ☐Yes ☐No
HEALTH & WELLNESS		
12.	Compared to others your (your child's) age, would you say your (your child's) health is…..	☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor
13.	What is your main health concern right now?	
14.	Do you/your child have any of these conditions? If other, list/describe: **What is your surgical history?**	☐ Amputation **Include diagnosis year for CCM** ☐ Asthma ☐ Breast Cancer ☐ Cancer ☐ Coronary Artery Disease ☐ Congestive Heart Failure ☐ COPD (Chronic Obstructive Pulmonary Disorder) ☐ Developmental Delay ☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ HIV/AIDS ☐ Kidney Disease ☐ LTSS/LTC ☐ Major Depression ☐ Major Organ Transplant ☐ Malnutrition ☐ Behavioral Health Issues (Schizophrenia, Bipolar, PTSD, ADHD, Autism) ☐ Paralysis ☐ Pregnancy ☐ Seizure Disorder ☐ Sickle Cell ☐ Stroke ☐ Substance Use ☐ None
14A.	If other, list/describe:	

MOLINA HEALTHCARE

Face to Face Comprehensive Needs Assessment (FCNA)

15.	What were the 3 objects I asked you to remember? Apple Apple Table Car	Recall: ☐Yes ☐No Recall: ☐Yes ☐No Recall: ☐Yes ☐No **Two "No" answers above? Add cognitive screening needed to individualized care plan at end of THRA.**
16.	Have you (your child) had any of the following screenings?	☐ Adolescent/Child Immunization ☐ Breast Cancer Screening ☐ Colorectal Cancer Screening ☐ Diabetes Eye Exam ☐ Glaucoma ☐ Influenza ☐ Lead Screening in Children ☐ One provider visit in the last year ☐ Pneumonia ☐ Well Child Visit ☐ None (Support member with scheduling appt as needed) ☐ Other
16A.	If other, list/describe:	
17.	How many times have you (your child) visited the ER in the last 6 months? Reason for Visit:	☐ Less than 2 visits ☐ 3-5 visits ☐ 6 visits or more ☐ None
18.	How many times have you (your child) been admitted to the hospital in the last 6 months? Reason for visit:	☐ 1 admission ☐ 2 admissions ☐ 3 – 4 admissions ☐ 5 admissions or more ☐ None
19.	Do you have pain?	☐Yes ☐No
19A.	If Yes, where is your pain located?	
19B.	If yes, do you have a pain management plan?	☐Yes ☐No
19C.	If yes, rate your worst pain on a 1-10 scale (10 worst).	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
20.	How much of the time have you experienced pain or hurting over the last 5 days?	☐Almost constantly ☐Frequently ☐Occasionally ☐Rarely ☐Unable to answer
21.	Over the past 5 days, have you limited your day-to day activities because of pain?	☐No ☐Yes ☐Unable to answer
22.	Over the past 5 days, has pain made it hard for you to sleep at night?	☐No ☐Yes ☐Unable to answer
23.	Have you fallen any time in the last 2-6 months?	☐No ☐Yes ☐Unable to remember
23A.	If yes, did you have any fractures or injuries related to a fall in the last 6 months?	☐No ☐Yes ☐Unable to remember

MOLINA HEALTHCARE

Face to Face Comprehensive Needs Assessment (FCNA)

24.	What is your weight?	☐pounds ☐kilograms Date:
25.	What is your height?	☐inches ☐centimeters
26.	BMI Calculation	CALCUALTION AUTO POPULATES
27.	Do you have any problems with the following-	☐Loss of liquids/solids from mouth when eating or drinking ☐Holding food in mouth/cheeks or residual food in mouth after meals ☐Coughing or choking during meals or when swallowing medications ☐Complaints of difficulty or pain with swallowing ☐None of the above
28.	Have you lost weight in the last few months?	☐Yes ☐No ☐Unsure
29.	If yes, how much?	☐Less than 5 pounds ☐Five to ten pounds ☐Ten pounds or more
30.	Was the weight loss on purpose?	☐Yes ☐No
31.	Do you have any problems that make it hard for you to chew or swallow?	☐Yes ☐No
31A.	If yes, check any or all:	☐Mouth/tooth/dentures ☐Pain or difficulty swallowing ☐Taste ☐Nausea ☐Saliva production ☐Other
31B.	If other, please describe:	
32.	Have you gained weight in the last few months?	☐Yes ☐No ☐Unsure
33.	How much?	☐Less than 5 pounds ☐Five to ten pounds ☐Ten pounds or more
34.	Was the weight gain on purpose?	☐Yes ☐No
35.	Are you on a special diet for medical reason?	☐Yes ☐No
35A.	If Yes, check any or all:	☐Calorie supplement ☐Low fat/cholesterol ☐Low salt/sodium ☐Low sugar/carb ☐Other
35B.	If Other, please describe:	
36.	How long have you been on this diet?	
37.	Why are you on this diet?	
38.	Do you have any problems with vision?	☐Blindness ☐Cataracts ☐Glaucoma ☐Macular degeneration ☐Required glasses or assistive devices to read ☐Retinal disease ☐Unable to read medications and/or large font ☐Uses Braille ☐None ☐Other
38A.	If other, list/describe:	
39.	Do you have any problems with hearing?	☐Deafness ☐Hearing aid ☐Hearing loss ☐Inactive hearing aid ☐Other amplification device ☐Requires TTY ☐Uses American Sign Language ☐None ☐Other

MOLINA HEALTHCARE

Face to Face Comprehensive Needs Assessment (FCNA)

39A.	If other, list/describe:	
40.	Do you have any problems with your bladder such as urinary leakage or getting to the bathroom quickly enough?	☐Always continent ☐Occasionally continent (less than 7 episodes of incontinence) ☐Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) ☐Always incontinent (no episodes of continent voiding) ☐N/A (member has catheter, urinary ostomy, or no urine output for the last 7 days)
40A.	If so, have you talked your doctor about treatment options?	☐ Yes ☐ No Please describe:
41.	Do you have any problems with your bowels such as getting to the bathroom quickly enough for bowel movements?	☐Always continent ☐Occasionally continent (One episode of bowel incontinence) ☐Frequently incontinent (Two or more episodes of bowel incontinence, but at least one continent bowel movement) ☐Always incontinent (no episodes of continent bowel movements) ☐N/A (member had ostomy, or no bowel movement for the last 7 days)
41A.	If so, have you talked your doctor about treatment options?	☐ Yes ☐ No Please describe:
42.	Do you have problems with constipation?	☐Yes ☐No
43.	Do you have any skin problems (e.g. rashes, wounds, burns or skin tears) that are slow to heal?	☐Yes ☐No
44.	Are you experiencing any problems with balance when doing the following: a. Moving from seated to standing position? b. Walking (with assistive device if used)? c. Turning around and facing the opposite direction when walking? d. Moving on and off the toilet? e. Surface to surface transfer (transfer between bed and chair or wheelchair)?	 ☐Steady at all times ☐Not steady, but able to stabilize without human assistance ☐Not steady, only able to stabilize with human assistance ☐Steady at all times ☐Not steady, but able to stabilize without human assistance ☐Not steady, only able to stabilize with human assistance ☐Steady at all times ☐Not steady, but able to stabilize without human assistance ☐Not steady, only able to stabilize with human assistance ☐Steady at all times ☐Not steady, but able to stabilize without human assistance ☐Not steady, only able to stabilize with human assistance
MEDICATION INFORMATION		
45.	Do you take 6 or more prescribed medications per day?	☐Yes **Do you take any past relevant medications? (CCM Only)** ☐No
46.	Do you have any allergies to medications?	☐Yes ☐No
47.	Do you take your medications as prescribed?	☐Yes ☐No
47A.	If no, which ones?	

MOLINA HEALTHCARE

Face to Face Comprehensive Needs Assessment (FCNA)

47B.	If no, what is preventing you from taking your medication as prescribed by your physician?	☐ Cost, ☐ Scheduling, ☐ Side Effect, ☐ Transportation, ☐ Understanding, ☐ Visual Problems, ☐ None, ☐ Other If Other, list/describe:
47C.	If No, plan to address adherence issues:	☐ Provided member with education ☐ Sent educational materials ☐ Scheduled MTMP appointment
48.	Do you understand what your medications are for and why you are taking them?	☐ Yes ☐ No
49.	Do you use tobacco?	☐ Yes ☐ No
50A.	If Yes, would you like help quitting?	☐ Yes ☐ No ✔ **If Yes, refer to Molina Smoking Cessation program.**

Prescribed Medication	Dose	Route	Frequency	Start Date	Stop Date	Reason for Medication

Over the Counter Medication	Dose	Route	Frequency	Start Date	Stop Date	Reason for Medication

Vitamins/Supplements Herbals	Dose	Route	Frequency	Start Date	Stop Date	Reason for Medication

SOCIAL

51.	What is your current living situation?	☐ Homeless ☐ Lives alone ☐ Lives in a group home ☐ Lives in a shelter ☐ Lives with other family ☐ Lives with others unrelated ☐ Lives with spouse ☐ Lives in assisted living fac. ☐ In a Nursing Facility ☐ Other
51A.	If Other, please describe:	
52.	Is your living situation at risk (loss of housing, domestic violence, dangerous neighborhood):	☐ Yes ☐ No
52A.	If Yes, please explain:	
53.	Over the last 2 weeks, how often have you been feeling down, depressed or hopeless?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
54.	Over the last 2 weeks, how often have you had little interest or pleasure in doing things?	☐ Not at all ☐ Several days ☐ More than half the days

MOLINA HEALTHCARE

Face to Face Comprehensive Needs Assessment (FCNA)

		☐Nearly every day
ADLs/IADLs		
55.	Are you **receiving** assistance with any of the following activities: **includes eating, toileting, transferring*	☐**Bathing** ☐Dressing ☐Housekeeping ☐**Personal Care** ☐**Preparing Meals** ☐Setting up medications ☐Shopping ☐None ☐**Adult Day Services** ☐Finances ☐Other **Response 1,4,5, or 9 will qualify mbr for LTSS referral at end of THRA**
56.	Do you **need** assistance with any of the following? (same options) **includes eating, toileting, transferring* If other, please list/describe:	☐Bathing ☐Dressing/Putting on clothes ☐Toileting ☐Hygiene/Grooming ☐Maintaining Continence ☐Eating/Feeding yourself ☐Walking and transferring (such as moving from bed to wheelchair ☐Other ☐None
57.	Do you **need** assistance with any of the following? If other, please list/describe:	☐Managing finances ☐Shopping ☐Preparing Meals ☐Using the telephone or help with other communication devices ☐Managing your medications ☐Housing/home maintenance/housekeeping ☐Other ☐None
58.	Are you using the following equipment or assistive devices? If other, list/describe:	☐Cane ☐C-pap or Bi-pap ☐Elevated toilet seat ☐Glucometer ☐Home vent ☐Hospital bed ☐ebulizer ☐Oxygen ☐Scooter ☐Suctioning ☐Shower chair ☐Walker ☐Wheelchair ☐None ☐Other
PARTICIAPTION		
59.	We have programs that can help you feel more confident in your ability to manage your (your child's) health. Are you interested in receiving any of our care coordination services? Would you like to work with a member of our team? Please rate your desired level of involvement in the care planning process:	 ☐Yes ☐No ☐Actively Managed ☐Mail only ☐Monitoring
HOME ENVIRONMENT ASSESSMENT		
60.		☐Building in need of repairs ☐Furniture in need of repairs ☐Inadequate/insufficient plumbing

MOLINA HEALTHCARE

Face to Face Comprehensive Needs Assessment (FCNA)

		☐ No/insufficient heat ☐ No/insufficient hot water ☐ No air conditioning ☐ Stove not working ☐ Refrigerator not working ☐ Telephone not working ☐ No telephone ☐ Flooring/rugs loose ☐ Light inadequate ☐ Stairs/railings unsafe ☐ Ramp needed/unavailable ☐ Grab bars/handrails needed ☐ Bathtub/shower unsafe ☐ Commode unsafe ☐ Electrical hazards ☐ Insect or other pests present ☐ Unsanitary conditions or odors ☐ Other-specify in comments Comments

What goals would you like to set and work on to improve your overall health? How would you prioritize these goals? (High, Med, Low)

We will hold an ICT meeting to review your case and make sure that all of your needs are being met, would you like to attend this or would you like me to discuss the outcome with you after the meeting?

Molina Healthcare, Inc.

Individualized Care Plan Report

Assigned Case Manager:

Paula T. [888-562-5442 x 155748]

Member Details:

Member Last Name:	[redacted]	Member First Name:	[redacted]
Member Middle Initial:		Date Of Birth:	**03/01/1986**
Medicaid ID:		Medicare ID:	
Medicaid Effective Date:		Medicare Effective Date:	
Current Acuity Level:	**Medium**		
Gender:	**M**	Primary Language:	**English**
Primary Phone:	**562-555-1010**		
Home Phone: Mobile Phone:			
Current Mailing Address:	**100 Ocean Hill, Long Beach CA 90801**		

E-Mail Address:

Caregiver / Representative: **CYFD - Case Worker, Smith, Ann**

Contact Phone: Relationship To Member: **Caregiver**

Associated Providers (past 6 months):

No associated provider.

Reason for Recent Health Visits/ Tests and/or Diagnosis History:

No chronic health concern.

Recent Authorizations (past 6 months):

No authorization.

No lab data.

Assessments (past 6 months):

Date	Name
03/19/2015	Face to face comprehensive needs assessment
03/02/2015	PHQ-9 [Score: 9]
02/12/2015	PHQ-9 [Score: 11]
01/12/2015	PHQ-9 [Score: 14]

Enrollment in Inpatient / Outpatient Facilities (past 6 months):

Skilled nursing facility 1-2-15

Molina Healthcare, Inc.

Individualized Care Plan Report

Allergies:

No allergy

Medications / Rx (past 6 months):

No Medication.

Individual Care Plan (ICP) Goals, Barriers, Interventions & Outcomes:

Type	Description	Priority	Due Date
Problem: Transition Plan			
Goal [Short Term]	Member safely and effectively transitions from a nursing facility back to his daughter's home in Long Beach		05/28/2015
Intervention	Case manager will contact member and perform a comprehensive needs assessment prior to his transition back home.	High	04/28/2015
Intervention	Case manager will identify the medical and HCBS short and long-term supports and interventions needed for member's safe and successful community reintegration.	High	04/28/2015
Intervention	Case manager to provide assistance to member and his daughter that facilitate self-directed services, including education on hiring providers and enlisting the help of a fiscal intermediary where appropriate.	High	05/14/2015
Intervention	Case member, member and member's daughter will develop an Individualized Care Plan that integrates member's Transition Plan and HCBS Service Plan based on member's needs, goals and preferences.	High	05/14/2015
Intervention	Case manager, member and his daughter set a goal date of 5-28-15 for transition taking into account their strength, desires, resources and needs	High	04/28/2015
Intervention	Case manager to provide care coordination to ensure the order and delivery of necessary DME, to include a hospital bed, Hoyer lift, and electric wheel chair.	High	05/25/2015
Intervention	Case manager to ensure that a home visit is scheduled to assess member's home environment before transition.		05/28/2015
Outcome	Member's caregiver and support service needs are met and member is satisfied with the services now in place.	High	05/28/2015
Outcome	Member has made a successful transition from NF to the community with his care and safety needs met.	High	05/28/2015

Goal [Long Term]	Ongoing care coordination and support from Molina Community-based Case Manager		08/28/2015
Intervention	Case manager, member and daughter integrate into the HCBS Care Plan a contingency plan to follow up with member to ensure that caregiver and support services are in place when there is a provider no-show or the daughter needs assistance with care. The contingency plan will identify Member's neighbor Sam Smith who is available and has agreed to act as a paid caregiver to member in emergencies and to provide respite as needed.	High	05/10/2015
Intervention	Case manager ensures a RN home visit is scheduled to assess member's environment for safety and wellness.	Moderate	06/28/2015

Molina Healthcare, Inc.

Individualized Care Plan Report

Intervention	Case manager educates member and daughter on the importance of regular PCP and specialist visits to maintain member's current improved level of functioning and health.	Moderate	06/28/2015
Intervention	Case manager to educate member and daughter on self-management techniques to address member's health conditions and safety risks.	Moderate	06/28/2015
Intervention	Member has transportation for medical appointments available from his daughter, neighbor/caregiver and his health plan benefits.	Moderate	06/28/2015
Intervention	Case manager monitor's member's Service Plan to ensure the necessary and appropriate supports are in place and are within member's state-approved annual budget.		08/28/2015
Intervention	Case manager to facilitate communication among member's Interdisciplinary Care Team to promote member receives the appropriate care, in the appropriate setting, at MD recommended timeframes.		
Outcome	Member adheres to his prescribed medication regime.		08/28/2015
Outcome	Member maintains his follow-up appointments.		08/28/2015
Outcome	Member maintains good management of his health conditions and has the necessary ongoing supports in place to lives safely in his home environment as he desires.		08/28/2015
Problem: Self-management activities			
Goal [Long Term]	Member will complete all health maintenance screening tests and vaccinations as scheduled.		08/28/2015
Intervention	Care manager to educate member and daughter on the importance of receiving all recommended vaccinations.	Low	08/28/2015
Intervention	Care manager will review medications and coach to bag meds and bring to MD appointments with member's daughter who will provide med management.	Low	08/28/2015
Intervention	Care manager will provide member's daughter with caregiver support group information		
Outcome	Member receives all recommended vaccinations.	Low	08/28/2015
Outcome	Member is able to follow medication regimen	Low	08/28/2015
Outcome	Member's daughter has adequate assistance and caregiver support in place	Low	08/28/2015

Molina Healthcare, Inc.

Individualized Care Plan Report

Service Plan:

Date	Expense Type	Units/Visits	Notes
04/21/2015	Waiver Transportation	26	transportation for medical visits - 26 round trips for 12 months at $25 each.
04/21/2015	Home Medical Equipment	12	Oxygen concentrator provided by ACME Durable Medical Equipment for 12 months at $35.00 a month. Ordering MD Dr. Brady.
04/21/2015	Nutritional Assessment	1	Dr. Brady ordered nutritional assessment and dietary education 1x in 12 months.
04/21/2015	Homemaker/ Chore services	12	Homemaking services provided by Daisy Housekeepers. One three-hour visit a month for 12 months.

Member Consent:

No Member Consent.

Telephone Assistance:

If you have any questions or concerns about your membership or current coverage, please call 1-888-562-5442, Monday-Sunday from 7:00 AM to 6 PM PST. If you are hearing impaired, please call TTY/TDD at 1-877-688-9891 to assist you with your call.

If you have trouble accessing the member portal, please call 1-866-449-6848.

If you have any questions or concerns about recent medical/health issues, please call 1-888-275-8750 or TTY/TDD at 1-866-735-2929. (Español: 1-866-648-3537; TTY/TDD 1-866-833-4703.)

If you have any questions or concerns about the information on this plan of care or the services you're receiving, please call your case manager.

----- END OF REPORT -----

Molina Healthcare, Inc.

Individualized Care Plan Report

Reminders for Doctor Appointments:

A visit with your doctor is a chance for you to let him/her know:

1. How you feel.
2. Share your family's health history.
3. Your list of medications (current and past).
4. Discuss any health concerns you may have.

Things you can do ahead of time in order to have a successful visit:

1. Call ahead and get an appointment.
2. Let them know if you need an interpreter. We need at least three days' notice to get an interpreter for you.
3. Make a list of all your questions and needs.
4. Bring a list of your medications.
5. If you cannot keep your appointment, please call your doctor's office to re-schedule.

At your appointment:

1. Try to get to your doctor's office about 15 minutes early. You may need to fill out paperwork.
2. Tell your doctor your concerns and symptoms as best as you can.
3. If you did not understand something your doctor said, be sure to ask questions.
4. Please try to be patient if your doctor is running late. He/she may have a very sick patient that needs extra time.
5. Sometimes your doctor may have an emergency. They may have to go to the hospital to take care of another patient. This can happen with doctors that deliver babies. You may be given the option of seeing another doctor at the office.
6. Your doctor may refer you to a specialist or other health care provider. Be sure to ask if you will need to make the appointment. Sometimes your doctor's office will make it for you. Ask for the phone number of the other doctor's office before you leave.

Confidential Protected Health Information:
This document contains confidential protected Health Information that is protected under HIPAA and other applicable federal and state laws. This information is intended only for use by the Authorized User or entity to which it has been disclosed. Any unauthorized use or disclosure of this information should be reported to Molina Healthcare's privacy Hotline.

Molina Healthcare Inc

Individualized Care Plan Report

Assigned Case Manager:

Kelly G. [888-562-5442 x 000]

Michelle H. [8885625442 x 311762]

William B. [8885625442 x 316018]

Member Details:

Member Last Name:	DOO	Member First Name:	SCOOBY
Member Middle Initial:	E	Date Of Birth:	01/01/1212
Medicaid ID:	1780610335	Medicare ID:	
Medicaid Effective Date:	01/01/2078	Medicare Effective Date:	
Current Acuity Level:	High		
Gender:	M	Primary Language:	ENGLISH
Primary Phone:		Home Phone:	8642254262 ext Unkn
Mobile Phone:			
Current Mailing Address:	111 East. Rocky Road Lane APT 1R SLC, UT 84111		
E-Mail Address:			
Caregiver / Representative:	Not Applicable	Contact Phone:	
Relationship To Member:			

Associated Providers (past 6 months):

No associated provider.

Reason for Recent Health Visits/ Tests and/or Diagnosis History:

DX Date	DX Code	Description
01/13/2014	196.0	NEOP, MLIG, LYMPH HEAD/NECK/FACE
01/24/2014	196.0	NEOP, MLIG, LYMPH HEAD/NECK/FACE
01/24/2014	199.1	NEOP, MLIG, NOS
02/25/2014	285.9	ANEMIA NOS
01/24/2014	311	DISORDER, DEPRESSIVE NEC

Recent Authorizations (past 6 months):

No authorization.

No lab data.

Assessments (past 6 months):

No assessment.

MOLINA HEALTHCARE

Molina Healthcare Inc

Individualized Care Plan Report

Enrollment in Inpatient / Outpatient Facilities (past 6 months):

No enrollment in Inpatient/Outpatient facility.

Allergies:

No allergy

Medications / Rx (past 6 months):

Date	Physician	Medication	Refill Status
8/28/2014	DOKTOR, FUHN E.	CEPHALEXIN CAP 500 MG (30)	Filled: 8/28/2014;
8/28/2014	DOKTOR, FUHN E.	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG (20)	Filled: 8/28/2014;
7/25/2014	DOKTOR, FUHN E.	LEVETIRACETAM TAB 1000 MG (60)	Filled: 7/28/2014;
7/25/2014	DOKTOR, FUHN E.	VENLAFAXINE HCL CAP SR 24HR 75 MG (BASE EQUIVALENT) (30)	Filled: 7/25/2014;
5/29/2014	DOKTOR, FUHN E.	ZOLPIDEM TARTRATE TAB 10 MG (30)	Filled: 5/29/2014; 5-refill remaining
5/29/2014	DOKTOR, FUHN E.	ZOLPIDEM TARTRATE TAB 10 MG (30)	Filled: 7/9/2014; 4-refill remaining
5/29/2014	DOKTOR, FUHN E.	ZOLPIDEM TARTRATE TAB 10 MG (30)	Filled: 8/13/2014; 3-refill remaining
5/29/2014	DOKTOR, FUHN E.	ZOLPIDEM TARTRATE TAB 10 MG (30)	Filled: 9/23/2014; 2-refill remaining

Individual Care Plan (ICP) Goals, Barriers, Interventions & Outcomes:

Type	Description	Priority	Due Date
Problem: Waiver Service Plan			
Goal [ShortTerm]	Mr. Doo has a back-up plan in the event the personal care attendant does not arrive to help him with his shower		11/19/2014
Intervention	If personal care attendant does not arrive to assist with bi-weekly shower, Mr. Doo will notify Daughter Velma Dinkley at 800-123-1234 to assist		11/19/2014
Outcome	Mr. Doo has a copy of the back-up plan on the fridge and can tell daughter and CM what it is		11/19/2014
Goal [ShortTerm]	Mr. Doo has an emergency response plan in the event there is an environmental emergency that puts him at risk for harm		11/19/2014
Intervention	Care Manager assists member in developing an emergency response plan		11/19/2014
Intervention	Care Manager reviews the emergency response plan with the member every 6 months		04/18/2015
Outcome	Mr. Doo has a copy of the emergency response/disaster preparedness form		11/19/2014
Goal [ShortTerm]	Level of Care criteria is reviewed and Mr. Doo is financially eligible for waiver		12/19/2014

Molina Healthcare Inc

Individualized Care Plan Report

Type	Description	Priority	Due Date
Intervention	The care manager ensures the Level of Care determination is received from the LOC Assessment completed by waiver service coordinator (Area Agency on Agency)		11/19/2014
Outcome	The member meets the state's Level of Care criteria to receive services		12/19/2014
Goal [LongTerm]	The member will receive ongoing monitoring for additional interventions for safety or unmet needs and satisfaction with service plan and providers		10/20/2015
Intervention	Care manager will update the service plan as needed		01/18/2015
Intervention	Member will receive ongoing monitoring for potential abuse, neglect, exploitation and other incidents		10/20/2015
Intervention	Care manager completes face-to-face visits with member every 90 days and as needed for any significant changes in health/functional status		11/19/2014
Outcome	The member is safe and maintaining their current level of health and functional status		02/17/2015
Outcome	Member's service plan is meeting the member's needs and he expresses satisfaction with services and providers		02/17/2015
Problem: TOC			
Goal [LongTerm]	Mr. Doo will be made aware of and follow his doctor's instructions when he leaves the hospital		01/18/2015
Intervention	Care Manager will review all instructions with Mr. Doo		01/18/2015
Outcome	Mr. Doo will repeat back the instructions		01/18/2015
Problem: Substance Use with other conditions			
Goal [ShortTerm]	Mr. Doo will stay Sober "to see his grand-kids"		12/19/2014
Intervention	Care Manager will give Mr. Doo resources to help him stay on path (these providers specialize in substance use)		12/19/2014
Intervention	Care Manager will educate member/family on effect of alcohol on disease process in the elderly population		12/19/2014
Outcome	Mr. Doo attended alcohol counseling class or AA meeting		12/19/2014
Outcome	Member recited one (1) complication related to alcohol consumption		12/19/2014
Problem: Knowledge of Diabetes Management			
Goal [ShortTerm]	Mr. Doo understands his diabetes		12/19/2014
Intervention	Care Manager will refer to Diabetic Education class		12/19/2014
Intervention	Care Manager will educate member on correlation between (Diabetes Blood Test) HgbA1C and blood sugar levels		12/19/2014
Intervention	Care Manager will facilitate notification to treating practitioner of potential health care or safety issues		12/19/2014
Outcome	Member able to teach back the ABC's of diabetes		12/19/2014
Outcome	Member able to teach back risk factors that contribute to diabetes		12/19/2014
Outcome	Member able to teach back the consequences of uncontrolled diabetes		12/19/2014
Outcome	Member able to teach back correlation between HgbA1C & blood sugar and interventions to improve		12/19/2014

Molina Healthcare Inc

Individualized Care Plan Report

Type	Description	Priority	Due Date
Outcome	Member has completed educational classes		12/19/2014
Problem: Bathroom Safety			
Goal [ShortTerm]	Member will make immediate simple changes in bathroom to improve safety (bath bench/ Shower Hose)		11/19/2014
Intervention	Care Manager will order Home Safety Equipment		11/19/2014
Outcome	Member is able to teach back reasons for us safety modifications in bathroom		11/19/2014

Service Plan:

Date	Expense Type	Units/Visits	Cost per Unit/Visit	Total
10/20/2014	Personal Care services	10	$64.00	$640.00
10/20/2014	Home Medical Equipment	1	$110.00	$110.00
10/20/2014	Home Medical Equipment	1	$28.00	$28.00
			SUM	$778.00

Member Consent:

No Member Consent.

Telephone Assistance:

If you have any questions or concerns about your membership or current coverage, please call 1-888-562-5442, Monday-Sunday from 7:00 AM to 6 PM PST. If you are hearing impaired, please call TTY/TDD at 1-877-688-9891 to assist you with your call.

If you have trouble accessing the member portal, please call 1-866-449-6848.

If you have any questions or concerns about recent medical/health issues, please call 1-888-275-8750 or TTY/TDD at 1-866-735-2929. (Español: 1-866-648-3537; TTY/TDD 1-866-833-4703.)

If you have any questions or concerns about the information on this plan of care or the services you're receiving, please call your case manager.

----- END OF REPORT -----

MOLINA HEALTHCARE

Molina Healthcare Inc

Individualized Care Plan Report

SIGNED ACKNOWLEDGEMENT AND RECEIPT OF INDIVIDUALIZED CARE PLAN

On behalf of member SCOOBY DOO, the Individualized Care Plan (dated 10/20/2014) has been fully reviewed between the following case manager and the member (or their authorized representative or designated caregiver). A copy of this Individualized Care Plan will be made available to the member and/or their authorized representative or designated caregiver.

_____ _____

Signature of Member or Authorized Representative

Member/Representative Signature Date

_____

Print Name of Member or Authorized Representative

_____

If Authorized Representative, declare Relationship to Member

_____ _____

Signature of Case Manager

Case Manager Signature Date

_____

Print Name of Case Manager

[Optional to use unless required by contract provisions and/or state regulations]

Molina Healthcare Inc

Individualized Care Plan Report

Reminders for Doctor Appointments:

A visit with your doctor is a chance for you to let him/her know:

1. How you feel.
2. Share your family's health history.
3. Your list of medications (current and past).
4. Discuss any health concerns you may have.

Things you can do ahead of time in order to have a successful visit:

1. Call ahead and get an appointment.
2. Let them know if you need an interpreter. We need at least three days' notice to get an interpreter for you.
3. Make a list of all your questions and needs.
4. Bring a list of your medications.
5. If you cannot keep your appointment, please call your doctor's office to re-schedule.

At your appointment:

1. Try to get to your doctor's office about 15 minutes early. You may need to fill out paperwork.
2. Tell your doctor your concerns and symptoms as best as you can.
3. If you did not understand something your doctor said, be sure to ask questions.
4. Please try to be patient if your doctor is running late. He/she may have a very sick patient that needs extra time.
5. Sometimes your doctor may have an emergency. They may have to go to the hospital to take care of another patient. This can happen with doctors that deliver babies. You may be given the option of seeing another doctor at the office.
6. Your doctor may refer you to a specialist or other health care provider. Be sure to ask if you will need to make the appointment. Sometimes your doctor's office will make it for you. Ask for the phone number of the other doctor's office before you leave.

Confidential Protected Health Information:
This document contains confidential protected Health Information that is protected under HIPAA and other applicable federal and state laws. This information is intended only for use by the Authorized User or entity to which it has been disclosed. Any unauthorized use or disclosure of this information should be reported to Molina Healthcare's privacy Hotline.

MOLINA HEALTHCARE

Mailed Health Risk Assessment (MHRA)

Member Name: **Responder's Name:** **Relationship to Member:** **Member Healthcare ID:** **DOB:** **Address:** **State:**	**Home Phone: ( )** **Cell Phone: ( )** **Other: ( )** **DATE: / /**

	QUESTION	RESPONSE
COMMUNICATION/ CULTURAL NEEDS/ GENERAL		
1	Do you or a covered family member have a language need other than English?	☐Yes ☐No
1a	If yes, choose language:	☐Arabic ☐Mandarin ☐Russian ☐Somali ☐Spanish ☐Vietnamese ☐Other
1b	If other language, please specify	Other:
2	Do you have a healthcare power of attorney or legal guardian?	☐Yes ☐No
2a	If yes, please specify name and phone number.	Name: Phone#:
3	Do you have any hearing, vision, cultural, religious or language needs that medical community providers need to be aware of to provide appropriate care and information to you?	☐Hearing ☐Language ☐Religion/Spiritual ☐Vision ☐Other ☐None
3a	If yes, please describe:	
4	Which provider/physician(s) do you see most frequently?	**indicate name and specialty and/or PCP*
5	When was the date of your last visit?	**list provider name and date*
6	Can you get a ride to the doctor's office or clinic if needed?	☐Yes ☐No ☐Not Sure
6a	If no, please describe:	
7	Other than yourself, would you like your caregiver or any other individual involved in discussions about your care?	☐Yes ☐No
7a	If yes, who?	

MOLINA HEALTHCARE

Mailed Health Risk Assessment (MHRA)

COGNITIVE SCREENING		
8	Do you have any trouble with your memory?	☐Yes ☐No
HEALTH & WELLNESS		
9	Do you/your child have any of these conditions?	Asthma ☐
		Behavioral Health Issues: ☐
		Describe: (i.e. Schizophrenia, Bipolar, PTSD,ADHD, autism)
		COPD (Chronic Obstructive Pulmonary Disorder) ☐
		Congestive Heart Failure ☐
		Diabetes ☐
		High Blood Pressure ☐
		High Cholesterol ☐
		Major Depression ☐
		Amputation ☐
		Cancer ☐
		Coronary Artery Disease ☐
		Developmental Delay ☐
		HIV/AIDS ☐
		Kidney Disease ☐
		Major Organ Transplant ☐
		Malnutrition ☐
		Paralysis ☐
		Pregnancy ☐
		Seizure Disorder ☐
		Sickle Cell ☐
		Stroke ☐
		Substance Use ☐
		Other ☐
9a	If other, list/describe:	
10	What is your most recent weight?	☐Pounds ☐Kilograms Date:
11	What is your height?	☐Inches ☐Centimeters
12	Compared to others your or your child's age, would you say your or your child's health is:	☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor
13	What is your main health concern right now?	

MOLINA HEALTHCARE

Mailed Health Risk Assessment (MHRA)

		Screening	Screening Date
14	Have you or your child had any of the following screenings?	☐ Adolescent/Child Immunization	
		☐ Breast Cancer Screening	
		☐ Colorectal Cancer Screening	
		☐ Diabetes Eye Exam	
		☐ Glaucoma	
		☐ Influenza	
		☐ Lead Screening in Children	
		☐ One provider visit in the last year	
		☐ Pneumonia	
		☐ Well Child Visit	
		☐ Other Screenings	
14a	If other, list/describe:		
15	How many times have you or your child visited the ER in the last 6 months? Reason for Visit:	☐ Less than 2 visits ☐ 3-5 visits ☐ 6 visits or more ☐ None	
16	How many times have you or your child been admitted to the hospital in the last 6 months? Reason for visit:	☐ 1 admission ☐ 2 admissions ☐ 3 – 4 admissions ☐ 5 admissions or more ☐ None	
17	Do you or your child have pain?	☐Yes ☐No	
17a	If yes, rate your pain on a 0-10 scale (10 worst).	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	
17b	If yes, do you have a pain management plan?	☐Yes ☐No	
MEDICATIONS			
18	Do you take 6 or more prescribed medications per day?	☐Yes ☐No	
19	Do you have any allergies to medications?	☐Yes ☐No	
19A	If yes, describe reactions:		
20	Do you take your medications as prescribed?	☐Yes ☐No	
21	Do you understand what your medications are for and why you are taking them?	☐Yes ☐No	

MOLINA HEALTHCARE

Mailed Health Risk Assessment (MHRA)

22	Are you taking any medications that have not been prescribed including Alcohol, OTC (Over the Counter) drugs and other substances? If yes, please explain:	☐ Yes ☐ No
23	Do you use tobacco?	☐ Yes ☐ No
23a	If Yes, would you like help quitting? Comments:	☐ Yes ☐ No
SOCIAL		
24	What is your or your child's current living situation? If other, please describe:	☐ Homeless ☐ Lives alone ☐ Lives in a group home ☐ In a Nursing Facility ☐ Lives in a shelter ☐ Lives in assisted living facility ☐ Lives with other family ☐ Lives with others unrelated ☐ Lives with spouse ☐ Lives in out-of-home placement ☐ Lives in out-of-state medical facility ☐ None of the above ☐ Other
25	Are you **receiving** assistance with any of the following activities: **includes eating, toileting, transferring* If other, please list/describe:	☐ Adult Day Services ☐ Bathing ☐ Dressing ☐ Finances ☐ Housekeeping ☐ Personal Care ☐ Preparing Meals ☐ Setting up medications ☐ Shopping ☐ None ☐ Other

MOLINA HEALTHCARE

Mailed Health Risk Assessment (MHRA)

26	Do you need assistance with any of the following? **includes eating, toileting, transferring* If other, please list/describe:	☐ Bathing ☐ Dressing/Putting on clothes ☐ Eating/Feeding yourself ☐ Hygiene/Grooming ☐ Maintaining Continence ☐ Toileting ☐ Walking and Transferring ☐ Other ☐ None
27	Do you need assistance with any of the following? If other, please list/describe:	☐ Housing/home maintenance/housekeeping ☐ Managing your medications ☐ Managing finances ☐ Preparing Meals ☐ Shopping ☐ Transportation ☐ Using the telephone or help with other communication devices ☐ Other ☐ None
28	Are you using the following equipment or assistive devices? If other, list/describe:	☐ Cane ☐ C-pap or Bi-pap ☐ Elevated toilet seat ☐ Glucometer ☐ Home vent ☐ Hospital bed ☐ Nebulizer ☐ Oxygen ☐ Scooter ☐ Suctioning ☐ Shower chair ☐ Walker ☐ Wheelchair ☐ None ☐ Other
29	Do you have a living will or an advanced directive in place?	Living will ☐ Yes ☐ No Advanced Directive ☐ Yes ☐ No ☐ Request further information ☐ Decline further information

MOLINA HEALTHCARE

Mailed Health Risk Assessment (MHRA)

30	Over the last 2 weeks, how often have you had little interest or pleasure in doing things?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
31	Over the last 2 weeks, how often have you been feeling down, depressed or hopeless?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
32	Have you ever been worried about how you are thinking, feeling or acting?	☐ Yes ☐ No
33	Has anyone ever expressed concerns about how you were thinking, feeling, or acting?	☐ Yes ☐ No
34	Have you ever harmed yourself or thought about harming yourself?	☐ Yes ☐ No
PARTICIPATION		
35	We have programs that can help you feel more confident in your ability to manage your or your child's health. Are you interested in receiving any of our care coordination services? Would you like to work with a member of our team?	☐ Yes ☐ No ☐ Yes ☐ No

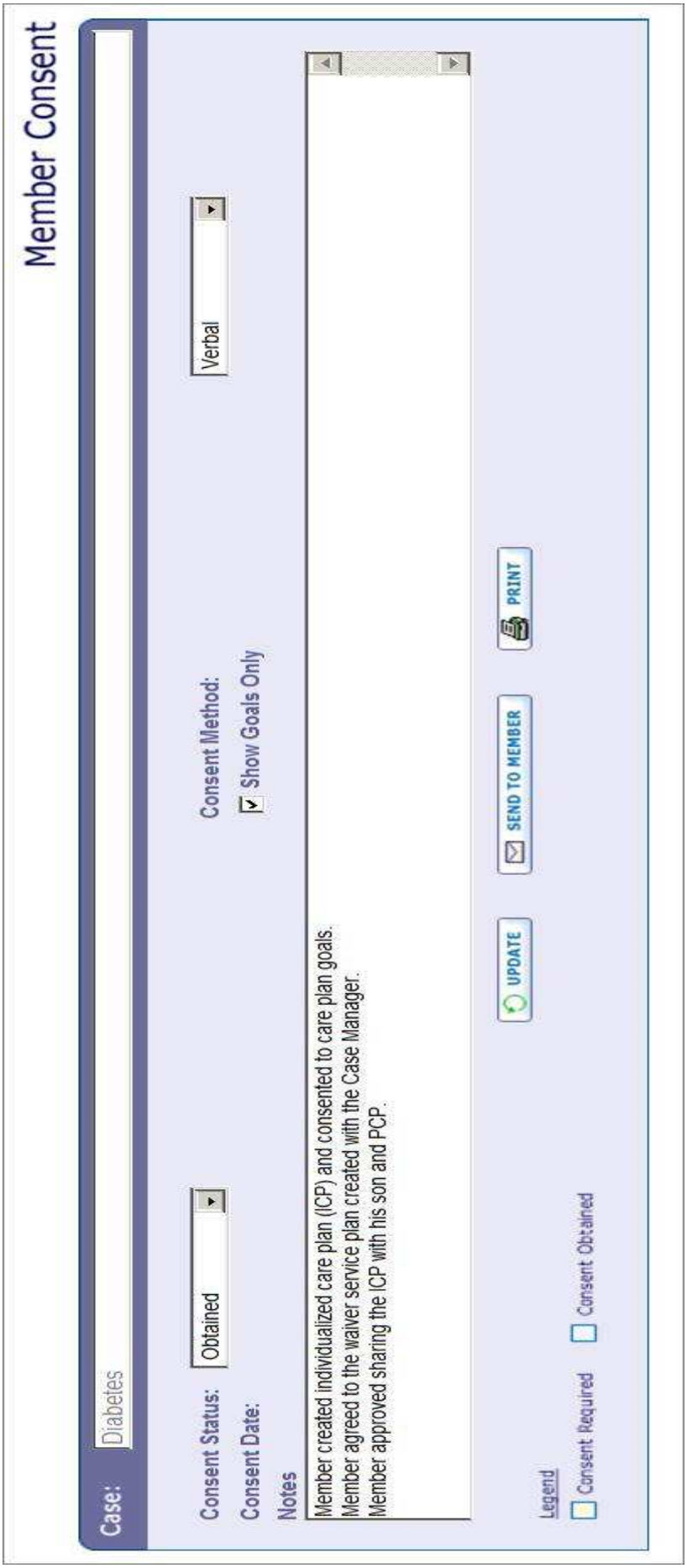
[[Molina Medicare Options Plus] [Healthy Advantage] HMO SNP is a Health Plan with a Medicare Contract and a contract with the state Medicaid program. Enrollment in [Molina Medicare Options Plus] [Healthy Advantage] depends on contract renewal.

[Healthy Advantage Plus HMO is a Health Plan with a Medicare Contract. Enrollment in Healthy Advantage Plus depends on contract renewal.]

This information is available in other formats, such as Braille, large print, and audio.

This information is available for free in other languages. Please call our customer service number at <(800) 665-3086>, TTY/TDD <711>, 7 days a week, 8 a.m. - 8 p.m., local time. Esta información está disponible gratuitamente en otros idiomas. Por favor, comuníquese a nuestro número de teléfono para servicio al cliente al <(800) 665-3086>,TTY/TDD <711>, los 7 días de la semana, de 8:00 a.m. a 8:00 p.m., hora local.

Attachment 4.4.6b-1- Informed Consent Contract (within Molina's Data Platform)



Documentation of Member Consent is documented within the Care Plan.

Service Plan:

Date	Expense Type	Units/Visits	Notes
10/21/2014	Rate increased by provider	20	

Member Consent:

The Member BARRETTA R TEST has acknowledged that this Individualized Care Plan has been developed in part with their personal participation, cooperation and input. The Member has also reviewed this document with their case manager and has consented to the contents and guidelines outlined in this Individualized Care Plan:

ConsentDate	Method	Status	Notes
4/9/2015 4:01:38 PM	Verbal	Obtained	Member created individualized care plan (ICP) and consented to care plan goals. Member agreed to the waiver service plan created with the Case Manager. Member approved sharing the ICP with his son and PCP.
4/9/2015 3:59:13 PM	Verbal	Obtained	Member created individualized care plan (ICP) and consented to care plan goals. Member agreed to the waiver service plan created with the Case Manager. Member approved sharing the ICP with his son and PCP.
7/23/2014 11:25:10 AM	Verbal	In Process	
7/23/2014 11:25:10 AM	Verbal	Obtained	

Telephone Assistance:

If you have any questions or concerns about your membership or current coverage, please call 1-888-562-5442, Monday-Sunday from 7:00 AM to 6 PM PST. If you are hearing impaired, please call TTY/TDD at 1-877-688-9891 to assist you with your call.

If you have trouble accessing the member portal, please call 1-866-449-6848.

If you have any questions or concerns about recent medical/health issues, please call 1-888-275-8750 or TTY/TDD at 1-866-735-2929. (Español: 1-866-648-3537; TTY/TDD 1-866-833-4703.)

If you have any questions or concerns about the information on this plan of care or the services you're receiving, please call your case manager.

Name: TEST, BARRETTA **Subscriber ID#:** 507985214001C

Risk Assessment and Agreement *(v.1)*

Printed 4/9/2015

** Required*

Risk Assessment Discussion Information

Person(s) present and dates of discussion:

Name and Date _____ Date _____

Name and Date _____ Date _____

Name and Date _____ Date _____

Name and Date _____ Date _____

Name and Date _____ Date _____

Risk Assessment Member Information

What are the identified risks based upon the assessment? _____
_____
_____

Include description of environmental hazards, behaviors such as non-compliance with prescribed medication and/or treatment or therapy regimen, durable medical or adaptive equipment that is in need of repair or failure to seek medical treatment or see a provider or other risks

What is the possible harm or negative consequence(s) that may result from the Member's choice or action: _____
_____
_____

What actions could be taken to reduce the risks listed above _____
_____
_____

(e.g. replacing durable medical equipment, identifying a provider, providing education about transportation benefits, assistance that could be provided from other supports in or outside of the home)

What is the Member/guardian's understanding of the risk(s) and how does the Member wish to address the risk(s)? _____
_____
_____

Internal use only

I:679|V:1|R:Jeff Rebultan|U:784|C:CM2459329|M:OHI092740745595|E:5|Q:1,3,5,7,9,11,12,13,14

Molina's billing and collections practices result in administrative efficiencies and appropriate stewardship of state taxpayer dollars while maintaining high standards of customer service for providers and members.

SECTION 5 – BILLING AND COLLECTIONS

Please explain how you propose to execute Section 5 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Molina understands, agrees and will comply with all Billing and Collections requirements in accordance with Section 5 of Attachment 1—Scope of Work.

Molina will leverage experience from its sister health plans that collect member premiums to fulfill the Iowa High Quality Healthcare Initiative billing and collections requirements.

Molina's Experience Managing the Cost Sharing Obligations of Dual Eligible Members

Molina has extensive experience managing cost sharing obligations for dual eligible individuals through the administration of Medicare Special Needs Plans, Medicare Advantage Prescription Drug plans and Medicaid contracts, where Medicaid is the payor of last resort. Molina has experience managing dual eligible individuals with both Molina Medicare and Medicaid coverage and members receiving Medicare services through either fee-for-service Medicare or another Medicare HMO. We currently provide quality and cost-effective care for 80,000 dual eligible members and administers Medicare Special Needs Plans (SNP) serving 45,000 dual eligible members in nine states (Molina is the eighth largest D-SNP in the country and the fifth largest D-SNP in our markets). Molina is also currently serving 35,000 dual eligible members in our Medicare-Medicaid Plans (MMP Demonstration plans) in five states. In all possible coverage scenarios, Molina coordinates cost share in a systematic manner to ensure all dual eligible members receive primary Medicare benefits and any additional Medicaid benefits and services available to them through state programs.

All cost share obligations for dual eligible individuals are either covered primarily through Medicare or secondarily through Medicaid. Members are not obligated to pay for cost share amounts for covered services under the hold harmless requirements of federal law with respect to dual eligible cost sharing. Molina identifies the two payment sources and tracks primary and secondary claims.

When Molina holds both Medicare and Medicaid coverage for a dual eligible member, Molina manages the operational portion of the member's cost share obligation via its claims system structure. Claims received in Molina's system are systematically reviewed to determine the primary payment source, and then processed against the correct primary and secondary sources. This process is seamless to providers; only one claim submission is necessary when members are enrolled with Molina for Medicare and Medicaid coverage.

Molina's provider contracts and Provider Manual contain specific language to explain the cost share protections for dual eligible members. The Provider Manual is updated annually and is available on Molina's Provider Web Portal. Molina's Medicare Member Services team works closely with members in cases where they may be erroneously billed and the team reaches out to providers to educate them about primary and secondary billing processes. The Member Services team then follows up with a letter to the provider to ensure clear communication and understanding of all aspects of dual eligible cost share management. If an issue cannot be resolved by Member Services, it is referred to Provider Services for additional support to obtain prompt resolution.

Molina's Experience with Collecting Patient Pay Amounts

Molina' experience with managing patient pay amounts includes more than 255,000 Qualified Health Plan (QHP) members participating in its Healthcare Exchanges. In addition, since 2009, Molina's sister health plan, Molina Healthcare of New Mexico, has been successfully managing the collection of premiums from members enrolled in the State Coverage Insurance (SCI) program. Molina Healthcare of New Mexico contracted with the New Mexico Human Services Department (HSD) to provide coverage for approximately 16,000 SCI members. SCI is a cost sharing health plan for uninsured adults offered to individuals with incomes up to 200% of FPL. SCI is offered directly to individuals but may also be utilized by employers with less than 50 eligible employees. The SCI enrollment process requires regular information exchange between HSD and Molina Healthcare of New Mexico; Molina Healthcare of New Mexico is notified of eligible members, and HSD is notified of those members who have completed the enrollment process and met monthly premium payment timelines for each month of enrollment.

Molina Healthcare of New Mexico is paid with a combination of a capitation paid by HSD in conjunction with payments received directly from the individual or the employer. Monthly premium amounts are determined by the New Mexico Income Support Division (ISD). If a member is enrolled as an individual, Molina Healthcare of New Mexico invoices these members directly. For members enrolled through an employer, Molina Healthcare of New Mexico invoices the employer directly.

Molina's current operating system (JD Edwards Accounts Receivable system or JDE) is used to manage premium invoices and receivables for SCI members. This automated system tracks client demographics, category of eligibility (COE), premium payment, billing, cash application and payment history. SCI members are invoiced monthly based on their COE, and payments are applied based on receipts received by the bank. Delinquent notices are generated for members whose premiums are 60 days past due. Members who do not pay the outstanding premium by the due date indicated on their notices are terminated for non-payment of premium in accordance with HSD regulations. These terminations are included on a monthly eligibility roster submitted to HSD indicating the termination reason for processing in their system. Based on its experience in New Mexico, Molina Healthcare of Iowa is well positioned to begin billing patient pay amounts and will have the system required to generate, monitor and report on amounts due.

Molina's Experience Managing Marketplace Premium and Billing & Claim Administration

Molina Healthcare, Inc. has been licensed to provide Individual Health Plans as a Qualified Health Plan (QHP) under the Marketplace in nine states since the initial launch of the Affordable Care Act in 2014. We sell individual policies in seven Federally Facilitated Marketplace states (Utah, New Mexico, Texas, Ohio, Michigan, Wisconsin and Florida) and in two State Marketplaces (Washington and California). Molina provides enrollment, premium and billing administration, coordinating with CMS or contracted State Marketplaces on the receipt and handling of 834 eligibility transactions, enrollment and premium administration on a subscriber-specific basis monthly. This administration requires the execution of complex matters, such as 1) invoicing with federal subsidies (Advanced Premium Tax Credits); 2) computing federal grace periods (90 days); and 3) state-specific grace periods (which vary). Molina offers multiple ways for members to pay their Marketplace premiums, including Auto Payment (recurring) via credit/debit card or checking account via ACH, receipt of premium payment by mail, phone or Money order (via MoneyGram). Today, Molina Healthcare, Inc. processes premium administration for over 255,000 Marketplace members monthly.

For members enrolled within the Marketplace, Molina Healthcare, Inc. provides claim administration of Bronze, Silver & Gold Metal plans in all nine states, and in addition, provides Catastrophic and Platinum level plans in CA under contract with Covered California, the State based Marketplace. Plan administration includes medical, vision and pharmacy benefits, inclusive of the application of deductibles, copayments, coinsurance and annual out-of-pocket maximum administration for over 255,000 members.

5.1 General Provisions

1. Describe your strategy for ensuring total cost sharing does not exceed five percent (5%) of quarterly household income.

During the health plan implementation phase, Molina's claims adjudication system will be configured to track annual household income of each member based on the enrollment eligibility files received from the state. Member copayments paid to the provider will be reconciled quarterly to identify members who have reached the 5% out-of-pocket maximum. Providers will be notified as members reach their maximum copayments. In those instances when the member has inadvertently exceeded the maximum copayment, Molina will reimburse the member the amount of overpayment and deduct that same amount from the provider's contractual payment.

2. Describe processes for making information on premium and cost sharing available to both members and providers.

Molina's Member Services Representatives receive information on premiums and cost sharing as part of their training curriculum, and are therefore able to answer member and provider questions about both topics. If providers have complex questions related to premiums and/or cost sharing, Molina's Member Services Representative will refer the provider to their assigned Provider Services Representative, who will answer their inquiry. Information about premiums and cost sharing will also be available to network providers in the Provider Manual, as well as in provider orientation materials.

Members will be able to find information in writing about premiums and cost sharing on the Member Website and in the Member Handbook, which directs members to contact Member Services if they have additional questions. Such information also appears on the member's ID card if their plan includes out-of-pocket expenses for services. Additionally, Molina fully supports the state's Healthy Behaviors Program, in which adherent members achieving the prescribed healthy behaviors will have their premium responsibility waived. Molina understands that there are approximately 30,000 enrollees that have achieved the Healthy Behavior Program requirements, and we are happy to comply with the proposed protocols approved by CMS. Molina will implement policies and procedures to ensure compliance, including establishing mechanisms to track member completion of the healthy behaviors and educating members on the importance and benefits of healthy behavior completion.

5.2 Reserved.

5.3 Copayments

1. Indicate if you propose to implement State Plan copayments on populations in addition to the Iowa Health and Wellness Plan and hawk-i members.

It is not Molina's practice to apply copayments above and beyond those required or mandated by state Medicaid agencies; therefore we do not propose to implement additional copayments for other populations defined as covered entities in this RFP. Molina is, however, prepared to implement any copayments currently in place for the Well Kids in Iowa (hawk-i) program. Molina anticipates that we may potentially review opportunities on new proposals to implement copayments, if necessary, but only to the extent that advancements in member accountability do not result in reductions in access and support necessary to sustain quality for high-need and/or low income members.

Due to the looming submission deadline for certification as a qualified health plan (QHP) for the plan year beginning on January 1, 2016, Molina will not be able to participate in the Iowa Health and Wellness

Plan until we can be issued QHP certification by the Iowa State/Federal Partnership Health Insurance Exchange. Molina anticipates that, upon award of a contract, we will apply for QHP certification with CMS on May 15, 2016 and will receive approval by the Iowa State/Federal Partnership Health Insurance Exchange to offer these benefits beginning on January 1, 2017.

2. Describe how exempt populations and services as outlined in Section 5.3.1 and 5.3.2 will not be charged copayments.

Molina's robust process for identifying and codifying IDHP eligibility groups and benefits includes customizing copayment amounts. Exempt populations and services are defined in Molina's core processing system, QNXT, to exclude copayments.

5.4 Patient Liability

1. Describe your proposed methodology for notifying providers of the patient liability amount and paying providers net of the applicable patient liability amount.

Molina notifies providers about the concept of patient liability through provider reference materials as well as during orientation and training for those providers who render services to which patient liability may be applied. A provider is notified of the specific patient liability deducted from a claim on the remittance advice that is sent to the provider with their payment. Molina's remittance advice includes a message with the specific amount of patient liability that was deducted from a claim.

Molina has developed and implemented a robust solution to deduct patient liability from claims that supports state-specific requirements, including but not limited to custom pricing, daily pro-ration and retroactive adjustments. Molina's claims processing system, QNXT, allows for a custom hook, called AutoQ, to be inserted into the claims adjudication process. The AutoQ solution allows us to build and apply custom pricing logic that would not normally be integrated into the QNXT system. Molina uses AutoQ to calculate the patient liability to be applied to a claim and store the amount to the claim. AutoQ calculates the net pay amount, so the claim is finalized accurately and consistently. The patient liability amount is included on the remittance advice to the provider along with other payment information, and providers are paid net of the applicable patient liability amount.

5.5 IDPH Sliding Scale

1. Describe how your organization will ensure the IDPH approved sliding fee schedule is implemented among network providers.

To ensure that the IDPH-approved sliding fee schedule is implemented among network providers, Molina inserts a custom hook, called AutoQ, into the claims adjudication process on QNXT, Molina's claims processing system. AutoQ allows us to build and apply custom pricing logic that would not normally be integrated into the QNXT system. Molina will configure our contracts in the system to route claims where the IDPH sliding fee pricing would apply to the AutoQ solution. AutoQ will then calculate the appropriate price using the IDPH-approved sliding fee schedule, and route the claim back to QNXT to complete the adjudication process. Molina has experience leveraging the ability to build custom pricing logic in AutoQ for other similar custom pricing situations and will ensure the effectiveness of this process for the IDPH-approved sliding fee schedule.

Molina has extensive experience implementing value-based Pay for Performance programs that align economic incentives that drive quality improvement and lower costs.

SECTION 6 – PROVIDER NETWORK REQUIREMENTS

Please explain how you propose to execute Section 6 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Molina understands, agrees and will comply with all Provider Network Requirements set forth in accordance with Section 6 of Attachment 1—Scope of Work.

6.1 General Provisions

1. Describe how you plan to meet all network composition requirements.

Network Development and Contracting

Molina's provider network development and contracting strategy is wholly focused on coordinating the health care needs of Iowa's wide range of eligible populations, including meeting the comprehensive physical, social, behavioral health and preventive needs of all members. The network composition of Molina's Iowa High Quality Healthcare Initiative will ensure:

- A sufficient number, mix and geographic distribution of providers in accordance with General Access Standards set forth in Exhibit B, General Access Standards;
- Compliance with the state's plan to work with existing Medicaid providers who wish to participate in supporting the goals of the Initiative;
- That Molina's provider network will meet all applicable requirements of Iowa law and have the necessary and current licenses, certifications and accreditation and/or designation approval per state requirements; and
- Our robust network meets all 42CFR 438.206 requirements for the delivery of services in a culturally competent manner and will permit members to choose providers based on cultural preference.

To achieve this goal, Molina will meet all network composition requirements through the establishment and maintenance of a statewide network of compassionate physical, behavioral health/substance use disorder and LTSS providers, along with the state's FQHCs and RHCs. These providers will be aligned with our mission, agree to sign provider contracts built on applicable regulatory requirements and Molina's business standards, help meet or exceed applicable access criteria, and are committed to providing quality healthcare for low income members and those with special needs in support of and service to the Iowa High Quality Healthcare Initiative.

Our Iowa High Quality Healthcare Initiative provider network will include PCPs, specialists, large provider groups, behavioral health providers and related entities, targeted hospitals, nursing facilities, urgent care facilities, family planning and maternal/child health centers, FQHCs/RHCs and other long-term services and supports, safety net and, home and community-based providers, creating a robust statewide network secured by binding provider contracts.

Molina continues to secure Letters of Intent (LOIs) with providers who are not prepared to sign a provider contract at this time; LOIs will be converted to provider contracts prior to Molina's contract effective date under the Iowa High Quality Healthcare Initiative. Molina is focused on forging key strategic

relationships with targeted healthcare systems, FQHCs and RHCs and related providers to ensure access to coverage throughout all program service areas.

Utilizing GeoAccess and Quest Analytics (Quest ACC) network reporting platforms, and other key Provider Contracting department resources to ensure compliance with program adequacy and access standards, [redacted]

See Attachment 6.1.1-1 Molina Provider Network GeoAccess Maps behind Tab 5, which provides a geographic overview sample of Molina's proposed provider network coverage in support of the Iowa High Quality Healthcare Initiative.

In compliance with Iowa High Quality Healthcare Initiative Scope of Work, Section 6.2.2.9, Molina will also secure LOIs with the intent to contract with the IDPH-procured provider network for IDPH-funded substance use disorder treatment facilities to ensure its members have access to such covered services through the state.

Molina continues to build the size and scope of its Iowa High Quality Healthcare Initiative network with the intent to convert all signed provider LOIs into formal provider contracts by program Go-Live January 1, 2016.

Partnering with Iowa's Leading Health Care Services Providers

Molina has secured LOIs and/or verbal agreements to contract upon award with many of the state's largest hospital systems, clinics, provider groups, behavioral health providers, public health agencies, nursing facility systems, waiver services providers, and community-based specialty/ancillary services providers with the intent to contract before program go-live January 1, 2016. [redacted]

CONFIDENTIAL

Partnering with Iowa's Federally Qualified Health Centers

Molina has secured LOIs with many of the state's leading FQHCs and intends to sign contracts before program go-live January 1, 2016. FQHCs provide vital primary medical, behavioral and dental care services to historically underserved areas and populations.

CONFIDENTIAL

[redacted]

[redacted]

Serving Children with Special Health Care Needs - Partnership with University of Iowa Hospital Alliance

Our exciting partnership with the University of Iowa Hospital Alliance will allow Molina to provide critical covered services to infant, child and young adult members with diverse disabilities through three innovative Alliance programs currently providing comprehensive clinical and community supports services.

These vital programs will play an integral role in the Iowa Integrated Care Model and in the development and implementation of optimal care programs for infants, children and young adults currently enrolled in ID/DD/waiver programs. These programs will be supplemented with support from Molina Care Management and other vital community providers in the design and implementation of comprehensive programs for these populations.

Center for Disabilities and Development – As an integral part of University of Iowa Children's Hospital, the Center for Disabilities and Development (CDD) and is dedicated to improving the health and independence of infants, children and young adults with disabilities while supporting and enhancing access to related community resources.

The CDD has been designated by the Administration on Intellectual and Developmental Disabilities division of the Department of Health and Human Services as Iowa's University Center for Excellence in Developmental Disabilities. The CDD provides state-of-the-art diagnostic, evaluation and treatment services for thousands of young Iowans with complex disabilities, including, but not limited to: ADHD; autism spectrum disorders; behavioral disorders; brain injury; cognitive and learning disorders; cerebral palsy; developmental delay; spina bifida; Down Syndrome/intellectual disabilities; swallowing and growth disorders; sleep disorders; speech and hearing deficits; and assistive technology needs.

CDD faculty and staff support initiatives that focus on quality of life and assist individuals with disabilities and their families and/or caregivers at home and in the community. Depending on a child's specific physical and behavioral health care needs, CDD's diverse, person-centered clinical service offerings are built around an interdisciplinary care team that may include:

- Developmental behavioral pediatrician;
- Advanced Registered Nurse Practitioner;
- Registered Nurse, Medical Assistant, Nursing Assistant;
- Clinical psychologist;
- Speech-Language Pathologist;
- Audiologist;
- Physical and/or occupational therapist;
- Educational consultant;
- Social worker; and/or
- Dietitian.

The CDD ensures that person-centered care is provided to infants, children and young adults with a particular focus on the involvement of the local care team and educational system.

CONFIDENTIAL

Child Health Specialty Clinics (CHSC) –In partnership with families, service providers, communities, and other stakeholders along with the Iowa Departments of Human Service, Public Health, and Education, CHSC is a family-centered, community-based public health program serving Iowa infants, children and young adults with special health care needs. CHSC administers Iowa's Title V program for children and youth with special health care needs (CYSHCN), which ensures the delivery of services in a coordinated, family-centered and community-based System of Care.

CHSC operates a network of 13 regional centers statewide featuring experienced public health professionals and clinical providers collaborating with communities to build local partnerships, improve service coordination, and promote optimal child health. The clinics also work closely with multiple agencies and partners statewide, helping conduct needs assessments, provide technical assistance, training, and education, and evaluate CYSHCN program efficacy.

Center for Child Health Improvement and Innovation - The Center for Child Health Improvement and Innovation is focused on caring for children with special health care needs and their families/caregivers, as well as seeking innovations that improve overall health system performance and management. The center's mission is built upon four core competencies, including Advocacy, Service, Quality, and Innovation. The center's care model is likewise designed specifically to meet the unique health care needs of children and ensures that families have a voice in their children's healthcare decisions; supports collaboration with other child health stakeholders; and leverages the science of improvement methodology.

Supporting Children's Behavioral Health - Partnership with Orchard Place

Another excellent example of our statewide provider contracting strategy and our commitment to serving the Initiative's diverse populations, Molina has signed an LOI with Orchard Place, the only children's mental health center in central Iowa and a respected leader in the provision of children's behavioral health/substance use disorder and other critical services. Orchard Place serves some 10,000 children annually through five major facilities in the Des Moines area and offers a wide range of services, encompassing patient-centered residential, outpatient, in-home and care coordination programs that include:

- Mental Health Consultation/Education;
- Evaluation, Assessment, and Psychological Testing;
- Psychiatric Therapy;
- Residential Treatment;
- Outpatient Mental Health Therapy;
- School-based Therapy;
- Tutoring and Mentoring;
- Functional Family Counseling;
- Individual Counseling;
- Behavioral Health Intervention and Outreach;
- Anger Management;
- Social Skill Development;
- Alternative Education;
- Juvenile Court Programs;
- Preventative Alcohol and Substance Use Disorder Education;
- Substance Use Disorder Services;

- Trauma Informed Care;
- Child Care Resources and Referral;
- Suicide Prevention; and
- Care Coordination.

Serving Members with Brain Injury/Neurological Impairments -

CONFIDENTIAL

[redacted]

Delivering Quality Behavioral Telehealth to Iowa's Rural Populations

For the Iowa High Quality Healthcare Initiative, a key element of our provider network strategy has been to focus on where the covered populations reside when building the network, with particular emphasis on rural populations that are historically underserved.

Molina understands that the state faces significant challenges in ensuring key populations covered under the Iowa High Quality Healthcare Initiative have access to quality behavioral health services. The number of psychiatrists and psychologists in rural areas is much smaller than those in urban areas. For rural patients residing in long-term care facilities, in particular, access to quality behavioral health practitioners can become severely limited by time, geography, weather and/or road conditions.

Understanding these distinct challenges, Molina is in discussions with a Board-certified psychiatrist owned and operated behavioral health system utilizing an innovative statewide telehealth platform to deliver quality psychology, psychiatry, and related medication management services to rural Iowans, including:

- Psychiatric Services – Psychiatric evaluation, medication reconciliation and ongoing psychotropic medication management with a focus on clinically appropriate medication reduction;
- Psychotherapy Services – Diagnostic evaluations, individual therapy and family therapy;
- Behavioral Services Review – Interdisciplinary meetings with facility staff to discuss provider performance, progress notes, prescriptions, and general clinical items;
- Clinical Services Reviews – Interdisciplinary care plan meetings with specific focus given to the reduction of psychotropic medications and behavioral problems; and
- Assessment and Evaluations – Administration of psychological/cognitive evaluations to clarify diagnoses and assist with treatment planning.

The provider's statewide network currently offers behavioral telehealth services to patients residing in more than 100 long-term care facilities, including 47 Skilled Nursing Facilities, throughout rural Iowa. The network hosts some 30,000 behavioral telehealth visits annually and continues to grow rapidly, with visits project to more than double to 65,000 in 2015. In fact, the network currently provides quality behavioral telehealth services in 10 states overall.

CONFIDENTIAL

All patients with a psychiatric diagnosis and/or psychotropic medication receive an initial assessment. Treatment includes diagnostic evaluations, collaborative treatment management, education, and outcomes monitoring. Patients are able to interact directly with their providers via two-way, interactive videoconferencing from the comfort of the facility where they reside, and can be reliably evaluated, diagnosed, and treated by their providers with psychotherapy, medications, and other follow-up care, as required.

The telehealth network encompasses a robust roster of behavioral health providers representing a wide range of specialties. Providers are licensed to practice telepsychiatry and telepsychology in the State of Iowa and a number of neighboring states, and must adhere to strict behavioral health clinical protocols that meet CMS Guidelines as well as ACHA initiatives for Best Practices.

For the Iowa High Quality Healthcare Initiative, Molina and the provider may explore the potential expansion of the network's behavioral telehealth services capabilities to encompass rural clinics, hospitals, crisis service hotline, in-home behavioral management, and other rural health care facilities, as part of an ongoing effort to enhance our capability to support our rural members' unique behavioral health needs.

Molina is also working with the Salus Telehealth, and has held initial discussions about collaborating on the establishment of a telehealth network in Iowa. For example, Salus (the umbrella organization for the Georgia Partnership for Telehealth) operates a robust telemedicine network encompassing more than 250 physicians and 650 presentation sites supporting some 200,000 clinical encounters annually in rural communities across the state of Georgia. Salus oversees multiple affiliates leveraging telemedicine technology in 13 other states and five countries and has expressed interest in entering into the Iowa Medicaid market.

Ongoing Provider Network Build Activities

While Molina is securing LOIs with the intent of converting to provider contracts, Molina will also secure single case agreements with non-contracted providers to provide services to its Iowa High Quality Healthcare Initiative members on an as-needed basis. In these cases, we will continue to engage these providers to secure binding provider contracts, ensure minimal disruption of service delivery to members, and continually expand its network. Provider education will be made available to all providers, whether in or out-of-network, who provide care to members as described above. We will also conduct outreach on an as-needed basis through our care coordination activities, and in partnership with relevant Iowa state agencies.

Across its health plans in 11 states and the Commonwealth of Puerto Rico, Molina achieves its strategic provider network goals through prompt identification and effective recruitment of new providers in a given community, whether urban or rural. Molina has developed a provider contracting packet for providers not currently contracted with Molina. Provider Contracting staff will follow up with providers who do not return contracts in a timely manner.

Molina's Provider Services department is tasked with assisting our Contracting Team in identifying new providers through their work in those established communities. Recruitment of new providers, especially in an identified area of provider shortage, is given the highest priority within the Molina Provider Contracting department. Provider recruitment is a team effort led by Molina's Vice President of Network Management and Operations, Associate Vice President of Provider Contracting, and the respective Directors of Provider Contracting, with input from Provider Services Representatives and other Molina health services professionals. Molina's Chief Medical Officer and Vice President of Healthcare Services are active participants in network planning and development strategy.

Molina is committed to establishing a contracted network of providers that embrace their role in providing holistic, person-centered, and self-directed care delivery to Molina's Iowa High Quality Healthcare Initiative members. All providers serving Molina's Iowa High Quality Healthcare Initiative

members will be oriented and trained on our criteria for participation in integrated and individualized care planning, Interdisciplinary Care Team (ICT) participation, and support of a member's self-determination concerning their care options. We conduct provider orientation and training upon on-boarding of new providers, with annual training going forward as well as on an as-needed basis.

In addition, Molina recognizes many members have a well-established relationship with the care team that provides most if not all of their primary care. This team may be primary care-based, medical specialty-based, or may even be a behavioral health care team. Therefore, Molina strongly supports the patient-centered medical home (PCMH) and Integrated Health Home models, where members can receive case management and care coordination services from their "primary" team.

In addition to fee-for-service (FFS) and value based reimbursement provider payment models tied to quality performance measures, Molina has several patient-centered medical home (PCMH) contracting relationships where practices are paid a per member per month (PMPM) dollar amount to cover medical/health home services, such as case management and care coordination.

Molina's shared emphasis on improving access to needed medical services, improving quality of care, and improving efficiencies and cost effectiveness is critical and necessary given the challenges each member might face when trying to access health care services, especially in rural areas. Molina will complement its own "ground up" provider network construction efforts with support from locally-based strategic partners, providers and vendors, especially those with existing experience and capacity.

To achieve these important objectives, we are building key relationships with strategic health systems and are focused on securing agreements with integrated health systems statewide. To complete its remaining supporting network infrastructure, Molina has identified potential providers by utilizing historical state Medicaid program data, the National NPI database, FQHC and RHC lists, existing business relationships, referral lists from providers in the community, consultant contacts, community service agencies, and the Internet.

Molina's network development strategy is centered on identifying key community providers experienced in managing Iowa High Quality Healthcare Initiative populations. In working closely with these providers, we are focusing on building our network from the "community out", working closely with providers to identify other providers and organizations that have similar and complimentary capabilities. This approach will enable us to better integrate services and execute its case management model based on its network development strategy.

Molina's Member-Provider Satisfaction Committee

Ensuring network adequacy and managing required provider composition levels is a dynamic undertaking which requires continuous evaluation and input. To ensure the proper accountability and diligence, Molina's Member-Provider Satisfaction Committee oversees the implement of our network development and management process to ensure the creation of a sufficient network that provides the full continuum of physical health, behavioral health and long term services and supports (LTSS) for Iowa High Quality Healthcare Initiative members. The committee further ensures continuous evaluation, monitoring, and improvement of the network; solicits continuous feedback from stakeholders and experts in the community; and leverages existing relationships and innovative approaches with network partners.

Our Member-Provider Satisfaction Committee is a multi-disciplinary committee established to develop network strategies, review, analyze and act upon data and information obtained from network monitoring activities. This multi-disciplinary approach ensures that inter-related issues are communicated effectively throughout the organization, are analyzed from multiple perspectives, and that integrated solutions are developed. The committee is comprised of members from Molina's Provider Services, Network Contracting, Utilization Management, Finance and Quality Improvement departments, as well as our Chief Medical Officer and Plan President. Other health plan functional areas are included as needed. The committee also serves as the key force in addressing issues within the provider network and in developing

plans to improve the network.

The Member-Provider Satisfaction Committee meets on a regular basis, or as needed, to address issues that emerge from data analysis and reports throughout the previous month, including:

- Monitoring enrollment trends, member demographics, service utilization, and provider terminations;
- Utilizing GeoAccess analysis to ensure adequate geographic coverage, including languages spoken by providers to identify and match members' cultural and linguistic needs;
- Analyzing member grievances and appeals;
- Monitoring feedback from Molina Case Managers and Community Connectors about access concerns or provider gaps;
- Reviewing use of out-of-network providers;
- Monitoring Consumer Assessment of Health Plans (CAHPS) results;
- Monitoring Healthcare Effectiveness Data Information Set (HEDIS) and other standard measures to assess if members are adequately receiving services;
- Monitoring member-to-provider ratios by specialty and by service area;
- Reviewing surveys of network providers to determine if appointment access is meeting standards, including average wait times and geographic access standards;
- Reviewing audits of appointment availability and wait times, including secret shopper and site visits by provider representatives.

The Member-Provider Satisfaction Committee is further tasked with affecting operational changes in the provider network, analyzing issues and establishing appropriate courses of action to intervene or take corrective measures. The committee receives direction from high-level committees such as the Quality Improvement Committee, to analyze and, if appropriate, affect change. This might include targeting providers for additional training, conducting provider outreach, adding new providers to the network, or terminating non-performing providers.

Moreover, the Member-Provider Satisfaction Committee tracks deliverables and reports outcomes. Molina recognizes that all of these provider issues impact the health plan as a whole, and therefore must be addressed in a cohesive and comprehensive manner. Strategies for network growth and improvement emerge from these monthly meetings to enable efficient network management and provide clear and measurable goals. For example, Molina will ensure sufficient capacity is available in all service areas in accordance with the service accessibility standards specified in the Contract.

In-State Resources

Paul Muench will serve as the interim Contract Administrator/CEO/COO (President) of Molina Healthcare of Iowa with clear authority over the general administration and implementation of the requirements detailed in the Contract. Mr. Muench will be responsible for overseeing the entire operations of Molina Healthcare of Iowa, has full and final responsibility for contract compliance, and will foster a success-oriented, accountable environment. Upon contract award, Molina Healthcare of Iowa will begin the process of hiring a full-time Plan President/CEO to be located at our headquarters in Des Moines. The Plan President/CEO will work with network development contracting staff and consultants as needed on Iowa High Quality Healthcare Initiative provider network development project efforts. The Plan President/CEO will serve as the provider network development lead and coordinate both local and corporate efforts. In addition to hiring local positions such as a Vice President of Health Services, an Associate Vice President of Network Management and Operations, and a Project Manager, Molina will begin aggressive hiring additional in-state provider network development support staff shortly after contract award and in a quantity sufficient to produce and maintain the statewide provider network prior to the Iowa High Quality Healthcare Initiative's estimated timetable to begin enrollment.

Out-of-State Resources

Molina's corporate headquarters are located in Long Beach, California. We have a strong and growing health plans in California, Florida, Illinois, Michigan, New Mexico, Ohio, South Carolina, Texas, Utah, Washington and Wisconsin. We also established a new health plan in the Commonwealth of Puerto Rico, which went live April 1, 2015. In aggregate, these 12 health plans currently serve more than 3.2 million Medicaid, Medicare and Affordable Care Act Marketplace members. Molina's corporate Provider Network Strategy & Services staff has specific and extensive experience in our previous expansion efforts, both organic and via acquisition, and is actively engaged and helping coordinate the Iowa High Quality Healthcare Initiative provider network development project and efforts. Corporate staff is able to leverage best practices, playbooks and toolkits developed primarily from its collaboration within our existing business and hands-on experience in new markets and re-procurements. Molina will also direct resources from its other aforementioned state health plans in order to aid in network development.

Outside Vendors

In order to focus on the core provider network build (e.g., FQHCs, RHCs, behavioral health clinics, key hospital systems) Molina will utilize the services of certain highly credible provider network vendors, many of whom Molina has positive experiences with in its existing business, to assist in building certain aspects of the provider network. These vendors will also ensure all ordered services are delivered and provided; assess the need for additional services or when services are no longer required; and conduct assessments for waiver services enabling providers to offer more cohesive and effective Home and Community Based Services.

Out-of-State Providers

Molina has analyzed DHS utilization data and will continue to analyze utilization once the program is operational to help extend network coverage to include providers outside the program's service areas and ensure continuity of care, as needed. We will also access out-of-state providers through our existing contracted provider network as well as through our partner provider's robust behavioral telehealth network featuring a diverse roster of behavioral health practitioners licensed in the State of Iowa and bordering states that serves more than 100 rural long-term care facilities statewide. We are also exploring relationships with strategic providers that are on the state's borders, which members may tend to cross depending on where they reside.

Next Steps

Molina will continue to foster network development contracting and develop relationships to take advantage of the time between RFP submission and contract award. Upon award of a contract, Molina will work closely with DHS to develop communications messaging and materials to inform and update the provider network. To quickly position Molina in all program service areas statewide and demonstrate its serious commitment to the Iowa High Quality Healthcare Initiative, Molina will mobilize dedicated staff and resources using the following approach:

- Continuously generate updated GeoAccess maps to enhance and refine provider network development outreach, focal points and targeting activities;
- Work collaboratively with DHS to help identify and enhance geographic areas where eligible enrollees may have historically had difficulties accessing health care services;
- Implement a marketing plan to build recognition of the Molina name and continue its outreach efforts with all providers to secure contracts;
- Notify providers who have agreed to contract with Molina should it be a winner to negotiate a Iowa High Quality Healthcare Initiative contract;
- Immediately reach out and partner with hospitals, physicians and clinics, including affiliated groups, systems and associations across the state;

- Use direct mail, phone, email and fax outreach to providers throughout every program service area, along with as many face-to-face meetings as possible, to target hospitals, urgent care clinics, FQHCs, RHCs, family/child care centers, and other key medical facilities and providers;
- Reach out to provider organizations able to help communicate the message of Molina or connect Molina to providers such as the Iowa Medical Group Management Association, Iowa Medical Society and Iowa Primary Care Association;
- Partner with hospitals to facilitate communication between their medical staff and Molina; and
- Initiate conversations with social service agencies to develop partnership relationships.

Molina's National Provider Network Experience

Molina has extensive national experience in building robust statewide networks with the types and numbers of providers required to support populations similar to Iowa's unique health care needs.

As one of the nation's largest multistate healthcare organizations, Molina operates licensed health plans in 11 states and the Commonwealth of Puerto Rico with nearly 162,000 contracted primary, specialty, hospital/clinic, behavioral health/substance use disorder, Home and Community-Based Services and other Safety Net providers, along with a strong network of Rural Health Clinics (RHCs), Federally Qualified Health Center (FQHCs) and Indian Health providers, which combined serve more than 3.2 million members.

Our provider networks serve a growing membership enrolled in a number of government-sponsored health care programs supporting populations similar those covered under the Iowa High Quality Healthcare Initiative, including:

- Temporary Aid to Needy Families (TANF);
- Children's Health Insurance Program (CHIP);
- Aged, Blind or Disabled (ABD);
- Long-term Care (e.g., Long-term Supports and Services, Skilled Nursing Facilities, Institutionalized, Palliative Care);
- Medicare Advantage Special Needs Plan;
- Medicare-Medicaid Eligible (Dual Eligible);
- Children with Special Health Care Needs/Children on SSI;
- Foster Care;
- Home and Community-Based Services (HCBS);
- Native American Health (e.g., IHS, Tribal 638, I/T/U); and
- Marketplace (Patient Protection and Affordable Care Act).

On April 1, 2015, Molina launched its newest Medicaid health plan in the Commonwealth of Puerto Rico, with some 1,500 contracted primary, specialty, hospital, and other Home and Community-Based Services and Safety Net providers serving some 375,000 new members.

Molina is also participating in Medicare-Medicaid Plan (Dual Eligible) demonstrations in six states, twice as many as any MCO in the nation. Nationally reported data indicates that Molina currently has the largest enrollment of Dual Eligible individuals among MCOs nationwide as of December 2014.

Molina's provider-focused approach to member care also encompasses direct delivery, owning and/or operating 31 primary care clinics serving more than 125,000 patients in California, Florida, New Mexico, Utah, Virginia and Washington, providing deeper insight and understanding of the care delivery challenges faced by providers and members than any other health plan. Through these clinics, Molina's contracted providers collectively support some 162,000 annual primary care visits.

The combined services of all Molina's fiscal agent contracts, including its Molina Medicaid Solutions unit, which provides business processing and information technology administrative services to Medicaid agencies in five states, touch approximately 3.8 million Medicaid beneficiaries and 325,000 providers, making Molina one of the nation's largest Medicaid vendors.

2. Describe any counties or areas of the state and any provider types in those areas where you anticipate facing network development challenges. Discuss your mitigation strategies.

[redacted]

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

[redacted]

[redacted]

For example, Molina Healthcare of Utah has built one of the largest provider networks in Utah's sparsely populated Non-Wasatch Front service area, encompassing more than 1,800 providers, including 50 unique health care facilities that encompass RHCs, FQHCs and other facilities ably serving the unique health care needs of Molina members. To meet the State of Utah's rural network access and availability standards, the health plan's network also encompasses providers in the states of Arizona, Colorado, Idaho, New Mexico, Nevada and Wyoming, providing comprehensive services to Molina members residing in Utah's rural border communities.

Molina's commitment to innovative care delivery, especially in rural areas, also includes its ongoing support of the Centers for Medicare and Medicaid Innovation (CMMI) and long-term partnership with Project ECHO (Extension for Community Healthcare Outcomes), a highly successful rural telehealth program based in New Mexico. Project ECHO's innovative structure includes an outpatient intensivist team made up of a nurse practitioner, Registered Nurse, behavioral health specialist and two community health workers to provide intensive, whole-person outpatient care to high-risk members. Molina's sister health plan, Molina Healthcare of New Mexico has enjoyed a successful partnership with Project ECHO focused on educating rural providers on best-practice protocols, increasing provider access to case-based learning resources and lectures, and multiplying our capacity to treat a wider spectrum of its members' health conditions in New Mexico's Rural, Frontier and Tribal areas.

CONFIDENTIAL

Leveraging the national experience of its sister health plans, Molina will have policies and procedures in place to support continual development, monitoring and enhancement of its statewide Iowa High Quality Healthcare Initiative network, and ensure compliance with all urban and rural access and availability standards. Member access to care will be monitored on an ongoing basis by our network management staff and reported on a quarterly basis to our Quality Improvement Committee. Access will be reported monthly during the first year of program implementation. Quarterly reports will measure the provider network against documented access standards, identify any areas for improvement, and identify progress made to remedy any deficiencies identified in the previous quarter. We will actively monitor data, trends, feedback, and provider and care planning activities to identify network needs and gaps. Activities will include:

- Monitoring enrollment trends, member demographics, service utilization, and provider terminations;
- Utilizing GeoAccess analysis to ensure adequate geographic coverage, tracking adequate geographic coverage plus languages spoken by members and providers to identify and match cultural and linguistic needs;
- Analyzing member grievances and appeals;
- Monitoring feedback from Case Managers and Community Connectors about access concerns or provider gaps;
- Reviewing the number and types of requests for out-of-network providers;
- Monitor Consumer Assessment of Health Plans (CAHPS) for member self-reports of access;
- Monitoring Healthcare Effectiveness Data Information Set (HEDIS) and other standard measures to assess if members are adequately receiving services;
- Monitoring member to provider ratios by specialty and by service area;
- Annual surveys of network providers to determine if appointment access is meeting standards including average wait times and geographic access standards; and
- Periodic audits of appointment availability and wait times, including secret shopper and site visits by provider representatives.

In compliance with Iowa High Quality Healthcare Initiative Scope of Work, Section 6.2.3 Network Adequacy, Molina will document adequate network capacity upon entering the Iowa High Quality Healthcare Initiative Contract; at any time there is a significant change in the State's operation or the program, changes in services, changes in benefits, changes in payments, or enrollment of a new population; or as otherwise requested by the State.

For immediate program-related service issues, Molina's experienced Case Managers will identify the need for a non-contracted provider and coordinate with our Provider Contracting department to facilitate securing an LOI. Continued use of non-contracted providers will be reported to Molina's Network Management and Operations department for inclusion in network evaluations. In the long term, all issues related to access will be reported to and reviewed by our Network Management and Operations department and Quality Improvement Committee to ensure that a long-term solution is established. Interventions are designed to address specific access barriers, close gaps, and ensure timely development and enhancement of the network. With oversight responsibility, the Quality Improvement Committee will ensure successful implementation of interventions and will continue to analyze issues and discuss appropriate courses of action to intervene or take corrective measures. Interventions might include targeting providers for additional training, adding a new clinic or telemedicine capabilities, admitting new providers to the network, or termination of a provider contract.

Establishing a Rural Behavioral Telehealth Network

Focusing on the challenges that come with ensuring covered services are provided in key historically underserved rural areas, Molina secured on LOI with a statewide behavioral telehealth network provider

to deliver quality psychology, psychiatry, and related medication management services to rural Iowans.

The provider's statewide network currently provides behavioral telehealth services to patients, residing in more than 100 long-term care facilities, including 47 Skilled Nursing Facilities, throughout rural Iowa. The network hosts some 30,000 behavioral telehealth visits annually and continues to grow rapidly, with visits project to more than double to 65,000 in 2015. In fact, the network currently provides quality behavioral telehealth services in 10 states overall. The telehealth network includes behavioral health providers representing diverse specialties. Providers are licensed to practice telepsychiatry and telepsychology in the State of Iowa and a number of neighboring states, and must adhere to strict behavioral health clinical protocols that meet CMS Guidelines as well as ACHA initiatives for Best Practices.

Supporting Provider Satisfaction and Network Composition Compliance

Molina has developed several successful strategies to support PCP satisfaction and ensure network composition requirements including leveraging the expertise of a Member and Provider Committee comprised of representatives from various health plan functional areas, network providers and Molina members that reviews various health plan statistics and surveys and initiates actions to improve member and provider satisfaction; facilitating frequent communication exchanges with network providers, including direct outreach such as joint operations meetings or joint operations committees; and fostering open communication with network providers.

Molina further encourages provider participation in Physician Advisory Committees (PACs), which allow Molina to solicit direct feedback from our providers. The PACs are comprised of network physicians and established in appropriate geographical areas of the state. PACs review and provide input on new or enhanced programs and may suggest approaches to communications. Understanding the providers' perspective is essential to ensuring that providers know Molina supports their efforts to provide high-quality care to members, and develops or enhances programs to meet those needs.

Molina further engages network providers and fosters open communication by encouraging their participation in Community Advisory Committees for a variety of needs, such as supporting provider engagement, key community organizations and behavioral health programs. To maximize Molina's understanding of provider and community needs, the advisory committees are comprised of individuals and organizations interested in discussing the provider and community perspective on barriers to access, such as linguistic and cultural barriers that prevent providing quality care. Our Community Advisory Committees foster strong collaborative relationships between advisory committee participants and maximize their roles and impact on the community. These committees meet quarterly in respective Molina's service areas and regions to help direct the development of programs and health education materials in ways that meet the needs and sensitivities of Molina's provider network and diverse communities.

In addition, Molina has implemented several value-based reimbursement (VBR) programs for providers, including a pay-for-performance program. VBR rewards physicians and other providers for taking a broader, more active role in the management of members' health and rewards them for outcomes, quality and value instead of solely for visits or procedures.

Our VBR agreements strive to better serve the needs of specific population segments through more robust elements of greater clinical integration. For instance, providers may receive additional compensation for telephonic outreach, preventive visits or arranging for other preventive services, such as dental services, lead screening, mammograms and cervical cancer screenings. Outcomes measures, such as reduced Emergency Department visits, which demonstrate enhanced primary care access, are also used to reward providers. Molina supports its VBR arrangements through its advanced claims/encounter and financial management systems which support fee-for-service, capitated and invoice-based arrangements.

CONFIDENTIAL

[redacted]

6.1.2 Provider Agreements

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP#MED-16-009, Scope of Work, Section 6.1.2 Provider Agreements.

1.Describe your process for reviewing and authorizing all network provider contracts.

Molina has written policies and procedures in place in all of its health plans nationwide and the Commonwealth of Puerto Rico that govern our process for reviewing and authorizing all provider network contracts. Molina utilizes a standard provider contract template reviewed and approved by the appropriate state agency. Should providers sign the standard template, no negotiation or changes are required. Molina also maintains a Preferred, Acceptable, Discouraged, Unacceptable (PADU) library to address financial and language changes to the standard template.

Molina's sister health plan, Molina Healthcare of California, utilizes the following process to review and authorize provider contracts for its diverse network. This process will likely be replicated to guide Molina's provider contract review and approval process in Iowa.

- A Molina Regional Director of Provider Services is responsible for ensuring that all new and amended provider contracts (i.e., PCP, Specialty, IPA/Group, Hospital, etc.) that exceed the maximum reimbursement allowed, as stipulated by Molina's Chief Financial Officer; contain non-standard payment methodologies; and contain non-standard utilization management procedures; are reviewed and approved by Molina's Contract Review Committee and approved using the Contract Review Committee Approval Form prior to the mailing of the contract or the amendment to the provider. Additionally, all language changes to the approved boilerplate agreement must be submitted to and approved by our Legal department and the Regional Director of Provider Services. Such language changes are completed in redline and strike-through with a copy placed in the contract file.
- All new or amended provider contracts that exceed the maximum reimbursement allowed must be reviewed by Molina's Contract Review Committee and approved using a Contract Review Committee Approval Form. Mandatory sign-off is required from Molina's Plan President/Chief Executive Officer, Chief Medical Officer, AVP of Provider Services, and Chief Financial Officer.
- All new or amended provider contracts that contain non-standard payment methodologies, must be reviewed by Molina's Contract Review Committee and approved in writing using the Contract Review Committee Approval Form. Mandatory sign-off is required from Molina's VP/Chief Medical Officer, Regional Director of Provider Services, Chief Financial Officer, Director of Claims, and Director of Contract System Configuration.
- All new or amended provider contracts that contain non-standard utilization management procedures must be reviewed Molina's Contract Review Committee and approved in writing using the Contract

CONFIDENTIAL

Review Committee Approval Form. Mandatory sign-off is required from Molina's Chief Medical Officer, Regional Director of Provider Services, and Director of Claims.

- Molina's Legal department and Regional Director of Provider Services must approve all new or amended contracts that include non-standard language that does not pertain to rates in excess of the maximum reimbursement; non-standard payment methodology; or non-standard Utilization Management procedures. A copy of a red-line version of the contract must be filed with the written approvals.

Upon receiving required approvals, the Regional Director of Provider Services (or his/her designee) sends the contract or amendment to the affected provider for signature. Upon securing full execution of the contract or amendment, the Regional Director of Provider Services (or his/her designee) must complete the Contract Routing Form (CRS) and Contract Proofing Form then forward the contract to Contract Administration for processing. The Regional Director of Provider Services (or his/her designee), must then notify all affected departments in writing via email when the contact is loaded in the QNXT information management system.

2. Provide sample provider agreements.

See Attachment 6.1.2-1 Sample Provider Services Agreement and Attachment 6.1.2-2 Sample Hospital Services Agreement, which can be found behind Tab 6.

3. Indicate if you propose to impose any requirements for exclusivity agreements for quality or payment purposes.

Molina does not and will not impose any requirements for exclusivity agreements for quality or payment purposes within the first year. While this policy will be reevaluated annually, it is not our standard practice in any of our health plans to impose any requirements exclusivity agreements for quality or payment purposes in its provider contracts.

4. Propose the percentage of provider contracts that will be consistent with value-based purchasing by January 1, 2018 and specify the percentage annually for each year thereafter. Will you move into value-based purchasing before 2018?

Molina has the operational experience, capability and capacity, and is prepared to ensure 100% of its provider contracts will be consistent with value-based purchasing (VBP) for the Iowa High Quality Healthcare Initiative by January 1, 2018 and every year thereafter, based largely on similar demonstrable VBP systems capability by the State and participating provider systems.

In accordance with Scope of Work, Section 6.1.2 Provider Agreements, Molina understands, agrees, and will comply with the requirement that its VBP arrangement must recognize population health outcome improvement as measured through the VIS combined with a decrease in total cost of care for the population in the VBP arrangement. Molina further understands that any members who are part of a VBP must be assigned by Molina to a designated PCP. Molina will immediately report related PCP information for use in system-wide DHS coordination enhancements such as provider alerts disseminated through the Iowa Health Information Network (IHIN). Finally, Molina understands that all contracted hospitals will be required to report admission and discharge information to support this exchange and coordination.

As an example of our national commitment to VBP, Molina's sister health plan, Molina Healthcare of Ohio, in partnership with the Ohio Governor's Office of Health Transformation and the Ohio Department of Medicaid, recently began launching its first wave of VBP programs (reporting only) focusing on three

clinical models, including Perinatal, COPD and Asthma. Initial results of these innovative programs will be forthcoming in the next few months. The health plan will also be working on a new reimbursement model pilot program with select provider partners later this year. Additionally, Molina Healthcare of Ohio is working with select network providers on innovative shared savings models linked to quality improvements in ER utilization, readmissions and HEDIS. These agreements are currently active.

6.1.3 Provider Credentialing

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP#MED-16-009, Scope of Work, Section 6.1.3 Provider Credentialing.

1. Describe your credentialing process.

In compliance with requirements set forth in Scope of Work, Section 6.1.3.1 Credentialing Policies and Procedures, Molina will develop and implement written policies and procedures, subject to DHS review and approval, for provider credentialing and recredentialing for the Iowa High Quality Healthcare Initiative. These policies and procedures will articulate Molina's understanding of all relevant credentialing and recredentialing requirements, and will direct Molina's and its subcontractors' compliance with all applicable federal and state standards related to provider credentialing, including those required in 42 CFR 438 and 455, Subpart E.

Furthermore, Molina understands, agrees and will comply with requirements set forth in Scope of Work, Section 6.1.3.3 Timelines, and will ensure that credentialing of all providers applying for network provider status will be completed as follows:

- Ninety percent (90%) within thirty (30) calendar days; and
- One hundred percent (100%) within forty-five (45) calendar days.

Molina's Credentialing Program ensures the Molina network consists of quality providers that meet clearly defined criteria and standards. Molina has established credentialing criteria and sources used to verify these criteria for the evaluation and selection of providers for participation in the Molina network as defined in written policy.

Our Credentialing Program has been developed in accordance with state and federal requirements and National Committee for Quality Assurance (NCQA) standards, while our credentialing process has been streamlined to achieve an average turnaround time of 30 days or less. The program and all related policies and procedures are reviewed annually and revised and updated as needed.

As is standard practice with its 12 sister health plans across the United States and in the Commonwealth of Puerto Rico, providers with which Molina will contract for the Iowa High Quality Healthcare Initiative must be credentialed prior to Contract implementation. Moreover, Molina recredentials all network providers, including organizational providers, at least every 36 months.

To be eligible to apply for participation in the Molina network, individual and organizational providers must meet all criteria formally outlined in Molina's Credentialing Policy. During the initial and recredentialing application processes, all providers must submit a completed credentialing application within the requested timeframe; attest to the application within the last 180 calendar days; and provide Molina adequate information to prove all criteria for initial participation or continued participation is met.

For individual providers, information and verifications reviewed include but are not limited to: State Medical Licenses; Current DEA or CDS Certificates; Appropriate Education and Training; Board Certification; Professional Liability Claims History; Professional Liability Insurance; Work History; State Sanctions, Restrictions on licensure or limitations on scope of practice; Lack of Medicare, Medicaid and

other Sanctions; Medicare Opt-Out Status; Hospital Clinical Privileges in good standing; Disclosure related to ownership and management, business transactions and convictions of crimes; and National Provider Identifier (NPI).

For facility providers, information and verifications reviewed include but are not limited to appropriate license, certification, and/or registration. Applicable facility employees must also be appropriately licensed, while all facility employees must undergo criminal background checks and no employee may have sanctions found on OIG or SAM. Verifications are also completed for any state sanctions, restrictions, limitations or conditions of license, certification or registration, sanctions by Medicare/Medicaid, accrediting agencies or state and federal agencies; accreditation or certification for hospitals, home health agencies, skilled nursing facilities, free-standing surgical centers, inpatient, residential or ambulatory behavioral healthcare providers, and all other organizational providers that are licensed, registered or certified; Medicare participation; Professional and/or General Liability Insurance; DEA; CLIA; disclosure related to ownership and management; business transactions; and criminal convictions.

Upon completion of the application and primary source verification process, Molina Credentialing staff performs quality reviews of each credentialing file to ensure completeness. During this quality review process, each credentialing file is assigned a level based on specific guidelines outlined in our Credentialing Policy. Credentialing files assigned to level 1 are considered clean credentialing files and are reviewed and approved by a Molina Medical Director(s) responsible for credentialing oversight. Credentialing files assigned to level 2 are reviewed by the Molina Credentialing Committee. Chaired by Molina's Medical Director and comprised of independent members of the physician community, the Credentialing Committee meets monthly to makes credentialing recommendations using an HCQIA-protected peer review process.

Molina's credentialing system is paperless. All credentialing information gathered is maintained in an electronic credentialing file for each individual/organizational provider applying for participation in the Molina network.

2. Describe methods to streamline the provider credentialing process.

Molina's Credentialing Program has established a successful track record across its health plans nationally by utilizing a streamlined process that brings qualified providers into our networks with greater efficiency while fully maintaining the integrity of our credentialing criteria and standards.

Molina's centralized Credentialing department has 55 dedicated staff members responsible for primary source verification. Our experienced team processes some 37,000 credentialing applications annually with an average turnaround time of 30 days or less. All Molina health plans include dedicated Credentialing staff responsible for key credentialing decision-making duties, including a weekly review of clean (level 1) credentialing files by the Medical Director and monthly meetings of the Credentialing Committee to review and approve the non-clean (level 2) credentialing files.

Our Credentialing department is committed to seeking and leveraging new and innovative ideas that reduce the administrative burden of the credentialing/re-credentialing processes without sacrificing quality. For example, during the initial provider network building process for the Iowa High Quality Healthcare Initiative, Credentialing staff may conduct clean credentialing file reviews on a daily basis while the Credentialing Committee may meet as often as weekly to streamline and expedite the overall process.

The Council for Affordable Quality Healthcare (CAQH) Universal Provider Datasource is Molina's preferred credentialing application and the industry standard for collecting provider data used in the credentialing process. Molina providers are able to complete their credentialing application electronically

and cost-free through CAQH system. In fact, Molina currently obtains some 90 percent of its credentialed provider information in the form of electronic applications from CAQH or through spreadsheets provided by groups delegated for credentialing.

While the Molina credentialing application process is primarily paperless, any paper applications received can be immediately scanned and processed through our credentialing management systems:

Visual Cactus – The Visual Cactus credentialing management application allows business users to define and store custom provider attributes to maintain provider licenses, certifications and education and malpractice information. Visual Cactus also tracks Drug Enforcement Administration (DEA), Clinical Laboratory Improvement Amendments (CLIA) documentation, as applicable, as well as National Provider Identification (NPI) IDs. Visual Cactus also has a robust security module to protect confidential information. Molina has designed proprietary technology that pulls credentialing data from CAQH and imports directly into Visual Cactus, significantly reducing manual data entry required during the credentialing process and decreasing overall turnaround time.

Laserfiche – Laserfiche is Molina's robust online document tracking program used to store electronic credentialing files. Laserfiche technology allows Molina to decrease application turnaround times and control credentialing costs while protecting confidential health information and ensuring compliance with HIPAA regulations.

Further streamlining the credentialing process, Molina also works closely with qualifying large provider groups that demonstrate the capability to assume delegation of credentialing activities while also meeting our strict delegation requirements. Molina's Delegation Oversight Committee must approve all delegation activities and arrangements, and retains the right to limit or revoke delegated credentialing activities when a delegate fails to meet Molina's requirements.

3. Describe your plans for performing criminal history and abuse checks and assuring all network providers hold current licensure as applicable.

Molina's credentialing and recredentialing process includes primary and secondary source verification of the provider's license to practice to assure all of our contracted providers are currently licensed and in good standing with the State.

Upon receiving a completed provider credentialing application, Molina performs primary and secondary source verification. Primary source verification is obtained directly from the entity that issued the credential, including professional license, Board Certification or residency/fellowship completion, DEA and DPS certificates and school diplomas.

In addition, Molina queries the National Practitioner Data Bank and Office of the Inspector General through Primary Source Verification to identify history of liability issues and potential sanctions, and queries the appropriate state licensing agency for board orders. The Medicare Opt-Out list is also queried to ensure that the provider has not opted out of this program.

Secondary sources or visual inspection are used to verify malpractice insurance, five-year work history, history of loss of licensure or felony/criminal convictions, history of loss of privileges or disciplinary sanctions. The application must indicate availability for 24-hour per day coverage, admitting privileges at a contracted facility or another physician able to admit patients on the provider's behalf, and willingness to accept new patients.

As a key part of the facility credentialing and verification process, all Molina Health Delivery Organizations must also sign a legal attestation that includes the following language:

> "I certify that the appropriate state license or certification source is checked for all new employees or contracted service providers prior to the first provision of service. I certify

that the appropriate state license or certification source is checked at least annually for existing and contracted service providers in order to ensure that every licensed individual providing services as a representative of the applicant holds current license or certification to provide services. I certify that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service. I certify the applicant does not employee or contract with any individual convicted of a felony for a health related crime, including but not limited to health care fraud, patient abuse and the unlawful manufacture, distribution, prescription, or dispensing of controlled substances."

4. Describe your plans for ensuring non-licensed providers are appropriately educated, trained, qualified and competent.

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP#MED-16-009, Scope of Work, Section 6.1.3.7 Non-Licensed Providers.

Based on applicable State licensure rules and/or program standards, Molina will be responsible for ensuring that when individuals providing covered services under the Iowa High Quality Healthcare Initiative Contract are not required to be licensed or certified, that they are appropriately educated, trained, qualified and competent to perform their job responsibilities.

Physical Health Network – Non-Licensed Providers – For non-licensed providers participating in our Iowa High Quality Healthcare Initiative physical health network, Molina will complete verifications of the following as applicable: Current DEA or CDS Certificates; Appropriate Education and Training; Board Certification; Professional Liability Claims History; Professional Liability Insurance; Work History; State Sanctions, Restrictions on licensure or limitations on scope of practice; Lack of Medicare, Medicaid and other Sanctions; Medicare Opt-Out Status; Hospital Clinical Privileges in good standing; Disclosure related to ownership and management, business transactions and convictions of crimes; and National Provider Identifier (NPI). In addition, when applicable, Molina will require non-licensed providers to be supervised by a licensed provider currently contracted and credentialed in the Molina network. Documentation supporting this arrangement will be collected during the credentialing process.

Behavioral Health Network – Non-Licensed Providers – To participate as a Molina behavioral health services provider, all signatory providers must be at least trained at the master's level and fully licensed to perform the scope of their duties (i.e., non-licensed providers that otherwise meet the designation for allowable services under Rule 132 will provide services under the signature of a supervising licensed provider).

Molina will complete verifications of the following as applicable: Current DEA or CDS Certificates; Appropriate Education and Training; Board Certification; Professional Liability Claims History; Professional Liability Insurance; Work History; State Sanctions, Restrictions on licensure or limitations on scope of practice; Lack of Medicare, Medicaid and other Sanctions; Medicare Opt-Out Status; Hospital Clinical Privileges in good standing; Disclosure related to ownership and management, business transactions and convictions of crimes; and National Provider Identifier (NPI). In addition, Molina will require non-licensed providers to be supervised by a licensed provider that is contracted and credentialed in the Molina network. Documentation supporting this arrangement will be collected during the credentialing process.

Substance Use Disorder Practitioners – In compliance with Scope of Work, Section 6.1.3.6 Substance Use Disorder Practitioners, Molina will further ensure that substance use disorder treatment services provided to Iowa High Quality Healthcare Initiative members are provided by programs licensed by IDPH in accordance with Iowa Code chapter 125 or by hospital-based substance use disorder treatment programs licensed and accredited in accordance with Iowa Code section 125.13.2(a). Molina will accept

counselor certification as specified in Iowa Administrative Rules 641—155.21(8) as an acceptable credential for practitioners employed by a licensed substance use disorder treatment program.

For substance use disorder providers participating in our Iowa High Quality Healthcare Initiative network, Molina will complete verifications of the following as applicable: Current DEA or CDS Certificates; Appropriate Education and Training; Board Certification; Professional Liability Claims History; Professional Liability Insurance; Work History; State Sanctions, Restrictions on licensure or limitations on scope of practice; Lack of Medicare, Medicaid and other Sanctions; Medicare Opt-Out Status; Hospital Clinical Privileges in good standing; Disclosure related to ownership and management, business transactions and convictions of crimes; and National Provider Identifier (NPI). In addition, Molina will require non-licensed providers to be supervised by a licensed provider that is contracted and credentialed in the Molina network. Documentation supporting this arrangement will be collected during the credentialing process.

6.1.4 Cultural Competence

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP#MED-16-009, Scope of Work, Section 6.1.4 Cultural Competence.

1. Describe your plans for ensuring the delivery of services in a culturally competent manner.

Molina provides comprehensive training to its diverse and well-trained employees and participating network providers to deliver quality, culturally competent services. To continue to ensure culturally competent care is provided to our culturally and linguistically diverse members and providers, we employ a well-coordinated, multi-faceted approach to cultural competency.

Molina has provided quality health care services to ethnically diverse communities for more than 30 years. As an industry leader in cultural competency, we established the Molina Institute for Cultural Competency (the Institute) in 2003 to demonstrate our commitment to quality healthcare delivery for all members. We recognized early on that our diverse cultural and ethnic membership will often face unique challenges and barriers to accessing quality health care services. The Institute, therefore, is charged with developing and providing essential tools and training to all Molina health plans to ensure the delivery of health care services in a culturally sensitive and competent manner. We have designed programs and policies to be culturally congruent with our regional membership and take pride in an extremely diverse workforce representing many ethnicities and languages while successfully integrating multi-cultural teams in various settings. We also make a concerted effort to assign PCPs from culturally similar backgrounds to our members to further ensure clear provider-member communication and greater cultural sensitivity.

Understanding Iowa's Diverse Cultural Landscape

Like most states, Iowa is experiencing demographic changes (most notably an increase in the Hispanic population) that reflect similar changes in overall diversity throughout the United States. These changes can often give rise to distinct health disparities that disproportionately affect minority/immigrant communities and require significant resources to address.

A recent study entitled *Healthcare Resource Gap Analysis for the Hispanic Community in Northeast Iowa*[1] found that while Hispanics make up only 5.5% of the state's population, 24% have no health insurance compared to a corresponding rate of 8.4% for all Iowans. The study further found significant

[1] *Kara Pederson, Healthcare Resource Gap Analysis for the Hispanic Community in Northeast Iowa, Luther College Department of Nursing, Presentation to Iowa Governor's Conference on Public Health, 2015*

barriers to care, including, but not limited to: cultural access, including a lack of providers sensitive to cultural needs or unique ethnic backgrounds; lack of interpreters for Hispanics with limited English skills; cost and transportation; healthcare services not always located near minority/immigrant population centers; and standard medical office hours operating concurrently with normal working hours, making office visits difficult to schedule.

Molina will bring unique sensitivity to the needs of Iowa's Hispanic populations and other vibrant cultural minority communities by leveraging its sister health plans' decades of collective experience serving diverse ethnic and cultural membership. Molina will ensure its members from all cultural backgrounds covered under the Iowa High Quality Healthcare Initiative receive the right care, at the right time and in the right setting, supported by a robust cultural competency plan that promotes member comprehension, participation and satisfaction.

Cultural Competency Plan

Molina will develop and implement a Cultural Competency Plan specific to the Iowa High Quality Healthcare Initiative population that promotes the delivery of culturally competent services, addresses barriers to care, and ensures the provision of linguistic access and disability-related access to all members, including those with Limited English Proficiency.

The plan will reflect guidelines outlined in *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, published by the U.S. Department of Health and Human Services and Office of Minority Health. The plan will also describe how Molina, its employees, contracted providers and potential subcontractors will effectively provide services, including wraparound services, to people of all cultures, races, ethnic backgrounds and religions, as well as those with disabilities and long-term care needs, in a manner that recognizes values, affirms and respects the worth of the individuals, and protects and preserves the dignity of each. The plan will be available on our secure Provider Web Portal, as well as Molina's internal intranet site for employee access.

Educating Employees

Molina conducts cultural competency training for its employees as part of initial training and orientation. We monitor service delivery to ensure incorporation of cultural awareness and cultural sensitivity into member services. Occasional reinforcement training reminds our employees to recognize and respond to members who may need translation services, interpreter services, or special assistance to navigate and access healthcare services.

Educating Providers, Staff and Community Organizations

Molina will integrate its Cultural Competency Program into its comprehensive provider training and quality monitoring programs in support of the Iowa High Quality Healthcare Initiative. Our integrated quality approach enhances the way our providers think about our members, service delivery, and program development, so that cultural competency becomes part of providers' everyday thinking.

Molina offers cultural competency education opportunities and programs to providers, their office staff and partner community-based organizations on a regular schedule as well as on an as-needed basis to ensure covered services are delivered with a deep understanding of our members' unique cultural and linguistic needs.

For the Iowa High Quality Healthcare Initiative, we will conduct comprehensive provider training that will include our Cultural Competency Program module during provider orientation, as well as through annual reinforcement training. Molina will provide additional training reinforcement through Continuing Medical Education (CME) monographs developed by the health plan, and periodically accompanying provider communications. Molina will deliver training modules using a variety of methods, including, but not limited to:

- Written materials, including our Provider Manual;

- Reference materials available through health plan representatives and the secure Molina Web Portal;
- Integration of cultural competency concepts into provider communications; and
- CME monographs.

Ensuring Access

Through new orientation, ongoing training, written materials including the Provider Manual and provider newsletters, and the secure Provider Web Portal, Molina ensures its contracted providers know how to assist members with access to our comprehensive language services such as written translation and interpreting services.

Molina provides access to qualified interpreter services 24 hours a day, seven days a week, ensuring all members and potential enrollees may receive information in their primary language. Upon member request, Molina provides written member materials in alternative formats such as Braille, audio or large print. Members may also request translation of material in any language. Availability of materials in a member's primary language leads to better communication, understanding and member satisfaction. Molina often provides access to programs and services that are congruent with cultural norms and provide quality care.

Provider Resources

Molina's secure Provider Web Portal features links in the "Health Resources" section regarding providing care to diverse populations. For our contracted Iowa High Quality Healthcare Initiative providers, the site will also feature information for Indian healthcare providers, offering advice and education about the importance of Native American belief systems related to health. Molina will continually add important culturally sensitive resources that are identified or requested to be linked to Molina's Iowa provider website.

The site will also provide instructions on how to access translation services as well as transportation services for Iowa High Quality Healthcare Initiative members. Existing providers also receive a packet when receiving an in-service for new staff and/or refresher of Molina policies and procedures. Both of these reference guides are available on the Molina website. These reference guides will be regularly reviewed and updated as necessary to ensure compliance with Iowa High Quality Healthcare Initiative Contract requirements.

All contracted providers can also access the Molina Provider Manual via our secure Provider Web Portal or in hard copy, if requested. The manual provides clear instruction on how to access translation services, as well as TTY/DDD Services for deaf, hard of hearing, or speech-disabled members. Molina requires all contracted providers at the time of their contract execution to acknowledge receipt of the Provider Manual via a Provider Agreement attachment, assuring each contracted provider has all information necessary to serve Molina members in culturally competent manner.

Molina ensures that culturally competent care is provided for all members, including native and non-native English speaking members as well as its Native American members. Molina's Cultural Competency Program Manual is available to all contracted providers. The manual emphasizes the importance of cultural competency and directs providers on obtaining additional information regarding cultural competency. For our Indian healthcare providers, the manual also provides important information on specific cultural practices related to Native Americans.

Translation Services

Molina's expert translation services are available to providers caring for members who may not speak English. Molina utilizes CyraCom, a global provider of over-the-phone interpretation (OPI) services from English into more than 150 different **languages.** CyraCom also provides translation services for Native Americans who request this service**.** A Molina Customer Support Services Representative will conference into the call ensuring the information communicated to the member is appropriate and accurate.

Translators from within the Customer Support Services department for various tribal languages can also assist Native American members in accessing health plan information.

Program and Policy Review Guidelines

Molina draws upon utilization data and quality measures to identify and address high risk health conditions related to population demographics. At regular intervals, Molina conducts assessments of the following information to ensure its programs, staff and contracted providers are most effectively meeting the cultural and linguistic needs of its members and providers:

- Annual review of membership and provider demographics (e.g., preferred language, ethnicity, race);
- Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment);
- Provider Network Assessment;
- Applicable national demographics and trends derived from publicly available sources;
- Health status measures such as those measured by HEDIS, as available; and
- Comparison with selected measures such as those in Healthy People 2010.

6.1.6 Provider Relations and Communications

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP#MED-16-009, Scope of Work, Section 6.1.6 Provider Relations and Communications.

1. Describe your provider relations and communications strategy.

Molina's experienced Provider Services staff is trained and equipped with the knowledge to work closely with network providers through consistent communications, leveraging multiple direct contact and innovative media channels to support the seamless delivery of covered services. Provider Services Representatives direct providers to appropriate resources to assist them in meeting their needs related to verifying member eligibility, routing provider calls to the appropriate department, obtaining information on behalf of the provider, obtaining referral authorizations, obtaining claims payment information, and accessing Molina-sponsored interpreter services. Provider Services staff training covers comprehensive policies and procedures that include the following responsibilities:

- Assisting PCPs, behavioral and physical health specialists, hospitals, facilities (e.g. long-term care, nursing facilities, HCBS) with verifying whether an individual is enrolled with the plan, identifying the member's PCP in a timely manner, and educating and promoting Molina's secure Web Portal to verify eligibility and obtain PCP rosters;
- Assisting providers with plan service accessibility standards including, but not limited to, prior authorization submission, verification, denial and referral policies;
- Assisting providers with electronic and paper claims submission and payment procedures;
- Educating providers about circumstances under which members may have direct access to a range of health care services including, but not limited to, behavioral health and substance use disorder services, family planning and public health services;
- Educating providers about member access to emergency care and after-hours care;
- Educating providers to ensure compliance with HIPAA patient privacy and related PHI data security guidelines;
- Responding to provider questions and complaints;

- Representing Molina in, at minimum, quarterly communication with network providers and overseeing provider education, training and orientation; and
- Ensuring providers are aware of Molina's library of provider education and training materials and media including the Provider Manual, Provider Newsletter and secure Provider Web Portal.

Provider Services staff will also conduct orientation and ongoing training for providers serving our Iowa High Quality Healthcare Initiative members, incorporating a variety of training methods (e.g., on-site, webinar, online, telepresence, telephonic) and tools (e.g., PowerPoint presentations, Provider Manual, provider newsletters, online presentations) and promoting attendance by providers and their staff. Provider Service staff will also modify training curricula for ongoing provider trainings as specific issues are identified for particular specialty types or service areas.

Molina's Provider Manual

In compliance with Section 6.1.6.1 Provider Manual, Molina's Provider Manual tailored for the Iowa High Quality Healthcare Initiative will include, at minimum, the following elements:

- Program benefits and limitations;
- Claims filing instructions;
- Prior authorizations criteria and request process;
- Cost sharing requirements;
- Urgent and emergency care definitions and requirements;
- Participants' rights;
- HIPAA and Health Information Technology for Economic and Clinical Health (HITECH) rules compliance;
- Providers' rights for advising or advocating on behalf of his or her patient;
- Provider non-discrimination information;
- Grievances and Appeals policies and procedures in accordance with 42 CFR 438.414 and 438.10(g)(1);
- Molina and DHS contact information, including addresses and phone numbers; and
- Third party liability and other collections policies and procedures.

The Provider Manual will be available 24/7 to contracted providers on the secure Molina Provider Web Portal. Hard copies will also be available and mailed to contracted providers upon request.

Molina Committees Promoting Stronger Provider Relations

Molina has also developed a number of successful formal committees in its state health plans nationwide to support provider relations and communications, improve provider satisfaction, and retain key providers in its robust networks.

Physician Advisory Committees – Molina leverages Physician Advisory Committees (PACs) to solicit direct feedback from providers. The PACs are comprised of network physicians and established in appropriate geographical areas of the state. PACs review and provide input on new or enhanced programs and may suggest approaches to communications. Understanding the providers' perspective is essential to ensuring that providers know Molina supports their efforts to provide high-quality care to members, and develops or enhances programs to meet those needs.

Member-Provider Satisfaction Committee – Molina's Member-Provider Satisfaction Committee, which is comprised of Molina network providers, representatives from various health plan functional areas, and Molina members, is charged with reviewing various health plan statistics and surveys and initiating actions to improve member and provider satisfaction; facilitating frequent communication exchanges with

network providers, including direct outreach such as joint operations meetings or joint operations committees; and engaging and fostering open communication with network providers by encouraging their participation in community advisory committees for a variety of needs, such as supporting provider engagement, key community organizations and behavioral health programs.

Community Advisory Committees – Molina further engages network providers and fosters open communication by encouraging their participation in Community Advisory Committees for a variety of needs, such as supporting provider engagement, key community organizations and behavioral health programs. To maximize Molina's understanding of provider and community needs, the advisory committees are comprised of individuals and organizations interested in discussing the provider and community perspective on barriers to access, such as linguistic and cultural barriers that prevent providing quality care. Our Community Advisory Committees foster strong collaborative relationships between advisory committee participants and maximize their roles and impact on the community. These committees meet quarterly in respective Molina's service areas and regions to help direct the development of programs and health education materials in ways that meet the needs and sensitivities of Molina's provider network and diverse communities.

2. Describe your policies and procedures to maintain communication with and provide information to providers.

Molina has policies and procedures in place to improve its networks by facilitating frequent communication exchanges with network providers. This includes direct outreach such as joint operations meetings or joint operations committees. By encouraging many varied communication opportunities, Molina builds strong network provider relationships and ensures knowledge transfer of health plan initiatives and requirements.

Molina will actively keep providers up-to-date on program standards and regulatory changes to ensure that Iowa High Quality Healthcare Initiative members continue to receive efficient and effective health care that results in positive health outcomes. Molina recognizes that keeping providers informed reduces their administrative burden and contributes to provider satisfaction. Additionally, effective communication offers improved operational efficiency, and proactive communication reduces calls to the customer service phone unit and claims rework. Molina utilizes multiple communication avenues to ensure provider awareness. The communication format depends upon the content of the communication.

Unlike many states where the Medicaid managed care program is established and familiar to providers, providers in Iowa will be faced with both the changes associated with the newly implemented Iowa High Quality Healthcare Initiative. As a result, the focus of initial communications with providers will be two-fold: 1) to provide information about Molina; and 2) to assist providers in understanding the Iowa High Quality Healthcare Initiative program and related requirements.

Molina's Provider Communications policies and procedures provide strict guidelines to the development of and continued review of the following materials, technology resources and activities.

Provider Manual - Molina's Provider Manual will contain comprehensive program information and the regulatory requirements necessary for efficient participation in the Molina provider network. Molina distributes the Provider Manual to all new practitioners when they join the Molina Provider Network, and will redistribute it to all practitioners in the network annually. The Provider Manual is also available to all providers through Molina's website. Updates to the Provider Manual are distributed throughout the year by direct mail, website updates, automated facsimile distribution and automated e-mail distributions.

Provider Services Representative Interaction - The best opportunity for communication with the Molina provider network is through the routine visits that Molina Provider Services Representatives conduct with providers, promoting face-to-face interaction. Molina emphasizes the importance of these

meetings when hiring and training Provider Services Representatives. As part of our Quality Improvement program, Molina monitors the effectiveness of communications by collecting, reviewing, and analyzing data that may indicate when a practitioner is failing to comply with current program and regulatory requirements. Molina reviews this data internally on a monthly basis and intervenes to correct a situation by targeting additional training or information to the provider. This proactive approach to keeping the provider network informed, current on provider issues, and actively involved in process improvement will minimize compliance conflicts and ensure positive outcomes with Molina, the network, and our members.

New Provider Orientation - All newly contracted Molina providers receive general orientation and orientation tailored to their specialty at the time of contract execution. Orientation tools and materials provided may include the Provider Reference Guide, including information and instruction on transportation, dental, vision and Language Line, Provider Manual, Diversity Pamphlet, Prior Authorization Matrix, Molina Contact List and provider newsletters. Ongoing training will be offered to providers identified as requiring continuing education on specific policies or procedures by internal Molina department staff who interact with providers (e.g. Healthcare Services, Customer Support Services, Claims, Member Grievances/Appeals, Quality Improvement, Anti-Fraud, Utilization Management and Pharmacy). Additionally, specialized training will be developed and executed as changes to the program require. Orientation will provide a thorough review of the Molina program, including but not limited to:

- An overview of Molina's organizational and administrative structure and the history of Molina Healthcare;
- An explanation of the structure of the Molina Provider Services Department and functions including contacts and department escalation of issues;
- Information concerning covered and non-covered services;
- Health plan requirements and limitations, including those applicable to and expectations regarding mental health, EPSDT, dental, maternity and family planning services;
- Information regarding Molina's policies for PCP assignment and access to specialists serving as the PCP;
- Detailed and clear information regarding Molina's rules for referrals to specialists and coordination with mental health providers, including community mental health centers;
- Detailed information on the Molina grievance system for both providers and Members;
- Information on reimbursement, COB, and how to file claims and encounters;
- Information on standard operating policies and procedures, including those applicable to utilization management, prior authorization and claims submission;
- A clear explanation of provider responsibilities, access standards, Member rights, Americans with Disabilities Act requirements, cultural competency policies, and information on accessing interpretation services and sign language assistance;
- Complete prior authorization and notification requirements, policy on claims medical review, and concurrent review process; and
- Descriptions of Molina's Fraud and Abuse Department and functions, and False Claims Act provision of the Deficit Reduction Act.

Secure Provider Web Portal - Molina's secure Provider Web Portal is another venue for communicating with providers. The Provider Web Portal allows providers to check member eligibility, file claims, review the status of claims or service requests, Nurse Advice reports, or obtain program information, such as Molina's drug formulary, prior authorization requirements, the Provider Directory, performance

measurement results, medical determination and practice guidelines, and standard reimbursement information. The Provider Web Portal will also be used to notify a PCP of a new member assigned to them within five days of the new Member's enrollment. The Provider Web Portal will be used to communicate program changes or when changes to laws and regulations take effect. Molina will post changes on the website to alert providers of changes that impact services or requirements.

Provider Newsletters - Molina publishes and mails a Provider Newsletter on a regular basis. The newsletter will note recent changes impacting providers, general information regarding the plan, updates on quality and compliance initiatives, and upcoming training events.

Direct Mail - Molina will also mail notifications to providers to inform them of regulatory, contract, or program changes. Notification will occur at least 30 days in advance of changes taking effect. The IT department will utilize software to support this process in an efficient and cost effective manner. The product, SmarterPrint, supported by AdminiSource software, offers the print communications service for selected provider mass mailings. AdminiSource's secure and advanced print and mailing facilities will produce, fold, insert into envelopes, and mail provider communications, adhering to federally mandated HIPAA regulations. Remittance advice (RA) notices that accompany payments can highlight initiatives globally or expand comments for specific providers or groups of providers. Of note, Molina will always provide written notice of the reason for declining a provider's inclusion in the Molina provider network. Additionally, Molina will notify providers 30 days in advance of any material change in Molina operating policies and procedures which may reasonably be expected to impact the providers operations. Additionally, Molina will provide the same advance notification to providers who may be impacted by a significant change in the Molina provider network. Molina will provide no less than 90 days prior written notice of not for cause termination of a provider agreement, which is a standard within Molina provider agreements.

"Just the Fax" Facsimile Notification – Molina will establish a database of secure provider facsimile telephone numbers to facilitate transmission of general updates and will use "Just the Fax" software to facilitate automated facsimile distribution.

Email - Molina will establish a database of provider e-mail addresses to facilitate electronic transmission of real time information to our provider network.

Physician Advisory Committee (PAC) Meetings – Molina will establish Physician Advisory Committees (PAC) across the state that will meet no less than biannually. The intent of the PAC meetings is to facilitate a communications with key physicians in each community. These meetings keep Molina aware of emerging issues within the network, and also give network providers a voice in the operation of the plan and a mechanism for continuous operational improvement.

Member-Provider Satisfaction Committee – Comprised of Molina network providers, representatives from various health plan functional areas, and Molina members, the Member-Provider Satisfaction Committee is charged with reviewing various health plan statistics and surveys and initiating actions to improve member and provider satisfaction; facilitating frequent communication exchanges with network providers, including direct outreach such as joint operations meetings or joint operations committees; and engaging and fostering open communication with network providers by encouraging their participation in community advisory committees for a variety of needs, such as supporting provider engagement, key community organizations and behavioral health programs.

Community Advisory Committees – Molina encourages provider participation in Community Advisory Committees which support a variety of needs, such as supporting provider engagement, key community organizations and behavioral health programs. Community Advisory Committees foster strong collaborative relationships between advisory committee participants and maximize their roles and impact on the community. These committees meet quarterly in respective Molina's service areas and regions to help direct the development of programs and health education materials in ways that meet the needs and

sensitivities of Molina's provider network and diverse communities.

Provider Office Manager Meetings – Molina will also afford an opportunity to update providers on the latest changes that affect the provider network. These training sessions are designed for provider office staff, and offer Molina a different perspective than the PACs. The training sessions will be conducted on a routine basis throughout the state and will include reminders to providers to access the Molina website on a regular basis to maximize the opportunity to access current information.

3. Describe your plan to develop a provider website and describe the kinds of information you will make available to providers in this format.

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP#MED-16-009, Scope of Work, Section 6.1.6.2 Provider Website.

Molina has developed number of online channels to effectively meet the needs of its providers, members, state agencies and external care team participants across multiple states and lines of business. These online channels include our public website (www.molinahealthcare.com), secure Provider Web Portal (https://provider.molinahealthcare.com), and our Interactive Voice Response (IVR) system.

Molina Website – Our www.molinahealthcare.com site enables contracted providers to instantly access important documentation that supports their ability to provide quality healthcare services to our members and manage their practices effectively. Providers can access commonly used forms such as prior authorization; coordination of care by state; Provider Handbook; formularies; member and provider rights and responsibilities policies; health resources; services guidelines; Rx forms; compliance training documentation; and other key supporting materials.

All of our health plans have experienced Provider Services Representatives who continually update the website's corresponding state Provider home pages to help our contracted providers stay informed through important alerts and messages.

Molina's Secure Provider Web Portal – Our Provider Web Portal is a secure site offering 24/7 access for our contracted providers. Providers are able to register on the Provider Web Portal and securely perform member eligibility checks; submit claims and authorization requests; obtain patient rosters; and download affiliation lists, among other critical functionalities. The Provider Web Portal also supports various functionalities for office administration and ease of use. Our eligibility verification systems, for example, meet all relevant state standards and are fully HIPAA compliant. Molina's Provider Web Portal functionality includes, but is not limited to the following:

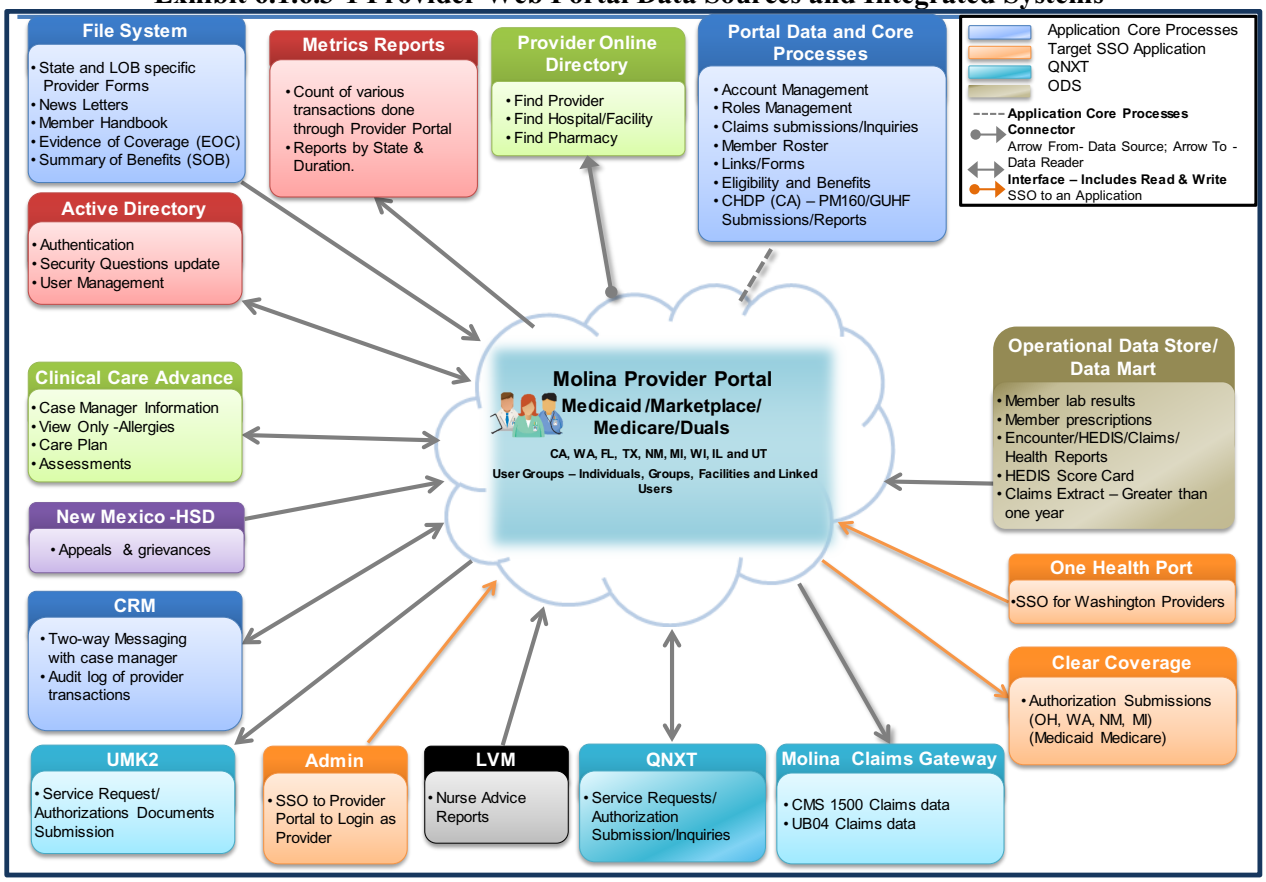
- Allows providers to perform real-time verification of member eligibility 24 hours a day, 7 days a week;
- Provides secure online access to a member's historical and current information;
- Provides access to a member's health record, including service history; service authorizations; lab results; medications; allergies; inpatient admissions and Emergency Department visits; care plan and related assessments; and HEDIS missed service alerts for PCPs and care team providers;
- Allows online submission of authorizations with attachments, including real-time responses (approvals or denials) to these requests utilizing McKesson's ClearCoverage, as well as inquiries (including utilization history for all review types);
- Allows access to a searchable Provider Manual as well as a searchable Provider Directory which is updated within five business days of a change to the Provider Network; the site also includes periodic Provider Newsletters as well as provider FAQs applicable enterprise-wide;
- Allows secure submission of provider inquiries that are responded to within one business day by Provider Services staff; inquiries not within Molina's scope of services are forwarded to the relevant state agency, for example, DHS;

- Supports two-way communication with a Molina Case Manager;
- Enables secure claims submissions, corrections, adjudication status, payments and related status inquiry, as well as the secure online submission of claims appeals;
- Provides information on Molina's Pharmacy Preferred Drug List (PDL) and Pharmacy coverage/utilization limits;
- Provides access to the current Member Roster for a contracted provider's relevant state, as well as our online Provider Directory and Member Handbook;
- Offers access to key information on covered member benefits and HEDIS Scorecard missed services;
- Allows provider groups to add staff users and manage their access; and
- Enables claims EDI file submissions.

Our Provider Web Portal contains additional resources such as downloadable patient education materials, frequently used forms, provider toolkits, continuing medical education opportunities, clinical practice guidelines, and services available to members. Molina's written policies and procedures ensure the Provider Web Portal is updated regularly and contains accurate information. For the Iowa High Quality Healthcare Initiative, Molina will conduct monthly reviews and updates to its provider Web Portal, or more frequently as program changes dictate.

Provider Portal Technology – The Provider Web Portal system is the web channel into Molina's various data management systems, including our dynamic QNXT information core management system, our Clinical CareAdvance Case Management and Disease Management platform, Operational Data Store, and other key operating systems. Exhibit 6.1.6.3-1 below provides an integration snapshot of Molina's Provider Web Portal.

Exhibit 6.1.6.3-1 Provider Web Portal Data Sources and Integrated Systems

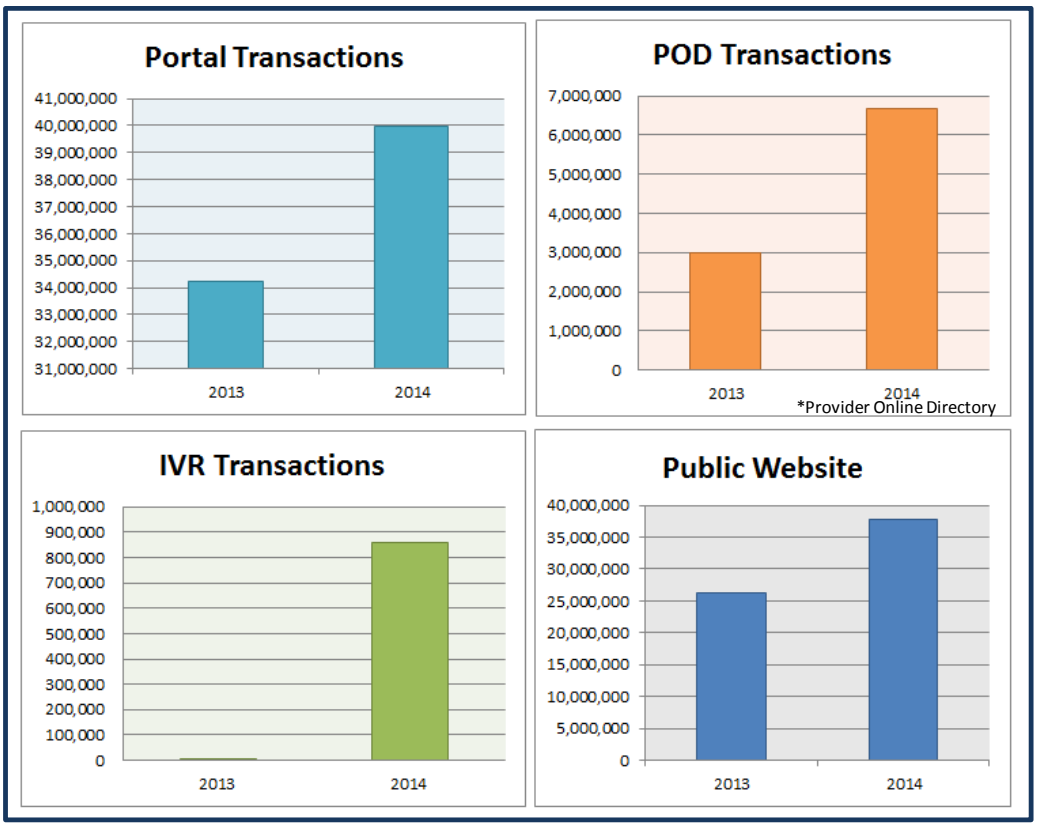


Provider Portal Support – All Molina web portals are supported by our Portal Specialized Service Desk, a single technical support point-of-contact for all Molina providers and members. The Portal Specialized Service Desk consists of specialized Molina support staff that is highly knowledgeable of the web portals and interconnected systems including QNXT, Clinical Care Advance, Operational Data Store, and other key systems. Our experienced staff provides guidance and support for account maintenance and user maintenance, conducts troubleshooting for providers and members, and perform various other technical support functions. The service desk has access to the admin portal tools that allows support staff to assist users effectively and in a timely manner. It also acts as a very important source of feedback from customers that makes its way into the ever evolving functionality of the Web Portals.

Online Systems Metrics – Molina's robust Provider Web Portal is utilized by some 50,000 providers and 103,000 supporting provider staff across multiple states and lines of business including Medicare, Medicaid, Marketplace and Medicare-Medicaid Eligible (Dual Eligible). In 2014 alone, the portal accurately managed some 32 million transactions across all Molina health plans and interrelated operations enterprise-wide.

Exhibit 6.1.6.3-2 below depicts key detailed metrics for 2013-2014 related Molina's primary online systems supporting our providers and members, including Online Secured Portals, Provider Online Directory (POD), provider/member IVR self-services, and our public www.molinahealthcare.com site.

Exhibit 6.1.6.3-2 2013-2014 Molina Online System Transaction Metrics



4. Describe your plans for the provider services helpline, including the process you will utilize to answer, route, track and report calls and inquiries.

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP# MED-16-009, Scope of Work, Section 6.1.6.3 Provider Services Helpline.

Molina will provide a single, toll-free Provider Services Helpline that will operate from 7:30 a.m. to 6:00 p.m. Central Time, Monday through Friday, excluding State holidays. The Provider Services Helpline will give providers access to experienced Provider Services Representatives prepared to respond to inquiries and complaints, such as Prior Authorization, Pre-Certification, Iowa High Quality Healthcare Initiative benefits, provider complaint system, eligibility and claims.

Provider Services Helpline staff will receive extensive training on covered services and program requirements for the Iowa High Quality Healthcare Initiative. Molina will use a proprietary training manual with training curriculum that includes a general overview of the Iowa High Quality Healthcare Initiative. It will also cover Molina's organizational structure, policies and procedures related to covered services, premium and cost sharing, authorizations and filing of complaints, and claims system (including appeals and disposition of a claim and authorization denials). Provider Services Helpline staff members will be knowledgeable about Molina's organizational structure and have the ability to route provider calls to the appropriate department, or obtain information on behalf of the provider. The Provider Services Helpline personnel will also participate in mandatory cultural diversity training and receive communications which promote understanding of various cultural beliefs and traditions.

For providers who call after hours, several alternatives will be available. Molina's automated, HIPAA-compliant Interactive Voice Response (IVR) system will give providers information on the center's

operating hours, as well detailed instructions on how to verify enrollment for a member with an urgent condition or an emergency medical condition. Providers will also be able to use the automated system for eligibility verification; claim status; ID card requests; PCP change requests and authorization status; leave a message for the Provider Services Helpline staff; and/or transfer to the Nurse Advice Line to speak with a nurse advisor. The automated IVR system and Nurse Advice Line will be available 24/7. If a provider chooses to leave a voice message for non-urgent issues, a Provider Services Helpline Representative will respond within twenty-four (24) clock hours.

After-hours callers will also be prompted to visit Molina's Provider Web Portal which offers a secure online resource available 24/7. The Provider Web Portal offers our contracted providers the following functionalities and conveniences:

- View messages, announcements and recent activity;
- Check Member Eligibility – View detailed member information, including member health record and needed services;
- View Member Roster – View updated member status, including Case Managed, Open Inpatient Authorizations, New, Termed;
- Service Request/Authorization – Create, view status, create templates and attach supporting materials;
- Submit Claims – Create professional (1500), institutional (UB04), correct, void, create templates, attach supporting materials, and batch submit;
- Claims Status Inquiry – View status, add attachments post submission and claims reports;
- Provider HEDIS Profile and Utilization report materials;
- Manage accounts and users;
- Create personal favorite links – Allows customization of most utilized functionalities and;
- Access training materials, and review and download required forms.

Call Routing to Ensure Timely and Accurate Provider Inquiry Response

Provider Services Helpline wait times are reduced by giving providers two options when they call. First, they can opt to use the automated voice system to verify member eligibility, allowing the provider to quickly obtain information with minimum wait times. Second, the system allows the provider to choose several options, including prompts for benefits, eligibility and claims. If the provider's question is about eligibility or benefits, the call will be routed directly to Helpline staff. Claims calls are answered by Helpline staff specifically trained to manage claims inquires. The caller may press "0" to be directly routed to Helpline staff without listening to the automated voice response system. The ability to automatically route calls to appropriate staff allows use of multiple units to balance workload and reduce wait times.

Provider Services Helpline Monitoring, Reporting and Performance Metrics

Molina's Provider Services department documents all inbound calls to the Provider Services Helpline through QNXT, Molina's medical management system, to accurately track and trend all provider inquiries and related staff responses. Reports are generated and reviewed by Provider Services leadership or designee to ensure consistent monitoring of the toll-free line for continuous compliance with access standards. If compliance is not met, corrective actions are taken. Reports are monitored daily, weekly, monthly, quarterly and annually by our management team.

In compliance with similar standards stated in Section 8.3.3 Member Services Helpline Performance Metrics, Molina will maintain a Provider Services Helpline service level of eighty percent (80%) of incoming calls answered within 30 seconds. This service level is calculated with the following required equation: SL-((T-(A+B)/T)*100) in which T=all calls that enter queue, A=calls that are answered after 30 seconds, B=calls that are abandoned after 30 seconds.

5. Describe your provider training plans.

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP# MED-16-009, Scope of Work, Section 6.1.6.4 Provider Training.

Molina applies a variety of approaches to create a comprehensive education and training program for its network providers. Molina will work with DHS and its community partners to initiate outreach to and education for the provider community about the benefits and changes that will be introduced under the Iowa High Quality Healthcare Initiative. In particular, the concept of holistic, person-centered care will be reviewed to reinforce the role of the member and their family in reviewing and deciding on treatment options, including provision of adequate information and guidance, and ways to access medical and non-medical services available from other providers or organizations.

Molina's goal is to offer exemplary customer service to network providers beginning with group and/or individual provider orientation training and moving to ongoing office or facility visits to provide education and speedy problem resolution. The key to provider satisfaction is Molina's service philosophy of "feet on the street" and "faces in the office", emphasizing frequent face-to-face contact to build and maintain the representative to provider/office staff relationship is a crucial component to having a successful network partnership.

Relevant training topics may be identified externally through trend tracking, national recommendations or internally through the various channels that providers may use to communicate with Molina, such as their Provider Service Representative, the Quality Improvement Committee or direct request to the Chief Medical Officer. Highly targeted educational programs, training methods and training materials are regularly developed for distribution to Molina's network providers. For example, for contracted PCPs, pediatricians and related physical and behavioral health specialists, training curriculum may focus on the importance of encouraging EPSDT visits, clinical guidelines, cultural and linguistic sensitivity, and tips on appropriate coding and information on services and materials available to members to promote preventive services according to age and gender appropriate schedule.

Iowa High Quality Healthcare Initiative Training

For the Iowa High Quality Healthcare Initiative, Molina will conduct comprehensive training for contracted providers encompassing program-specific topics that will include, but will not be limited to:

- The role of the Care Coordinator and the importance of notifying a member's care coordinator, as expeditiously as warranted by the member's circumstances, of any significant changes in the member's condition or care, hospitalizations, or recommendations for additional services;
- Critical incident training as described in Iowa High Quality Healthcare Initiative Scope of Work, Section 10.4.3 Critical Incidents Training;
- Abuse and neglect training including procedures and requirements for preventing, identifying, reporting, investigating, and remediating suspected member abuse, neglect and exploitation;
- Provider requirements and responsibilities;
- Prior authorization policies and procedures;
- Claims submission processes;
- Claims dispute resolution processes;
- Any applicable Medicaid policies including updates and changes;
- Person Centered Planning Process; and
- HCBS settings per CMS regulations.

Molina provider training will further support traditional LTSS providers in transitioning to providing

services under the Iowa High Quality Healthcare Initiative through assistance with resources such as IT, billing and systems operations.

Molina makes its Provider Manual available to all new providers. Molina trains providers and their staff on contract requirements and members' special needs either face-to-face through scheduled office visits, group training at public conference sites, or via Webinars for providers with Internet access. Molina conducts training following the completion of the contracting process. Molina has dedicated Provider Services staff in each contracted service area to ensure access to training. Provider training includes an overview of processes, requirements and responsibilities, as well as provider-specific information by provider type. Training is further required for those providers who do not participate within expected timeframes. Retraining is also required on a case-by-case basis for providers who may experience difficulty.

Molina's Iowa High Quality Healthcare Initiative provider training program will be conducted telephonically, face-to-face, via televideo or in classroom settings, depending on provider availability, and will consist of core topics that are applicable to all network providers supplemented by topics that are specific to specialty providers or PCPs. Molina will also address training requirements according to provider responsibilities and differences between the covered benefits of the Iowa High Quality Healthcare Initiative and other programs. Molina has developed and will utilize a PowerPoint presentation, upon DHS approval, as its core training tool and reference for any provider process or policy associated with Molina. The PowerPoint presentation will also be available for provider review on Molina's secure Provider Web Portal.

Molina Provider Services staff will train providers on Molina's policies and procedures to ensure understanding of Iowa High Quality Healthcare Initiative Contract requirements and the unique needs of the Iowa High Quality Healthcare Initiative population. Prior to go-live, Provider Services staff will conduct initial orientations to train providers on the Provider Manual and related policies and procedures. Subsequent communications and regular joint operations meetings will provide ongoing avenues for Provider training.

Iowa High Quality Healthcare Initiative Program Orientation

All participating Molina providers will be invited to attend the Iowa High Quality Healthcare Initiative provider orientation program, including newly contracted physicians. We will schedule sessions according to location, provider type and program, since PCPs, behavioral health providers, family planning providers, specialists and other contracted providers assume different responsibilities within the program. The orientation sessions will be scheduled no later than 90 days prior to Iowa High Quality Healthcare Initiative program implementation. Orientation tools and materials provided may include the Provider Reference Guide, including information and instruction on transportation; dental, vision and Language Line; Provider Manual; Diversity Pamphlet; Prior Authorization Matrix; Molina Contact List and quarterly Molina Healthcare of Iowa provider newsletters.

Continuing Education

Molina utilizes a variety of approaches to continuing education and training for its network providers, including in-person provider presentations/trainings, webinars, and written materials including the Provider Manual, Provider Newsletter and bulletins, all of which are accessibly electronically via the Molina website 24 /7. Relevant training topics will be identified through trend tracking and national recommendations, frequently asked questions received by Provider Service Representative, Molina's Quality Improvement Committee, or direct request to the Chief Medical Officer. Educational programs, training methods and training materials are regularly developed for distribution to our network providers and posted to the secure provider Web Portal. We further offer education and training on Molina policies and procedures to its participating providers on an ongoing basis.

Specialized ongoing provider training will be developed as innovations to Iowa High Quality Healthcare

Initiative service delivery require. Furthermore, ongoing training will be offered to providers identified as requiring continuing education on specific policies or procedures by internal Molina department staff who interact with providers (e.g. Health Care Services, Customer Support Services, Claims, Member Grievances/Appeals, Quality Improvement, Anti-Fraud, Utilization Management and Pharmacy).

6.1.8 Notification of Provider Disenrollment

1.Describe procedures for ensuring continuity of care and communication with members when a provider disenrolls.

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP#MED-16-009, Scope of Work, Section 6.1.8 Notification of Provider Disenrollment.

Molina has policies and procedures in place to ensure member continuity of care in case of the termination or loss of a large-scale provider, health system or subcontractors' provider network from the Molina Iowa High Quality Healthcare Initiative network. Following such a termination or loss, an immediate meeting will be initiated for a multidisciplinary team that includes the leaders of our Health Care Services, Member Services, and Provider Services departments. Specific members of the team and data reviewed may vary based on the type of provider. The team will always approach recovery in such a way so as to promote the best quality of care for the member; support seamless continuity of care and minimize disruption to the member and providers; and affect the outcome that will minimize future disruption to the provider and the member. The team will implement the following actions in the case of the loss of one of the abovementioned providers from the Iowa High Quality Healthcare Initiative network:

- A formal approach to notification of members, providers, DHS, and other stakeholders, both internal and external, will be followed 60 calendar days prior to provider termination or suspension, unless an immediate termination was issued, in which case the termination notification will occur immediately. A written explanation will be included in the DHS notice of termination within 15 calendar days to any member that has received services from a provider or otherwise sees the provider on a regular basis when a for-cause termination has been issued;
- Identification of members who will require relocation or continuation of services, as well as any special needs of these members;
- Telephone outreach and care coordination by a Molina Case Manager for members who will require relocation or are in active care, as well as any special needs of these members, at least 60 calendar days before the effective date of the suspension or termination, or immediately for immediate terminations;
- Prioritization of members based upon their medical, safety, social and behavioral health needs;
- Molina Case Manager-led meetings as soon possible with members, their families, and their caregivers to discuss transition of care and identify any preferences that may exist;
- A specific continuity of care plan of action to transition members' to alternative sites or providers to ensure no disruption in care occurs, including transportation arrangements;
- Documentation of all actions of the recovery team, including when and where the enrollees were transferred, notifying the Agency of specific actions taken;
- Appropriate transfer of all medications, medical equipment, and medical charts to the receiving facility or provider;
- Establishment of on-site monitoring of the receiving facility or provider to ensure the appropriate quality of care is provided by the new facility or provider;

- If a member is placed in a residential facility that is not their first choice, track availability of other facilities that better reflects the member's wishes;
- Analysis of the network to identify new network gaps and limitations in member choice created by the provider loss; and
- On-site follow up visits by Case Manager within the first week of transfer.

Continuity of Care is a key component of our Member Services training curriculum. Member Services Representatives are trained on internal processes as well as how to accurately identify continuity of care issues and assist members who call into the hotline.

6.1.9 Medical Records

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP#MED-16-009, Scope of Work, Section 6.1.9 Medical Records.

1. Describe your process for transmitting and storing medical data, including the use of technology and controls to ensure confidentiality of, and access to, medical records.

Molina understands its considerable responsibility in handling highly sensitive medical data and related information about its members, and takes transmitting, storing and protecting member privacy and confidentiality very seriously. Molina is committed to complying with all state and federal laws and regulations regarding medical records containing Protected Health Information (PHI) and related confidential medical data. Molina uses and discloses PHI pertaining to its members in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable laws.

For the Iowa High Quality Healthcare Initiative, Molina will develop and implement policies, procedures and contractual requirements for participating provider medical records content and documentation in compliance with the provisions of Iowa Admin. Code 441 Chapter 79.3, subject to DHS review and approval. Upon approval, Molina will communicate these policies and procedures to its network providers and will assure that its records and those of its participating providers document all medical services members receive in accordance with State law and are consistent with utilization control requirements in 42 CFR 456.

Molina currently administers a comprehensive set of administrative, technical and physical safeguards to ensure that PHI is appropriately stored and processed so that it is protected against unauthorized use or disclosure. The types of member information that Molina safeguards include, but are not limited to, the following:

- Member names and addresses;
- Medical services provided;
- Social and economic conditions or circumstances;
- Medical data, including diagnosis and past history of disease or disability; and
- Any information received, stored or processed in connection with Molina's program integrity operations.
- Molina's policies and procedures generally limit the use and disclosure of a member's PHI to the following:
- For treatment, payment and health care operations;
- To the member or the member's personal representative (e.g., parent or legal guardian);

- To the Secretary of the U.S. Department of Health and Human Services; and
- As otherwise required or permitted by law, such as for public health purposes, legal proceedings, law enforcement or health care oversight activities.

For all other releases of a member's PHI, the member or their personal representative must sign a written authorization consenting to the release of the information. Molina's policy is to limit releases of PHI to the minimum necessary information to perform a transaction or process or to respond to a request for information. Molina staff must follow specified procedures to verify the identity and authority of the recipient prior to releasing PHI.

Molina requires all of its employees complete HIPAA Privacy and Security Training within 30 days of date of hire and annually thereafter. We utilize online and classroom modules to effectively deliver job-specific HIPAA training to its employees. Our online HIPAA training is used to address the core HIPAA training needs for all Molina employees and is supplemented by specialized classroom training.

To ensure our providers understand their role in identifying and reporting potential HIPAA violations, the Provider Manual is incorporated by reference into our standard provider contract agreement, which states: "Provider will comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act and any regulations promulgated thereunder (collectively the "HIPAA Rules")." (Provider Manual, Section 2.7.c. HIPAA)

Molina's HIPAA-Compliant Medical Information Management System

Molina's secure, fully integrated and HIPAA compliant QNXT multi-level medical management system and web-based Clinical CareAdvance Care Management system ensures secure entry, storage and transfers of PHI and other critical medical data, while also aiding, tracking and improving patient outcomes, as well as summarizing data for reporting of key performance indicators. QNXT Systems' Electronic Data Interchange (EDI) solution, the Molina EDI Gateway, complies with all EDI and HIPAA requirements for data transfer and acquisition. Highlights of our efforts to remain compliant with Federal and State legislative requirements and guidelines are provided below:

- 5010 and ICD-10 Compliance – Molina is 5010 compliant and on track to comply with ICD-10 published deadlines.
- Electronic Health Record (EHR) – In the case of Eligible Professionals and hospitals which deliver care via Medicaid managed care programs, Molina's contracted providers may be eligible for incentive payments at the State's option.
- Medicaid Infrastructure Technology Architecture (MITA) guidelines – Molina has aligned its Architecture and Development guidelines with MITA in key areas such as, Security, Open Source and Non-proprietary, Decision Support Systems and Governance.
- Compliant Security Processes and Tools – Molina employs the advanced security technology and policies to protect its member data, including security and antivirus systems.
- HIPAA Security and Privacy Training – Molina trains all employees on the privacy and security of PHI.
- Molina has established process, policies and procedures to recover IT systems and operations after a declared disaster event.
- Molina utilizes RecoverPoint Disaster Recovery technology to enable 30-minute recovery of Molina core systems to its data hot site.
- Periodic Audits – Molina engages in annual internal and external audits and several state audits that oversee IT controls for Administrative, Physical and Technical security.

Data Security and Risk Management

Molina has implemented a broad set of operational and technical best practices that help protect the company's sensitive data. This is achieved through use of a data lifecycle plan that allows the company to respond in a timely, accurate manner.

Molina IT Security has deployed several tools that guard against a wide range of security issues. Molina will continue to monitor industry trends and update our tools, policies and procedures as needed. Some of the specific tools currently deployed include:

- FireEye – Blocks inbound Web exploits and outbound multi-protocol callbacks, and identifies zero-day malicious software;
- Symantec Endpoint Protection – Security platform installed on all workstations and servers. This includes Anti-Virus, application and device controls (USB access);
- Intrusion Prevention and Detection System - Monitors and blocks malicious traffic;
- IT Security Risk Management program – Utilizes NIST 800 series and SANS critical controls that helps assess security risks associated with Information Technology assets;
- Data Loss Prevention – Workstation and network monitoring for sensitive information leaving the network via unsecured/unauthorized channels;
- Penetration Testing - Focuses on current top 10 common and significant web security pitfalls based on the Open Web Application Security Project (OWASP);
- Vulnerability Management - Employed to review and remediate application and operating system bugs; and
- IronPort - Email security appliance that provides advanced threat prevention, blocks spam and viruses, encryption and is a key component in Molina email policy enforcement.

Encouraging Provider Utilization of Secure Electronic Health Records

Molina encourages its providers to use secure Electronic Medical Records (EHRs), e-prescribing and electronic claims/encounter submissions to decrease the potential for medical errors and loss of data. Molina works with its providers, Pharmacy Benefit Manager, and EDI clearinghouse to identify barriers providers experience in moving to electronic functionality and regularly evaluates its in-house tools (e.g., Web Portal) and systems (e.g., claims) to determine areas for process improvements.

For example, Molina enhanced its secure Provider Web Portal by developing functionality that allows providers to submit claims directly through the portal. This is particularly valuable to low-volume providers or providers with limited resources to purchase electronic solutions. Molina also reduced the number of attachments required for claims adjudication, allowing a higher volume of claims to be submitted electronically. In alignment with these efforts, some of our pay-for-performance initiatives are based on a provider's utilization of electronic tools to manage certain practices functions and information exchanges.

To further encourage providers to adopt secure EHRs management technologies and protocols, Molina also participates in state-sponsored Health Information Exchange (HIE) sites nationwide intended to mobilize health care information electronically and securely across organizations within a certain geography or community.

Molina Healthcare of Michigan - Covinsint HIE Project Partnership

One example of Molina's commitment to innovative HIE participation is the Covisint project, which provides the framework for an HIE network serving physician organizations throughout the State of Michigan. In partnership with the Michigan Association of Health Plans (MAHP) and the Michigan State Medical Society (MSMS), all members of MSMS (15,000+ providers) are given free access to the Covisint site. Covisint provides a platform, accessible by a single secure sign-on, from which physicians

will have access to patient information, including labs and eligibility, as well as e-prescribing access. Molina, in collaboration with Covisint has created a link on the secure Provider Web Portal to allow providers to access a wide variety of services. These services will include e-prescribing, multi-payer eligibility, multi-payer claims status, secure file exchange services and secure email. Future planned functionality will allow providers to access members' prescription and medical claims history and allow online authorizations and integration with health information exchange functionality. Our participation supports physician access to Molina and other Medicaid health plan sites (Web Portal) directly through the single-source login.

6.1.10 Availability of Services

1. Describe your plans to ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable Medicaid members.

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP#MED-16-009, Scope of Work, Section 6.1.10 Availability of Services.

It is critical that all members have access to appropriate care during regular hours of operation. As such, both Molina and the state have established provider coverage requirements for hours of operation that are no less than the hours of operation offered to commercial health plan members or enrollees in comparable Medicaid plans. Molina becomes aware of non-compliance with these standards through member complaints received by staff in Member Services, Service Coordination, or the Member Advocate. Molina also conducts annual access and availability studies to assess compliance with standards.

When Molina identifies a PCP who does not meet the hours of operation requirements, a Provider Services Representative immediately contacts the PCP office to investigate the complaint. The purpose of the investigation is to determine if the incident was a one-time occurrence or a systemic problem. In the rare occurrence of a systemic issue, The Provider Service Representative then educates the provider on required hours of operation. A re-audit of the provider's hours of operation is conducted several weeks later to confirm the issue has been resolved. If it has not been resolved, we take additional corrective action including potentially closing the provider's panel and/or terminating the provider's contract. The member will be reassigned to another provider and services will be authorized to ensure continuity of care.

6.1.11 Provider Compliance

1.Describe procedures for ensuring network providers comply with all access requirements and for monitoring providers for compliance.

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP# MED-16-009, Scope of Work, Section 6.1.11 Provider Compliance.

For the Iowa High Quality Healthcare Initiative, Molina will establish and implement procedures, subject to DHS review and approval, to ensure that its network providers comply with all program access requirements, including but not limited to appointment times set forth in Exhibit B, General Access Standards, and will be able to provide documentation demonstrating monitoring of compliance with these standards.

Across all of its health plans nationwide, Molina's Provider Services department consistently monitors contracted PCPs and other providers for compliance with network performance standards, most notably wait time and appointment standards. Providers not in compliance with performance standards are sent letters notifying them of findings and the need for corrective action. Our Provider Services staff confirms

the deficiency has been corrected or, if unresolved, is referred to the Network Operations Committee for further action.

Molina's Member-Provider Satisfaction Committee will be responsible for ensuring the maintenance of an appropriate range of covered services for our Iowa High Quality Healthcare Initiative members. The committee further ensures the Molina provider network has a sufficient number, mix and geographic distribution of Medical Home providers to meet its members' unique health care needs in full compliance with all applicable requirements, including maintenance of practice guidelines and adequate access and availability. The committee continuously monitors and addresses all issues within the provider network and focuses on effective long-term strategies to improve the network.

All Molina health plans include a Member-Provider Satisfaction Committee which reviews quarterly member grievance and appeal summaries, updated GeoAccess and time/distance reports, Nurse Advice Line reports, provider satisfaction surveys, and summaries of activity with non-contracted providers. Molina utilizes this information to identify potential gaps in its networks, monitor member access to key specialties, and identify all necessary action items.

Molina's Quality Improvement staff also oversees provider Appointment Availability and After-Hours Access studies each year while our Provider Services Team conducts random office audits whereby staff calls the PCP's office, posing as patients, in order to verify that patients can get appointments scheduled within the state-required timeframes. Any office that does not meet the standards is contacted by our Provider Services department for focused intervention with the provider to effect timely access. Provider education is performed, and the PCP must submit a corrective action plan.

Monitoring Access and Appointment Standards

In accordance with requirements set forth in Exhibit B, General Access Standards, Molina will consistently and proactively monitor, address potential gaps, and ensure its Iowa High Quality Healthcare Initiative provider network and related participating provider types are compliant with access and appointment standards depicted in Exhibit 6.1.11-1 below.

Exhibit 6.1.11-1 Provider Access and Appointment Standards

Provider Type	Distance/Time Standard	Appointment Time Standard
Primary Care Physicians	30 miles or 30 minutes from the personal residences of members	Not to exceed 4-6 weeks from the date of a member's request for a routine appointment, within 48 hours for persistent symptoms and urgent within one day
Specialty Care	60 miles from the personal residence of members for at least 75% of non-dual members; 90 miles from the personal residence of members for all non-dual members	No more than thirty (30) days for routine care or one day for urgent care
Hospital and Emergency Services	Hospitals – no more than 30 minutes, except in rural areas where access time may be greater (if greater, community standard for care access applicable); Emergency Care - immediate, at the nearest facility available, regardless of whether the facility or provider is under contract with Molina	N/A

Provider Type	Distance/Time Standard	Appointment Time Standard
Long-Term Care Services	Institutional Providers - All licensed and Medicaid certified Nursing Facilities and ICF/IDs included in provider network for minimum two years; network enrollment evaluated annually thereafter; HCBS - contract with at least two providers per county for each covered HCBS in the benefit package for each 1915(c) HCBS waiver	Transport distance to licensed Adult Day Care providers not to exceed 20 miles for members in urban areas, 30 miles for members in suburban areas, 60 miles for members in rural areas, except where community standards and documentation apply
Behavioral Health Services	Outpatient services: 30 miles, except where community standards and documentation shall apply; Inpatient, residential, intensive outpatient, partial hospitalization - 60 miles in urban areas, 90 minutes in rural areas using GeoAccess standards for rural and urban travel time	Emergency – within 15 minutes of presentation; Mobile Crisis – within 30 minutes of presentation; Urgent – within one hour of presentation; Persistent symptoms – within 48 hours of reporting symptoms; Routine – within three weeks of appointment request; Substance Use Disorder & Pregnancy – within 48 hours of seeking treatment; Intravenous drug use – within 14 days of admission request or 120 days if no program has the capacity to admit and if interim services are made available no more than 48 hours after request
Other Services	General Optometry - 30 minutes, except in rural areas where community standards and documentation apply; Lab and X-Ray Services - 30 minutes, except in rural areas where community standards and documentation apply; Pharmacy – minimum two pharmacy providers within 30 miles or 30 minutes, excluding pharmacies participating in the Specialty Pharmacy Program	No more than three weeks for regular appointments, 48 hours for urgent care; No more than three weeks for regular appointments, 48 hours for urgent care; N/A

2. Describe emergency/contingency plans in the event a large provider is unable to provide needed services.

Molina maintains an up-to-date and effective emergency/contingency plan for caring for our members in the event a facility or provider terminates its provider contract, is terminated by Molina, or is unable to provide needed services either to new members or existing members on the provider's panel. We will also notify members in accordance with the provisions of the Iowa High Quality Healthcare Initiative Contract and state and federal law regarding provider termination.

Molina's provider network will be adequate to ensure the availability of alternative facilities or contracted

providers in the event of termination and to promote member choice. Where Molina offers no alternative contracted provider, non-contracted providers will be utilized. At a higher level, we will maintain a health plan culture which reinforces each staff member's responsibility to manage to the needs of our members and the contract between Molina and DHS.

Molina will further establish cross-departmental teams to support this culture of responsibility throughout the organization. This cross-departmental approach will eliminate departmental silos and improve early identification of issues with providers and promote more effective recovery in the event of a network loss.

Member Transitions

Molina has policies and procedures in place to support members with provider transitions in the event of a large-scale provider or health system contract termination. After any immediate concerns regarding member care are first addressed, Molina will follow the specific terms of the contract with the facility or provider. Facility and provider contracts feature specific provisions concerning the transition of member care and the continuation of care requirements following termination of the contract.

In cases in which a patient's health is subject to imminent danger or a provider's ability to practice medicine or otherwise provide services is effectively impaired by an action by the board of Medicine or governmental agency, notice to both the provider and the Agency shall be immediate. Molina will work cooperatively with the Agency to develop and implement a plan for transitioning enrollees to another provider. For members in active care, the Case Manager will notify the member and transition of care efforts will begin immediately. Other members will be notified in writing with a follow-up phone call by the Case Manager to ensure future services are appropriately redirected. Immediate needs and safety along with preferences of the member will be the priority when pursing transitional options.

In those instances where a transition of care requires a less emergent approach, the transition will be initiated by any member of an interdepartmental team, which includes the leaders of the Case Management, Medical Services, and Provider Services departments, as well as the Plan President, Vice President of Network Management and Operations, and Chief Medical Officer. Molina's Vice President of Network Management and Operations will hold ultimate responsibility for Molina's Network Recovery Plan.

Continuity of Care

Molina has policies and procedures in place to ensure member continuity of care in case of the termination or loss of a large-scale provider, health system or subcontractors' provider network from the Molina Iowa High Quality Healthcare Initiative network. Following such a termination or loss, an immediate meeting will be initiated for a multidisciplinary team that includes the leaders of our Health Care Services, Member Services, and Provider Services departments. Specific members of the team and data reviewed may vary based on the type of provider. The team will always approach recovery in such a way so as to promote the best quality of care for the member; support seamless continuity of care and minimize disruption to the member and providers; and affect the outcome that will minimize future disruption to the provider and the member. The team will implement the following actions in the case of the loss of one of the abovementioned providers from our network:

- A formal approach to notification of members, providers, DHS, and other stakeholders, both internal and external, will be followed 60 calendar days prior to provider termination or suspension, unless an immediate termination was issued, in which case the termination notification will occur immediately. A written explanation will be included in the DHS notice of termination within seven (7) business days of when a for-cause termination has been issued.
- Identification of members who will require relocation or continuation of services, as well as any special needs of these members;
- Telephone outreach and care coordination by a Molina Case Manager for members who will require relocation or are in active care, as well as any special needs of these members, at least 60 calendar days

before the effective date of the suspension or termination, or immediately for immediate terminations;

- Prioritization of members based upon their medical, safety, social and behavioral health needs;
- Molina Case Manager-led meetings as soon possible with members, their families, and their caregivers to discuss transition of care and identify any preferences that may exist;
- A specific continuity of care plan of action to transition members' to alternative sites or providers to ensure no disruption in care occurs, including transportation arrangements;
- Documentation of all actions of the recovery team, including when and where the enrollees were transferred, notifying the Agency of specific actions taken;
- Appropriate transfer of all medications, medical equipment, and medical charts to the receiving facility or provider;
- Establishment of on-site monitoring of the receiving facility or provider to ensure the appropriate quality of care is provided by the new facility or provider;
- If a member is placed in a residential facility that is not their first choice, track availability of other facilities that better reflects the member's wishes;
- Analysis of the network to identify new network gaps and limitations in member choice created by the provider loss;
- On-site follow up visits by Case Manager within the first week of transfer.

Post Recovery Evaluation
Once transition is complete, a follow-up meeting with the transition team will be convened to assess the effectiveness of their recent actions and to identify areas for improvement. The team will also assess if any early indicators of facility loss were present and if they were properly identified. Any lessons learned from this process will be incorporated into the recovery plan.

6.2 Network Development and Adequacy

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP#MED-16-009, Scope of Work, Section 6.2 Network Development and Adequacy.

1. Describe in detail your plans to develop and maintain a comprehensive provider network, including goals and tasks and the qualifications and experience of the staff members who will be responsible for meeting network development goals.

Molina will meet all Iowa High Quality Healthcare Initiative provider network development and adequacy standards through a proactive and multifaceted provider network development strategy to effectively recruit and retain providers by:

- Conducting comprehensive outreach to physicians, hospitals and clinics, including affiliated groups, potential subcontractors, health systems and associations during the RFP stage and after contract award;
- Introducing and leveraging Molina's expertise in collaborating with providers to manage Medicaid programs;
- Conducting face-to-face meetings, using direct mail, phone and fax outreach to a wide range of PCPs, specialists, large provider groups, behavioral health providers and related entities, targeted hospitals, urgent care facilities, family planning and maternal/child health centers, FQHCs/RHCs and other safety net and community-based providers;

- Generating GeoAccess software reports and/or similar electronic mapping solutions to continually monitor and refine provider network development outreach, focal points and targeting strategies to ensure composition requirements are maintained;
- Working with DHS and other key stakeholders to help identify and bolster areas where beneficiaries may have historically had issues accessing health care services; and
- Establishing direct contact with providers and seeking to understand the challenges they might face in serving Iowa High Quality Healthcare Initiative beneficiaries.

Provider Network Development Strategy

Molina's provider contracting strategy is focused on ensuring network adequacy to serve the Initiative's expected enrollment; an appropriate range of services, including primary and preventive care services; and a sufficient number, mix and geographic distribution of providers in accordance with the program's General Access Standards.

Utilizing GeoAccess and Quest Analytics (Quest ACC) network reporting platforms, and other key Provider Contracting department resources to ensure compliance with program adequacy and access standards, [redacted]

Molina continues to build the size and scope of its Iowa High Quality Healthcare Initiative network with the intent to convert all signed provider LOIs into formal provider contracts by program Go-Live January 1, 2016.

As an example of our statewide provider network development efforts, Molina has secured LOIs and/or verbal agreements to contract upon award with many of the state's largest hospital systems, clinics, provider groups, behavioral health providers, public health agencies, nursing facility systems, waiver services providers, and community-based specialty/ancillary services providers with the intent to contract before program go-live January 1, 2016. [redacted]

CONFIDENTIAL

[redacted]

In compliance with Iowa High Quality Healthcare Initiative Scope of Work, Section 6.2.2.9, Molina will further contract with the IDPH-procured provider network for IDPH-funded substance use disorder treatment facilities to ensure its members have access to such covered services through the state.

Molina's Provider Network Management and Operations team manages the provider network contracting process and employs the following strategies for initiating provider relationships that will ensure a comprehensive provider network that best serves the needs of the Iowa High Quality Healthcare Initiative's diverse membership:

- **Assess Network Adequacy** – Molina utilizes available market information and historical encounter and payment data to help identify and contract with providers especially those with experience caring for low income members. Molina's contracting goal is to meet or exceed the minimum provider ratios for the statewide Iowa High Quality Healthcare Initiative network in all provider categories, and to meet full compliance with General Access Standards set forth in Exhibit B, General Access Standards. In the event a ratio cannot be achieved due to provider refusal or lack of providers of a determined specialty, Molina may seek to contract with providers in contiguous counties or service areas. Molina maintains all supporting documents, validating refusal or lack of certain providers and will provide this information to DHS if it becomes necessary to obtain a waiver from the specific ratio requirement.
- **Provider Contracting -** Molina has a team of highly trained Provider Services staff "on the ground" to lead the network development recruitment and provider contracting efforts. These efforts emphasize the establishment of full-risk contracts with qualifying Primary Care Physicians (PCPs), specialists, large provider groups, behavioral health providers and related entities, targeted hospitals, urgent care facilities, family planning and maternal/child health centers, FQHCs/RHCs and other safety net and community-based providers capable of being responsible for providing all Iowa High Quality Healthcare Initiative covered services to Molina members; demonstrate administrative and financial capacity to meet contractual obligations; and perform certain functions on Molina's behalf, for example, credentialing, claims processing and/or care management. Molina further intends to execute contracts for the first two (2) years of the Iowa High Quality Healthcare Initiative Contract with the following currently-enrolled DHS providers: community mental health centers; 1915(i) HCBS Habilitation Services providers; nursing facilities; ICF/IDs; health homes; and 1915(c) HCBS waiver providers, with the exception of case managers and care coordinators.

  In accordance with Scope of Work, Section 6.2.2.6, Molina intends to secure contracts for the first two years of the Iowa High Quality Healthcare Initiative Contract with the following currently-enrolled

CONFIDENTIAL

DHS providers: community mental health centers; 1915(i) HCBS Habilitation Services providers; nursing facilities; ICF/IDs; health homes; 1915(c) HCBS waiver providers, with the exception of case managers and care coordinators; and substance use disorder treatment programs in the IDPH-funded network. During this two-year period, Molina may recommend disenrollment of providers not meeting defined performance measures. Molina understands DHS will retain authority for performance standard development, with input from program contractors, and maintain final authority for review and approval of any disenrollment recommendations. After the two-year period, Molina will continue to reimburse these provider types at a rate equal to or exceeding the current Iowa Medicaid fee-for-service rate. Molina understands that for all provider types not described in Section 6.2.2.6, in the course of developing its network during the first six months of the Contract, Molina will extend contract offers, at minimum, at Medicaid fee-for-service rates. After this six-month time period, Molina will continue to reimburse these provider types at a rate equal to or exceeding the current Iowa Medicaid fee-for-service rate.

Molina has a clear understanding that all provider contracts and any subsequent contract modifications must receive prior approval from DHS and must meet all the requirements set forth by DHS. Molina further understands that LOIs may be utilized on an interim basis until such time provider contracts can be fully executed. Molina intends to execute provider contracts to the extent possible and rely on LOIs only as needed.

- **Provider Credentialing –** In compliance with Iowa High Quality Healthcare Initiative Scope of Work, Section 6.2.2 Network Development and Maintenance, Molina will demonstrate to DHS that all of its network providers are credentialed. Further, in compliance with Scope of Work, Section 6.2.2.3. Molina will develop and implement written policies and procedures, subject to DHS review and approval, for the selection, credentialing, recredentialing and retention of its network providers in accordance with 42 CFR 438.214(c). Molina reviews its providers through an NCQA-accredited credentialing process that verifies licensure, education, and reviews overall ability of the provider to render quality services to members. Participating members of Molina's Credentialing Committee, which reviews and approves these providers, includes established practicing providers from the Molina network. Molina utilizes VisualCACTUS©, a robust and scalable Credentialing Electronic Record System used by thousands of leading health care organizations. Molina will ensure that all Molina network providers are appropriately credentialed and qualified to provide services in accordance with requirements set forth by DHS. The credentialing process will include the collection and verification of applicable information using the standard credentialing form prescribed by DHS; provider site visits; review and approval by the Molina Credentialing Committee; and completion within contractually required timeframes.
- **Provider Communication Plan –** Molina's Provider Network Management and Operations team maintains a provider communication plan that includes phone calls, email, text messaging alerts, mailings and in-person visits to introduce providers to the Molina network and help begin the contracting process. On an ongoing basis, Molina understands that a successful network partnership begins with building a strong relationship between Molina team representative and provider/office staff. Molina supports a feet-on-the-street and faces-in-the-office approach, along with frequent contact to build and maintain the provider/office staff relationship.
- **Provider Education -** Molina Provider Services staff provides education and training on Molina policies and procedures an ongoing basis. Provider education will be expanded to include the required 20 hours of continuing education curriculum, divided into five hours per calendar quarter. The curriculum will address key topics, such as EPSDT, behavioral health integration, and other clinical issues, along with topics in the PBM's Academic detailing program.
- **Provider Training –** Molina maintains a Provider Manual and supplemental materials in electronic and hard copy formats that are available upon request. These materials represent a compilation of

Molina's policies and procedures, standards and specimen documents. From time to time, Molina may unilaterally amend or modify these documents which are for the use and instruction of contracted providers and to which contracted providers must adhere. Molina will expand the Provider Manual to include Provider Guidelines that are distributed to all Molina network providers as part of the contracting process. Molina understands and acknowledges that Provider Guidelines content must address topics as specified by DHS and must receive prior approval from DHS.

- **National Provider Contracting –** Molina's contracting strategy includes the identification of any providers or vendors with which Molina also contracts on a national basis in its other markets and who may enter into contracts with Molina or its delegate(s) to render or arrange for the rendering of covered services in the State of Iowa This approach further ensures continuity of care and consistency of adherence to Molina's policies and procedures.
- **Staffing Plan –** Molina's contracting strategy includes the development of a staffing plan to support the recruitment, hiring and training of local staff to perform Network Management and Operations functions.
- **Business Requirements Documents Review –** Molina's contracting strategy includes the review of provider network-related forms and materials necessary for Molina to implement and administer business functions, provider and contract data configuration, claims payment administration, and division of financial responsibility matrices related to contracted provider capitated financial arrangements.

Molina's Provider Network Development Staff

To build its robust network in Iowa, Molina Healthcare of Iowa will leverage the deep experience of the Provider Contracting and Provider Services teams of its parent company, Molina Healthcare, Inc., which have built a national network of some 161,800 providers that include physical and behavioral health providers and provider groups; hospitals and clinics; FQHCs and RHCs; family planning and maternity/child care centers; nursing homes and skilled nursing facilities; long-term care providers; and Safety Net and Home and Community-Based Service providers in support of more than 3.2 million Medicaid beneficiaries in 11 states and the Commonwealth of Puerto Rico, making Molina one of the nation's largest Medicaid vendors.

Molina's provider network development activities are conducted by a 20-member New Markets Network Development team led by two New Market Development professionals with more than 40 years of combined national experience on behalf of large national managed care organizations serving Medicaid and Medicare populations. This team was directly responsible for the recent successful network development of new Molina markets in Illinois, South Carolina and the Commonwealth of Puerto Rico, which serve more than 590,000 Medicaid and Dual Eligible members combined.

Network Composition Monitoring and Addressing Network/Coverage Gaps

Molina will continually develop and enhance its statewide Iowa High Quality Healthcare Initiative network. Member access to care will be monitored on an ongoing basis by our network management staff and reported on a quarterly basis to our Quality Improvement Committee. Access will be reported monthly during the first year of program implementation. Quarterly reports will measure the provider network against documented access standards, identify any areas for improvement, and identify progress made to remedy any deficiencies identified in the previous quarter. We will actively monitor data, trends, feedback, and provider and care planning activities to identify network needs and gaps, including:

- Monitoring enrollment trends, member demographics, service utilization, and provider terminations;
- Utilizing GeoAccess analysis to ensure adequate geographic coverage, tracking adequate geographic coverage plus languages spoken by members and providers to identify and match cultural and linguistic needs;

- Analyzing member grievances and appeals;
- Monitoring feedback from Case Managers and Community Connectors about access concerns or provider gaps;
- Reviewing the number and types of requests for out-of-network providers;
- Monitor Consumer Assessment of Health Plans (CAHPS) for member self-reports of access;
- Monitoring Healthcare Effectiveness Data Information Set (HEDIS) and other standard measures to assess if members are adequately receiving services;
- Monitoring member to provider ratios by specialty and by service area;
- Annual surveys of network providers to determine if appointment access is meeting standards including average wait times and geographic access standards; and
- Periodic audits of appointment availability and wait times, including secret shopper and site visits by provider representatives.

In compliance with Iowa High Quality Healthcare Initiative Scope of Work, Section 6.2.3 Network Adequacy, Molina will document adequate network capacity upon entering the Iowa High Quality Healthcare Initiative Contract; at any time there is a significant change in the State's operation or the program, changes in services, changes in benefits, changes in payments, or enrollment of a new population; or as otherwise requested by the State.

Short and Long-Term Interventions to Address Network/Coverage Gaps

For immediate program-related service issues, Molina Case Managers will identify the need for a non-contracted provider and coordinate with our Provider Contracting department to facilitate an LOI needed. Continued use of non-contracted providers will be reported to our Network Management and Operations department for inclusion in network evaluations. In the long term, all issues related to access will be reported to and reviewed by our Network Management and Operations department and Quality Improvement Committee to ensure that a long-term solution is established. Interventions are designed to address specific access barriers, close gaps, and ensure timely development and enhancement of the network. With oversight responsibility, the Quality Improvement Committee will ensure successful implementation of interventions and will continue to analyze issues and discuss appropriate courses of action to intervene or take corrective measures. Interventions might include targeting providers for additional training, adding a new clinic or telemedicine capabilities, admitting new providers to the network, or termination of a provider contract.

Molina has developed several successful strategies to support PCP satisfaction and ensure network composition requirements including leveraging the expertise of a Member and Provider Committee comprised of representatives from various health plan functional areas, network providers and Molina members that reviews various health plan statistics and surveys and initiates actions to improve member and provider satisfaction; facilitating frequent communication exchanges with network providers, including direct outreach such as joint operations meetings or joint operations committees; and fostering open communication with network providers.

We further encourage provider participation in Physician Advisory Committees (PACs), which allows direct feedback to be solicited from our providers. The PACs are comprised of network physicians and established in appropriate geographical areas of the state. PACs review and provide input on new or enhanced programs and may suggest approaches to communications. Understanding the providers' perspective is essential to ensuring that providers know Molina supports their efforts to provide high-quality care to members, and develops or enhances programs to meet those needs.

Molina further engages network providers and fosters open communication by encouraging their participation in Community Advisory Committees for a variety of needs, such as supporting provider

engagement, key community organizations and behavioral health programs. To maximize Molina's understanding of provider and community needs, the advisory committees are comprised of individuals and organizations interested in discussing the provider and community perspective on barriers to access, such as linguistic and cultural barriers that prevent providing quality care. Our Community Advisory Committees foster strong collaborative relationships between advisory committee participants and maximize their roles and impact on the community. These committees meet quarterly in respective Molina's service areas and regions to help direct the development of programs and health education materials in ways that meet the needs and sensitivities of Molina's provider network and diverse communities.

Provider Incentives

In addition, Molina has implemented several value-based reimbursement (VBR) programs for providers, including a pay-for-performance program. VBR rewards physicians and other providers for taking a broader, more active role in the management of members' health and rewards them for outcomes, quality and value instead of solely for visits or procedures. VBR agreements strive to better serve the needs of specific population segments through more robust elements of greater clinical integration. For instance, providers may receive additional compensation for telephonic outreach, preventive visits or arranging for other preventive services, such as dental services, lead screening, mammograms and cervical cancer screenings. Outcomes measures, such as reduced Emergency Department visits, which demonstrate enhanced primary care access, are also used to reward providers. Molina supports its VBR arrangements through its advanced claims/encounter and financial management systems which support fee-for-service, capitated and invoice-based arrangements.

2. Describe your strategies for provider outreach and contracting in rural areas.

For Iowa High Quality Healthcare Initiative members residing in rural areas, Molina's rural provider network development and maintenance strategy will include a comprehensive focus on rural provider outreach and contracting as well as regular monitoring of network adequacy based on General Access Standards stated in Exhibit B, General Access Standards.

Though the state has seen a steady shift in population migration from rural to urban areas for the last several decades more than 40% of Iowans still reside in rural communities. To meet the unique health care needs of our rural members, Molina is committed to contracting with all of the state's RHCs and FQHCs, critical access and rural hospitals, regional and affiliate AgriSafe Clinics serving patients in the farming and agricultural industries, and other key Safety Net providers, to support its network of rural PCPs and specialists, hospitals and clinics. This commitment will further ensure our members living in rural counties currently defined as "underserved" by the Iowa Department of Public Health have access to the full range of the Iowa High Quality Healthcare Initiative's covered services.

We continually monitor our networks to ensure an appropriate range of required covered services are available as well as a sufficient number, mix and geographic distribution of providers (including subcontractors) to ensure timely access to needed primary and specialty services regardless of members' geographic isolation.

Molina will also leverage the deep experience and best practices of its sister health plans in successfully contracting with rural providers and health systems, along with proven and emerging Telemedicine technologies to ensure adequate provider access and availability for members residing in some of the nation's most sparsely populated regions.

For example, as the only Utah-based health plan offering both CHIP and Medicaid plans since 1997, Molina Healthcare of Utah has built one of the largest provider networks in Utah's sparsely populated Non-Wasatch Front service area, specifically rural southeast Utah, a region historically underserved. For

this service area, Molina Healthcare of Utah has a vast network of more than 1,800 providers, including 50 unique health care facilities that encompass RHCs, FQHCs and other facilities ably serving the unique health care needs of Molina members. To meet the State of Utah's rural network access and availability standards, the health plan's network also encompasses providers in the states of Arizona, Colorado, Idaho, New Mexico, Nevada and Wyoming, providing comprehensive services to Molina members residing in Utah's rural border communities.

When establishing and maintaining the provider network or requesting enrollment level increases, Molina reviews each covered service and related provider type independently to ensure adequate network capacity, and takes the following into consideration: the anticipated number of members; the expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented; the numbers and types (in terms of training, experience and specialization) of providers required to furnish the covered services; the numbers of participating providers who are not accepting new members; and the geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members and whether the location provides physical access for Medicaid members with disabilities.

For immediate service issues, Molina Case Managers identify the need for a non-contracted provider and coordinate with our Provider Contracting department to facilitate a single case agreement. Continued use of non-contracted providers is reported to Molina's Network Management and Operations department for inclusion in network evaluations. In the long term, all issues related to access are reported to and reviewed by Molina's Network Management and Operations department and the Quality Improvement Committee to ensure that a long-term solution is established.

Interventions are designed to address specific access barriers, close gaps, and ensure timely development and enhancement of the network. With oversight responsibility, our Quality Improvement Committee ensures successful implementation of interventions and continues to analyze issues and discuss appropriate courses of action to intervene or take corrective measures. Interventions might include targeting providers for additional training, adding a new clinic or Telemedicine capabilities, admitting new providers to the network, or termination of a provider contract.

Molina's Member-Provider Satisfaction Committee meets on a regular basis to review the current network status for each covered service, including mix and geographic distribution, and address issues that emerge from collected data and reports throughout the previous month. Trends that have been identified are discussed and a strategy developed to address any discrepancies identified in meeting the needs of the minimum and anticipated enrollment levels. The scope of this exercise includes services being rendered or received outside of the member's service area.

Molina will be committed to increasing provider capacity throughout Iowa High Quality Healthcare Initiative service areas particularly in rural areas with physician shortages and access barriers. We will contract with providers in counties adjacent to areas with physician shortages to enhance access to care in those areas. We further continue to seek LOIs with providers for identified gap areas to establish the best possible provider network for managed care program members. Molina will also use single case agreements and network development targeting highly-utilized out of network providers.

The single case agreement process is used when a member and/or a provider contacts Molina for services, there is no available provider in the network and an out of network qualified provider is willing to provide needed services. Molina contacts the provider and offers to sign a single case agreement for that member to continue to receive services from the specified provider. This ensures continuity of care and provides opportunity for our Utilization Management team to identify in network providers for transfer. Along with this process the network development team works with identified out of network providers to pursue contracting opportunities in order to bring them into our network, ensuring the member can continue to see the established provider.

If PCPs, specialists or hospitals are not available within the travel distance requirements of a member's residence as specified in Exhibit B, General Access Standards, Molina Member Services staff will arrange transportation service for Iowa High Quality Healthcare Initiative members to the nearest available provider to ensure these members receive the right care in the right setting.

3. Detail any way in which you propose to limit members to in-network providers.

Adhering to our fundamental commitment to ensuring member access to quality health care providers and services no matter where they live, Molina has no plan to limit access for its Iowa High Quality Healthcare Initiative members to in-network providers only. Molina continuously evaluates its statewide provider network in order to identify areas where the network can be enhanced to create improved access for its members. When these areas are identified, Molina contracts with providers to enhance the network. Molina's discipline evaluation is a comprehensive review of network capacity and member access, which enables us to quickly identify and resolve any network issues.

In those rare cases in which an in-network provider cannot be leveraged for a member's care needs, we will secure the services of an out-of-network provider through a Single Case Agreement (SCA). As successfully implemented in its other state health plans, Molina will utilize SCAs and network development strategies targeting highly utilized out-of-network providers to successfully resolve access issues in new service delivery areas, including rural settings where provider networks are more difficult to develop and maintain. Our SCA process is used when a member and/or a provider contacts Molina for services, there is no available provider in the network, and a qualified out-of-network provider is willing to provide needed services. We contact the provider and offer to sign an SCA for that member to continue to receive services from the specified provider.

Our SCA strategy ensures continuity of care for members and provides an opportunity for Molina's Utilization Management team to identify in-network providers for transfer of care. Additionally, the network development team identifies highly utilized out-of-network providers who meet credentialing standards to expand the Molina network, ensuring that the member continues to see the established provider. Molina is also engaged in reviewing network adequacy in all service delivery areas and reviews GeoAccess maps and access tables to ensure that the established networks meet projected increases in membership.

4. Describe your plans to ensure providers do not balance bill its members and plans to work with members to help resolve billing issues.

In Molina's vast experience working with providers nationwide, we have experienced few incidents of member cost-sharing/balance billing issues. This is primarily due to established provider education activities and strict provider contract management, while our Provider Manual also includes consistent reviewed and updated information on balance billing prohibits. In the rare instance of provider non-compliance, Molina takes all corrective actions necessary up to and including termination of the provider.

Molina's Member Services and Appeal and Grievances Teams work to assist members in resolving any and all billing issues. We utilize member grievances to closely monitor provider compliance regarding prohibited balance billing activities. When a member contacts Molina about a provider balance billing beyond any applicable copayment amount, or is denied a service or benefit covered under Medicaid, members of our Member Services and Appeal and Grievance teams work closely with the member throughout the process until the billing issue is resolved. When an investigation is conducted into a member billing complaint, Molina provides specific education to the provider office about their obligations under their contract and participation in the Medicaid program. When an emergent member need arises, Molina investigates the complaint promptly and takes immediate action as necessary to remediate the issue.

6.3 Requirements by Provider Type

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP# MED-16-009, Scope of Work, Section 6.3 Requirements by Provider Type.

1. Indicate if you will use a primary care provider (PCP) model of care delivery.

Molina affirms it will use a primary care provider (PCP) model of care delivery for its Iowa High Quality Healthcare Initiative provider network in compliance with 42 CFR 438.208. All Molina members will be able to select or will be assigned to a single practitioner responsible for coordinating care and making referrals to specialists. Under this PCP model, Molina will ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person formally designated as primarily responsible for coordinating the health care services furnished to the member. Moreover, Molina will ensure that any limitation imposed on a member's freedom to change between PCPs will be no more restrictive than the limitation on disenrollment.

Molina's provider network strategy is focused on contracting with PCPs who support a Medical Home environment as well as specialists, hospitals and ancillary providers to ensure adequate access to practitioners with experience treating TANF, CHIP, chronically ill populations, persons with developmental disabilities, physical disabilities, and behavioral health needs.

As part of its commitment to providing its members access to quality care, Molina builds all of its service delivery networks to meet geographic distribution requirements, member-to-provider ratios and the cultural needs of the local population. In all of its health plans, Molina enters into written contracts with properly credentialed providers to ensure all members have access to the full range of covered services. Contracted provider types include, but are certainly not limited to PCPs, specialists, pediatricians, behavioral health providers, acute care hospitals, OB/GYNs, substance use disorder services providers, and Safety Net and Home and Community-Based Services providers.

Molina's contracted providers demonstrate a willingness to deliver health care services to Medicaid members. These providers make an active commitment to:

- Dedicating a portion of their practice/business to working with the Medicaid population;
- Providing quality care and partnering with Molina to improve health outcomes;
- Maintaining state and federal regulatory compliance and meeting all contractual obligations;
- Minimizing administrative costs by submitting claims and other data using electronic methods;
- Accepting a reimbursement structure that is appropriately matched to program funding; and
- Working collaboratively to identify and implement solutions to challenges.

Using these characteristics to build a dynamic network of PCPs that offer the benefits of a Medical Home ensures members are being seen by qualified PCPs available to address their unique needs.

2. If a PCP model will be utilized, describe the following:

a. Physician types eligible to serve as a PCP.

Molina will seek to maximize member access to care by allowing as many qualified provider types as possible to serve as PCPs, PCPs for children, and outpatient behavioral health service providers for Iowa High Quality Healthcare Initiative members. Molina will utilize the following provider types to serve as PCPs:

- Internal Medicine practitioners;

- Family Practitioners;
- General Practitioners;
- Advanced Practice Nurses (APNs) and Physician Assistants (PA) when practicing under the supervision of a physician specializing in Family Practice;
- Internal Medicine;
- Pediatrics or Obstetrics/Gynecology;
- Pediatricians;
- OB/GYNs; and
- Providers within FQHCs and RHCs and similar community clinics.

All providers participating as PCPs are required to assume the full responsibilities of a Medical Home. Molina will also make specialists as well as nurse practitioners available to its members in accordance with Section 6.3.2 Physician Extenders. All PCP duties must be within the scope of the specialist's license as well. Molina Provider Service Representatives deliver focused training to specialists who assume these responsibilities to ensure that preventive services are compliant with Molina's clinical guidelines and periodicity schedules. If needed, Molina may process a provider through an expedited credentialing process to ensure member continuity of care.

Credentialed certified nurse midwives may assume the responsibilities of an OB/GYN or PCP for female members. They must consult, collaborate or refer to other health professionals for patient care issues outside of their area of competency. Certified nurse midwives may have prescriptive authority delegated by a collaborating physician if the certified nurse midwife meets the requirements of the Board of Nursing for the State of Iowa.

Outpatient Behavioral Health service providers will be Masters and Doctorate-level trained practitioners who practice independently, at community mental health centers, free-standing outpatient clinics or hospital outpatient departments. These will include persons who are credentialed as LCSWs, LPCs, LMFT, PsyDs, EdD, PhDs, Psychiatrists and QMHP-CS (under the direction of a Masters level clinician).

b. Any panel size limits or requirements.

As part of its commitment to providing its members adequate access to care, Molina builds all of its service delivery networks to meet geographic distribution requirements, including provider panel sizes that consistently meet strict member-to-provider ratios, as well as the cultural needs of the local population. In all of its health plans, Molina enters into written contracts with properly credentialed providers to ensure all members have access to the full range of covered services.

c. Proposed policies and procedures to link members to PCPs.

Molina maintains and implements written policies and procedures governing the process of member selection of and/or assignment to a PCP and requests for change, with the exception of HCBS waiver members. For HCBS waiver members, Molina will coordinate primary, acute, behavioral health and long-term care services with the member's Medicare PCP.

PCP Assignment and Changes – To ensure timely access to care, Molina will provide members with the means to select a contracted network Primary Care Provider (PCP) within five days of processing the State's enrollment file for Iowa High Quality Healthcare Initiative members awarded through this procurement. Members will have the option to select a PCP by calling Molina Customer Support Services or their Case Manager, using our Interactive Voice Response (IVR) system, through Molina's secure member Web Portal, or by mailing the PCP selection form included in their member Welcome Packet.

Members will be allowed to change their PCP at any time for any reason, and may request to do so using the means mentioned above. We will also contact all members designated as pregnant by the State's Iowa High Quality Healthcare Initiative enrollment file to assist these members with their PCP selection within five business days of processing the file.

If a member does not select a PCP within the contractually required timeframe of enrollment, Molina's multi-level medical management system QNXT, will auto-assign the member to a PCP based on programmed auto-assignment criteria that includes provider specialty, member age, mileage (using GeoAccess software), member grievances, the member's PCP history, PCP language, benefit plan, and family synchronization (i.e. assigning all children in a family to the same pediatrician). PCP Assignment criteria will also ensure that the provider is active through the member's eligibility period, the provider's plan matches the member plan, and that the provider accepts persons of the member's age and gender.

To maintain continuity of care, reinstated members will be assigned to their previous PCP of record (within the last 60 days) as long as the PCP is in the same geographical area. Molina will consider the member's last PCP if the PCP is known and available in Molina's network and is closest to the member's home address and/or zip code location; that children/adolescents within the same family are assured assignment to the same PCP; and the member's gender (OB/GYN). If there is no PCP available for the reinstated member, Molina will assign a PCP using the same method as if enrolling a new member, ensuring the PCP is located within 30 miles or 30 minutes from the member's residence.

Additionally, Molina will maintain procedures that proportionately include contracting traditional and safety-net providers in the auto-assignment process. Molina will ensure that adverse selection does not occur during the assignment process of members to PCPs.

Member Notification – Molina will mail each new member an identification (ID) card within 30 calendar days of enrollment to ensure they know their assigned PCP. When a member notifies Molina of a lost or stolen card, or that their information needs to be changed, a new ID card will be re-issued within 10 calendar days of the notification. The ID card will include all information as specified in Contract requirement 4.14.8, including, but not limited to, the member's assigned PCP's name, telephone number, address, and options to select a different PCP.

Enrollment of Native American Members – Molina will allow qualifying Native American members participating in the Iowa High Quality Healthcare Initiative to have access to all Indian healthcare providers, including Indian Health Service (IHS) facilities statewide. Native American members may choose any IHS facility as their primary care clinic and any PCP practicing within these facilities, or they can select to choose another network provider. If they choose a non-IHS PCP in Molina's network, they may still utilize IHS providers directly. If the member does not actively select a PCP, the member will be assigned to the PCP site where services have been previously provided, based on available historical data.

3. If a PCP model is not proposed, describe methods to ensure compliance with 42 CFR 438.208 as described in Section 6.3.1.

Molina affirms it will use a primary care provider (PCP) model of care delivery for its Iowa High Quality Healthcare Initiative provider network in compliance with 42 CFR 438.208 under which all members may select or will be assigned to a single physician responsible for coordinating care and making referrals to specialists. Under this PCP model, Molina will further ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person formally designated as primarily responsible for coordinating the health care services furnished to the member.

4. Describe your plan for providing a sufficient network of all provider types outlined in Section 6.3, including timelines and tasks.

Molina is currently executing a provider contracting strategy to create a robust statewide network capable of serving the diverse needs of the Iowa High Quality Healthcare Initiative population living in urban and rural settings. Our strategy includes completing provider agreements within an estimated six to nine months post-contract award with the following provider types:

- Primary Care Providers (PCPs) – In compliance with compliance with 42 CFR 438.208, Molina is committed to contracting with a statewide network of PCPs in sufficient numbers to ensure its Iowa High Quality Healthcare Initiative members have an ongoing source of primary care appropriate to their needs within required time and distance standards stated in Exhibit B, General Access Standards, and a person formally designated as primarily responsible for coordinating each member's health care services.
- Physician Extenders – Molina is committed to contracting with nurse practitioners statewide to ensure sufficient member access.
- Behavioral Health Providers – Molina is committed to contracting with a network of appropriately credentialed behavioral health providers to assure the availability of covered services for both adults and children and to meet general access requirements. By some estimates, some 700,000 Iowans experience at least some symptoms of mental disorder each year, with most never accessing the public mental health service system[2]. Molina understands the depth and breadth of the state's challenges related to its population's access to, and the appropriate delivery of, quality behavioral health services, and in meeting DHS Iowa Mental Health and Disability Services Plan objectives.

  Molina's national experience in contracting and innovatively collaborating with qualified behavioral health providers is exemplified by its Molina Healthcare of Washington sister health plan, which implemented memoranda of understanding (MOUs) with the state's Regional Support Networks. Under the terms of the MOUs, the RSNs are able to provide critical mental and behavioral health services outside the scope of the health plan's responsibility. This collaborative relationship allows for secure data sharing and seamless care coordination to ensure appropriate services for like members are delivered in the right place, at the right time and in the right setting.
- Essential Hospital Services – Molina is committed to contracting with hospitals statewide to ensure sufficient member access to essential hospital services, serve the expected enrollment, and to meet Iowa High Quality Healthcare Initiative access and availability requirements. [redacted]
- Physician Specialists – Molina is committed to contracting with a network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical and behavioral health needs of its members without excessive travel requirements.
- Health Homes – Molina has national experience and is committed to contracting with a network of Integrated Health Homes and Health Homes, and will employ proven strategies to encourage additional participation, particularly in areas of the State where participation has been low. Molina will ensure all providers meet the minimum requirements for Health Home participation as defined in the State Plan and DHS policy.
- FQHCs/RHCs – Molina is committed to contracting with all FQHCs and RHCs in the State of Iowa. Molina will establish quality standards for FQHC/RHC eligibility for network participation, subject to

[2] *Iowa Department of Human Services (2011), Olmstead Plan for Mental Health and Disability Services: State Plan Framework (2011 - 2015)* http://iowamhdsplan.org/wp-content/uploads/2011/02/ExecutiveSummary1-18-11.pdf

CONFIDENTIAL

DHS review and approval. Molina will reimburse all FQHCs and RHCs the Prospective Payment System (PPS) rate in effect on the date of service for each encounter, and will not enter into alternative reimbursement arrangements without prior approval from the State. Molina recognizes the pivotal role FQHCs and RHCs play in serving vulnerable populations and in providing access to health services in medically underserved areas. These providers often serve as the "front door" through which many individuals access health care, and have extensive experience in dealing with the various health and social issues of families that turn to them for services.

- Family Planning Clinics – Molina is committed to contracting with all local family planning clinics currently receiving Title X funding.
- Maternal and Child Health Centers – Molina is committed to contracting with all maternal and child health centers currently receiving Title X funding.
- Urgent Care Clinics – Molina is committed to contracting with urgent care centers statewide in sufficient numbers to adequately support the delivery of care to our Iowa High Quality Healthcare Initiative members. Our focus on building a quality urgent care network will integral to our overall approach to providing assistance and direction to members and their caregivers about appropriate health care services utilization. By increasing members and their caregivers about increasing their use of health home providers and/or urgent care, when appropriate, Molina typically sees a commensurate decrease and inappropriate member ER utilization.

  In accordance with Scope of Work, Section 6.3.10 Urgent Care Clinics, Molina understands, agrees, and will comply with the requirement that Molina obtain DHS approval of its proposed approach to urgent care clinic utilization as part of its network. Molina also understands it will implement and adhere to the DHS-approved approach, and that changes to the approach must receive prior approval from DHS.
- Other Safety Net Provider and Community Partners – Molina will leverage the deep experience and best practices of its sister health plans nationwide to contract with a sufficient number of Safety Net providers and community partners to support the delivery of quality health care services to our Iowa High Quality Healthcare Initiative members. Over the years, Molina's sister health plans have established long-standing relationships with a wide range of FQHCs, CSBs, AAAs, ADCs, SNFs and other community providers throughout its health plans nationwide, translating into highly successful care coordination for our more than 3.2 million Medicaid, Medicare, CHIP and Dual Eligible members.

  For example, Molina Healthcare of Washington's Health Home program provides care coordination for high cost/high risk members as identified by a PRISM score of 1.5 or higher, helping these members navigate and integrate their unique health care and social service needs. To support this initiative, the health plan's Provider Network Management staff has secured provider contracts with a wide range of medical, mental/behavioral health, substance use disorder, and Long Term Services and Supports (LTSS) providers. Also included is a robust network of Community Care Organizations (CCOs) and other key community-based social support entities, including AAAs, CBOs, and various non-physical medicine providers statewide. While the plan's Healthcare Services department manages the Health Home program, Provider Network Management staff collaborates on member education and outreach, while continuing to monitor and enhance the statewide network in support of the program.

  Iowa features an excellent community health and Safety Net system with high engagement and interest in the Iowa High Quality Healthcare Initiative. Molina understands that rural parts of the state in particular are faced with specialty care and primary care shortages that are more acute than its urban areas. As a provider of care, Molina will leverage its national contracting experience to incorporate the utilization of Safety Net providers and other community-based entities to help the underserved most effectively and efficiently receive care in these areas.

  In accordance with Scope of Work, Section 6.3.11 Other Safety Net Providers and Community

Partners, Molina understands, agrees, and will comply with the requirement that Molina obtain DHS approval of its proposed approach to safety net provider/community partner utilization as part of its network. Molina also understands it will implement and adhere to the DHS-approved approach, and that changes to the approach must receive prior approval from DHS.

- Community-based Residential Alternatives – Molina's contracting strategy will include an ongoing focus on developing network capacity necessary to support a travel distance of no more than 60 miles between a member's community-based residential alternative placement and the member's residence before entering the facility.
- Indian Healthcare Providers – Molina's contracting strategy will ensure compliance with Scope of Work, Section 6.3.13 Indian Healthcare Providers, and will include an ongoing focus on developing a sufficient network of Indian healthcare providers to support eligible Native American members' ability to choose to receive covered services from an Indian healthcare provider within required time and distance standards, and to allow its Native American members to choose a Molina-contracted Indian healthcare provider as their PCP as long as the provider has the capacity to provide such a service.

Regular Monitoring of Member Access to All Provider Types

To ensure a sufficient network of all provider types is consistently maintained, Molina will conduct regular development and enhancement activities that will include ongoing monitoring of member access to care by our network management staff and quarterly reporting to our Quality Improvement Committee. Access will be reported monthly during the first year of program implementation. Quarterly reports will measure the provider network against documented access standards, identify any areas for improvement, and identify progress made to remedy any deficiencies identified in the previous quarter. We will actively monitor data, trends, feedback, and provider and care planning activities to identify network needs and gaps, including:

- Monitoring enrollment trends, member demographics, service utilization, and provider terminations;
- Utilizing GeoAccess analysis to ensure adequate geographic coverage, tracking adequate geographic coverage plus languages spoken by members and providers to identify and match cultural and linguistic needs;
- Analyzing member grievances and appeals;
- Monitoring feedback from Case Managers and Community Connectors about access concerns or provider gaps;
- Reviewing the number and types of requests for out-of-network providers;
- Monitor Consumer Assessment of Health Plans (CAHPS) for member self-reports of access;
- Monitoring Healthcare Effectiveness Data Information Set (HEDIS) and other standard measures to assess if members are adequately receiving services;
- Monitoring member to provider ratios by specialty and by service area;
- Annual surveys of network providers to determine if appointment access is meeting standards including average wait times and geographic access standards; and
- Periodic audits of appointment availability and wait times, including secret shopper and site visits by provider representatives.

5. Describe your plans for meeting the requirements regarding Indian Healthcare Providers.

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP# MED-16-009, Scope of Work, Section 6.3.13 Indian Healthcare Providers.

Molina will leverage its sister health plans' deep experience and best practices in New Mexico and other

key states working with diverse Native American populations and the Indian healthcare professionals who care for them to comfortably meet the exacting needs of its Native American members and Indian healthcare providers in Iowa.

In compliance with Iowa High Quality Healthcare Initiative requirements, Molina will permit any eligible Native American member to choose to receive covered services from an Indian healthcare provider. A Native American member may also choose an Indian healthcare provider as his/her PCP if the provider participates in our network and has the capacity to provide the service. Molina will further demonstrate to DHS in a regular time and manner required that its network includes a sufficient number of Indian healthcare providers to ensure its eligible Native American members have timely access to services available under the Iowa High Quality Healthcare Initiative Contract.

Indian Healthcare Provider Resources

Molina's secure Provider Web Portal features links in the "Health Resources" section regarding providing care to diverse populations. For our contracted Iowa High Quality Healthcare Initiative providers, the site will also feature information for Indian healthcare providers, offering advice and education about the importance of Native American belief systems related to health. Molina will continually add important culturally sensitive resources that are identified or requested to be linked to our secure Provider Web Portal.

The site will also provide instructions on how to access translation services as well as transportation services for Iowa High Quality Healthcare Initiative members. Existing providers also receive a packet when receiving an in-service for new staff and/or refresher of Molina policies and procedures. Both of these reference guides are available on the Molina website. These reference guides will be regularly reviewed and updated as necessary to ensure compliance with Iowa High Quality Healthcare Initiative Contract requirements.

All contracted providers can also access the Molina Provider Manual via our secure Provider Web Portal or in hard copy, if requested. The manual provides clear instruction on how to access translation services, as well as TTY/DDD Services for deaf, hard of hearing, or speech-disabled members. Molina requires all contracted providers at the time of their contract execution to acknowledge receipt of the Provider Manual via a Provider Agreement attachment, assuring each contracted provider has all information necessary to serve Molina members in culturally competent manner.

Molina ensures that culturally competent care is provided for all members, including native and non-native English speaking members as well as its Native American members. Molina's Cultural Competency Program Manual is available to all contracted providers. The manual emphasizes the importance of cultural competency and directs providers on obtaining additional information regarding cultural competency. For our Indian healthcare providers, the manual also provides important information on specific cultural practices related to Native Americans.

Native American Staff

Molina employs native language-speaking staff in its Customer Support Services department. Additional translation services that cannot be handled within the Customer Support Services department are available to all Indians through its third party translation services provider, CyraCom.

Provider Directory

Molina captures information on Indian healthcare providers through the credentialing application process. Molina compiles this information in its master provider database, which is available to employees as needed. Upon request, Customer Support Services Representatives assist members in selecting primary care practitioners and other providers with multiple language skills. Our provider directory lists any languages other than English spoken by practitioners and providers, and also lists the provider's gender to allow greater choice and selection for members.

The directory lists all contracted providers, which includes PCPs, behavior and physical health specialists, substance use disorder providers and facilities, hospitals, pharmacies and facilities (home health, DME, etc.). The directory will also feature a special section for all contracted urban and rural Indian healthcare providers in our Iowa provider network. Both the Provider Directory and Provider Manual are available on Molina's website. Native American members are also informed in the Provider Directory of their ability to seek care from any of Molina's contracted providers, including Indian healthcare providers. The directory also informs Native American members of their ability to seek and obtain care from any Indian Health Service provider, regardless of contract status.

Molina distributes a Provider Directory to all Native American members at the time of enrollment, and upon request, and to all contracted practitioners/providers at the time they contract with Molina, and upon request. Additionally, the Provider Directory, which is updated monthly and available online, Member and Provider Newsletters, Member Handbook, Health News, Tips and Preventive Care Incentives and Provider Manual are available on Molina's website. Our secure Web Portal also allows members to change their PCP; check eligibility; view their preventive health schedule and receive reminders when preventive health care is due; request a new or replacement ID card; and access and download forms.

Translation Services

Molina's expert translation services will be available to Native American members who may not speak English as a first language. Molina utilizes CyraCom, a global provider of over-the-phone interpretation (OPI) services from English into more than 150 different **languages, including a deep roster of N**ative American languages and dialects**.** A Molina Customer Support Services Representative will conference into the call ensuring the information communicated to a Native American member is appropriate and accurate. Translators from within the Customer Support Services department for various tribal languages can assist Native American members in accessing health plan information.

Monitoring Indian Healthcare Provider Access and Availability

Molina's Indian Healthcare provider access and availability standards for the Iowa High Quality Healthcare Initiative will dovetail with the State's established provider coverage requirements for hours of operation that are no less than the hours of operation offered to commercial health plan members or enrollees in comparable Medicaid plans. As is standard for its sister health plans serving similar populations, Molina will be alerted of non-compliance with these standards through member complaints received by staff in Molina Member Services, Service Coordination, or the Member Advocate. We will also conduct annual access and availability studies to assess compliance with Iowa High Quality Healthcare Initiative Contract standards.

When Molina identifies a PCP who is not meeting hours-of-operation requirements, a Provider Services Representative immediately contacts the PCP office to investigate the related member complaint and to determine if the incident was a one-time occurrence or a systemic problem. In the rare occurrence of a systemic issue, the Provider Service Representative educates the provider on required hours of operation. We then conduct a re-audit of the provider's hours of operation several weeks later to confirm the issue has been resolved. If it has not been resolved, we take additional corrective action including potentially closing the provider's panel and/or terminating the provider's contract. The member will be reassigned to another Molina network provider and services will be authorized to ensure continuity of care.

Indian Healthcare Provider Payment/Reimbursement

Molina will make prompt payments to reimburse Indian healthcare providers, in or out-of-network, for covered services provided to Native American members eligible to receive services from such providers at a rate negotiated between Molina and the provider. If there is no negotiated rate, Molina will reimburse the Indian healthcare provider at a rate not less than the payment level and amount made if the services were provided by a non-Indian, in-network Molina provider. Molina will further submit utilization and/or reimbursement data related to applicable supplemental payments to Indian healthcare providers in a time

and manner requested and required by DHS.

Finally, Molina will not reduce payments to Indian healthcare providers, or other providers of contract health services under referral by an Indian healthcare provider, for covered services provided to a Native American member by the amount of a co-payment or other cost-sharing that would be due from the Native American member if not otherwise prohibited under Section 5006(a) of ARRA.

Leveraging Member/Provider Input to Improve the Healthcare Experience

Molina will leverage the deep experience and best practices of its sister health plan in New Mexico to support and enhance the healthcare experience of Native American members and Indian Healthcare providers participating in the Iowa High Quality Healthcare Initiative.

To gain a better understanding of its own Native American provider issues, Molina Healthcare of New Mexico established the Molina Native American Advisory Council, a diverse provider workgroup engaging individual experts to provide input and define strategy specific to Native Americans.

Through this council Molina continues to seek input and recommendations regarding provider and member incentives, member materials and any other concern or recommendation raised. For example, Indian Health Service and Tribal 638 providers offered feedback on member materials and presented suggestions about what topics should be communicated as a general guide. This council has been a great resource for helpful recommendations about the transportation benefit.

The council has emphasized to Molina Healthcare of New Mexico that each Native American community has its own unique needs, and outreach and materials should be tailored to meet those needs. Through the council, Molina has identified opportunities to remove barriers, better utilize services available in these communities, enhance care coordination, and improve access to I/T/U and non-I/T/U services. The Molina Native American Advisory Council has proven to be an invaluable resource to the health plan's operation and understanding of native community issues.

Molina encourages members' freedom of choice and participation in decisions about their health, including the ability to choose their own PCP.

SECTION 7 – ENROLLMENT

Please explain how you propose to execute Section 7 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP#MED-16-009, Scope of Work, Section 7. Enrollment.

With more than 3.2 million members nationwide and the Commonwealth of Puerto Rico, Molina brings deep experience in managing Medicaid, Medicare and Marketplace member eligibility and enrollment. Molina has written policies and procedures for all of its health plans that are reviewed and updated annually, dictating protocols for accurate enrollment and disenrollment, member self-selection and auto-assignment. Additional processes are further established related to specific populations in full compliance with applicable state and federal guidelines, for example, 1915(c) HCBS Waiver enrollees and Institutional populations eligible for the Iowa High Quality Healthcare Initiative.

Molina's eligibility/enrollment process is completely automated through its fully integrated and HIPAA-compliant QNXT multi-level medical management system, including processes such as PCP auto assignment, member ID card, and welcome packet generation. Our inbound eligibility/enrollment process leverages a custom-developed, highly-integrated technology solution utilizing .NET and Microsoft BizTalk to provide extensibility and scalability for managing and processing inbound eligibility data before it is loaded into QNXT. Molina can accept HIPAA-standard 834 enrollment data files as well as files based on proprietary formats.

The whole life cycle of member enrollment is ultimately recorded and managed through QNXT. This includes enrollment lapses, disenrollments, changes in family composition, and/or changes in eligibility category which may determine access to certain benefits or cost-sharing requirements, and movement in and out of a specific service area. When applicable, we also transmit member eligibility/enrollment data securely to the File Transfer Protocol sites of our subcontractors.

Molina's systems integrate all member information to assist in identifying a PCP who can best meet the members' needs. This includes location, previous relationships, language, age and access. Member notification includes, but is not limited to, the PCP's name, location and telephone number. Molina is committed to allowing new members to have freedom of choice and encourage member participation in decisions about their health, including the ability to choose their own PCP, to the extent the chosen PCP's panel is open to new members. We also provide comprehensive information to beneficiaries and/or their representatives regarding our provider network in advance of initial enrollment to allow for time to review options and select a PCP.

Our enrollment process allows a new member to select a PCP and other providers, including the locations of any emergency settings and pharmacies in close proximity to where they live, using the Provider Directory, which also includes physical accessibility symbols to help members select a provider that meets their physical accessibility needs. Because patients' trust and comfort level with their PCPs is essential, Molina offers an array of PCPs from which members may select, including linguistically diverse providers representing threshold languages for general and specialty practice, family practice, internal medicine, pediatric and long-term care provider types.

Molina works closely with providers, and/or other agencies to ensure that services for members in an active course of treatment for acute or chronic health conditions are not disrupted or interrupted post-

enrollment. This includes requesting a data feed with all open authorizations to allow our Utilization Management staff to proactively identify and reach out to members with continuity of care needs. Likewise, we work directly with the member's prior physician and health plan in transitioning members to preserve existing relationships whenever possible.

Members requiring transitional care are evaluated on an individual basis by our Utilization Management staff in collaboration with a Molina Case Manager to determine the length of time transitional care is needed. In order to ensure continuity of care for outpatient services and Home and Community-based Services (HCBS) and supports, we work closely with the treating physician or service provider to develop a care transition plan for a specified period of time. Molina is particularly sensitive to transitions of care for behavioral health services and highly respects the importance of those established relationships.

New Member Welcome Calls and Welcome Kits upon Enrollment

Molina utilizes a New Member Welcome Call performed within the first 30 days of enrollment to educate and encourage members to obtain preventive health services and to emphasize the importance of establishing a relationship with their PCP. During the Welcome Call, members are given the opportunity to change their assigned PCP to a PCP of their choice. The call also encourages an Initial Health Assessment within 90 days of enrollment and establishes a relationship with Molina for access and support when members need assistance.

All members also receive a Welcome Kit that includes information on how to choose a PCP. The materials include our transition of care policy and specific instructions on how to ensure continued access to their existing provider. Our primary goals are to keep members with their existing and/or preferred providers whenever possible and to ensure timely authorizations and coordination of needed services during this critical period of adjustment. Members with known open authorizations will be contacted by our Utilization Management department to facilitate the transition of care. In addition, all dual eligible members are contacted by their assigned Case Manager upon enrollment to perform an assessment which includes addressing continuity of care needs. Physicians and service providers who qualify, but are not part of our provider network, will be invited to join the network in an effort to maintain long-term continuity of care for members and keep them with their preferred providers.

Auto-Assignment

Molina understands, agrees, and will comply with all requirements in Scope of Work, Section 7.2.3 Auto Assignment.

If members do not select a PCP within the contractually required timeframe of the effective date of enrollment for the Iowa High Quality Healthcare Initiative, Molina's QNXT system will auto-assign each new member to a PCP based on programmed auto-assignment criteria, such as provider specialty, members' age/sex, provider distance from members' residence, members' PCP history, and members' primary language.

If a member in a current Fee-for-Service (FFS) program does not select a PCP within the contractually required timeframe of the effective date of enrollment, Molina will use the member's FFS utilization data or other data sources, in compliance with all federal and state privacy laws, to establish existing provider relationships for the purpose of PCP assignment, including a specialist or clinic if the member indicates a preference for either.

Based on the Iowa High Quality Healthcare Initiative Contract requirements, Molina will auto-assign members to PCPs (or specialists assuming the PCP role) through use of the QNXT system Member Module to ensure each member is assigned to an appropriate PCP. As an example of the auto-assignment process Molina Healthcare of Iowa will leverage, our Molina Healthcare of California sister health plan utilizes the following guidelines for its own member auto-assignment operations:

- The provider is open to accepting new members;
- Age restrictions;
- Family PCP assignment;
- Molina will consider the member's last PCP (if the PCP is known and available in Molina's network), closest PCP to the member's home address, zip code location, keeping children/adolescents within the same family together, and gender (OB/GYN);
- Re-instated members will be assigned to their prior PCP (within the last 90 days) as long as the PCP is in the same geographical area; and
- If there is no PCP available for the reinstated member, Molina will assign a PCP using the same method as if enrolling a new member. If there is no PCP available within the member's zip code, the following rules are applied when assigning a PCP:
  - Urban residence – no more than 30 miles travel distance or 30 minutes travel time.
  - Rural residence – no more than 60 miles travel distance or 60 minutes travel time.

If there are no providers available within contractually required travel standards, the member will be assigned to the nearest provider. Additionally, we will maintain procedures that proportionately include contracting traditional and safety-net providers in the auto-assignment process. We will ensure that adverse selection does not occur during the assignment process of members to providers.

Molina will provide the member with a written notice via surface mail with the contractually required timeframe after the member's enrollment that includes the date of enrollment, the name, telephone number and address of the member's PCP assignment, and options to select a PCP other than the PCP assigned to the member. We will also notify PCPs within the required timeframe of the member's selection or assignment.

7.4 Member Disenrollment

1. Describe your grievance process for addressing member quality of care concerns and member disenrollment after the first ninety (90) days of enrollment.

Molina's Member Appeal and Grievances department has overall responsibility and oversight of all grievances, including member quality of care concerns and member disenrollment after the first 90 days of enrollment. Molina understands members may disenroll without cause during the first 90 days of initial enrollment with Molina. Molina also recognizes that following this initial 90-day period and prior to the next annual open enrollment period, the member may only request disenrollment from Molina for cause, as set forth in Section 7.4.1.1.

Molina further understands that members are also permitted to change contractors at least once every 12 months during an annual open enrollment period, and that members may also request disenrollment when the state imposes the intermediate sanction specified in 42 CFR 438.702(a)(3). Finally, Molina understands that disenrollment provisions apply regardless of mandatory or voluntary enrollment.

In addressing member grievances related to quality of care or disenrollment, Molina provides first call resolution through its Member Services Call Center at the time of the initial member call. If the member's concern is not fully resolved, the grievance is forwarded to our Appeals and Grievance department via QNXT, Molina's core information management system. All grievances (both open and closed/resolved) are automatically "mapped" to the AnG Application in QNXT, which houses all appeal and grievance information, including those resolved by our Call Center staff.

Each grievance is immediately assigned a case number and assigned to an Appeals and Grievance Coordinator who is responsible for reviewing, investigating (when applicable) and resolving the grievance. As part of the standard grievance resolution process, all quality of care related grievances are forwarded to our Quality Improvement department for documentation and review. The Quality Improvement department investigates the potential quality of care issue in accordance with its internal guidelines covering all critical tasks, from documenting the grievance for tracking and trending, to a site visit at a provider's office, when applicable. The Quality Improvement and Appeals and Grievance departments then coordinate appropriately to resolve the grievance.

All member disenrollment requests, including those received after 90 days of enrollment, are coded in QNXT as a grievance, automatically captured in the QNXT-based AnG Application, and then assigned unique case numbers. A Member Services Call Center Representative will confirm the member's reason for disenrollment and then attempt to remedy the problem and retain the member. Every effort is made resolve the issue at the Call Center level.

In cases requiring deeper research, the member grievance is forwarded to our Appeals and Grievances department, after member approval, as an open grievance requiring resolution. Such grievances are treated as "urgent" to expedite a formal response back to the member. If the member remains dissatisfied with the outcome, an Appeals and Grievance Representative will direct the member to the Enrollment Broker to request disenrollment. Molina will provide the member's grievance record to allow the Enrollment Broker to render a recommendation to DHS regarding approval or denial of the disenrollment request.

Molina will not disenroll a member or encourage a member to disenroll because of their health care needs or a change in health care status; utilization of medical services; diminished capacity; or uncooperative or disruptive behavior resulting from the member's special needs, except in cases in which the member's continued enrollment seriously impairs Molina's ability to furnish services to either the particular member or other members.

Member Services Representatives are thoroughly trained and ready to provide quality communications with members to ensure they understand all aspects of their covered benefits, Value-added Services and other incentive programs.

SECTION 8 – MEMBER SERVICES

Please explain how you propose to execute Section 8 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Molina understands, agrees and will comply with all Member Services requirements set forth in accordance with Section 8 of Attachment 1—Scope of Work.

8.1 Marketing

1. Describe in detail your marketing and outreach plans.

Molina provides an extensive outreach program for its members. Some of the most important functions relate to the member's experience in entering the plan and accessing services. The crucial first step is selecting a PCP so that each member has a medical home. Iowa High Quality Healthcare Initiative program enrollees must also be fully informed of covered benefits and services, and how to exercise their rights should there be a disagreement about a treatment, procedure or service. In compliance with federal rules, Molina is prepared to accept all members without regard to physical or mental condition, health status, need for health services, marital status, age, sex, sexual orientation, national origin, race, color, religion or political beliefs.

Recognizing the unique needs of each member, Molina utilizes a multi-faceted approach to member education that is customized to meet each member's particular needs. Molina provides member education directly to members/member's Legally Authorized Representative (LAR) through mediums such as the member website; Member Handbook; newsletters; targeted mailings on health education; participation in health, wellness and disease management programs; telephonic education delivered through Molina's Nurse Advice Line; and in-person education provided by the member's Service Coordinator. In addition, Molina partners with the member's PCP and other providers to identify gaps in care and arrange for needed education and training on particular health topics.

The Member Handbook informs and educates members on how to access information about available Molina programs and services. New Molina members receive a Welcome Packet that includes information on benefits, services, the Quality Improvement Program and initiatives such as current immunization schedules. Additionally, educational materials on the importance of obtaining regular well checks and getting immunized, as well as Health Education and Disease Management program information, are also provided.

See Attachment 8.1.1-1 Proposed Marketing Plan for a detailed description of Molina's proposed marketing outreach plan.

Community Outreach

Additionally, Molina's Community Outreach team conducts health education events within the community to promote and educate enrollees about chronic health conditions and self-care. Molina continues to seek new locally relevant, convenient and culturally sensitive forums and locations, in addition to the traditional social service venues, to educate members and potential members about the benefits and services provided by managed care programs. Molina is committed to educating the

community on managed care, healthy behaviors, use of benefits, and access to PCPs and other health information through its participation in many venues such as, health fairs, festivals, school nurse associations, various church and community center sites, WIC sites, and many more.

Molina's Community Outreach and Quality Improvement departments developed programs that enhance education on preventive health services and benefits at New Member Orientations, and community events via additional presentations, health educator presence and new member educational materials. Special events are also implemented to target members in need of preventive health services, such as well-care checkups, dental checkups, immunizations and recommended diabetes management screenings.

8.2 Member Communications

1. Describe your overall strategy for communicating with members.

Molina develops and distributes member materials tailored to meet each member's particular needs to inform the member about available services. Molina provides member education directly to members through mediums such as the Member Web Portal and Molina website; Member Handbook; newsletters; targeted mailings on health education; participation in health, wellness and disease management programs; telephonic education delivered through Molina's Nurse Advice Line; and in-person education provided by the member's Care Coordinator. In addition, Molina coordinates with the member's PCP and other providers to identify gaps in care that indicate a need for targeted education and training on particular health topics or accessing services.

Health Education and Written Materials. Molina distributes the following materials to members throughout the year using mail, the member website, and electronic transmission:

- *Health & Family Newsletter* – This member newsletter contains timely information on health and public health-related issues such as flu shots, the importance of wellness and preventive services, cultural competency issues, and other appropriate health information.
- Health Management Newsletters – Molina sends health management newsletters biannually to members participating in disease management programs: asthma/COPD, and heart disease/diabetes.
- Health education brochures – Molina's health education brochures are available to Members through a variety of health management programs. Molina's Content Management department developed standard packets of health education brochures to support all health education programs and meet the needs of Case Managers. Topics include stress reduction, nutrition, exercise, weight management, diabetes, cholesterol, asthma, smoking cessation, wellness and injury prevention. Molina also distributes health education brochures to members through targeted quality improvement interventions.
- Clear & Easy Booklets – Molina developed the Clear & Easy series of booklets to address 17 common health topics, including chronic disease conditions. Extensive field-testing demonstrated that the target audience found them useful and easy to read. Molina mails the Clear & Easy booklets to all members who participate in a disease management program. They also support our Motherhood Matters® program for pregnancy and postpartum. Molina occasionally sends them to a target population to address utilization of services.

Member Welcome Packet. Molina's Welcome Packet provides new members with easy-to-understand information about covered services and how to efficiently access health services. The Welcome Packet, including the Member ID Card and Member Handbook, is available in English and Spanish, and will be distributed to members within five (5) business days of receipt of enrollment information via the eligibility files provided by DHS. The Member Handbook is available in alternate formats such as audio, Braille and large print.

Case Managers and Community Connectors. Within thirty (30) days of a member's initial enrollment, a Case Manager reaches out to conduct a Health Risk Assessment (HRA), verify that the new member understands how their plan works, and to answer any questions the member may have regarding plan benefits, restrictions, rights and responsibilities. The HRA also includes the assessment and identification of members with special health care needs requiring special services assistance. Molina's internal and external community-based Case Managers serve as the single point of contact responsible for engaging members, coordinating their care, and ensuring effective communication. Case Managers are individually assigned to members based on their cultural, cognitive, and medical needs. After initial outreach, a Case Manager continues to work directly with a member face-to-face and/or telephonically as appropriate based on the member's needs.

Molina designed the Community Connector Program to improve communications, care coordination, and compliance for complex populations. Community Connectors share ethnicity, language, socioeconomic status, and life experiences with members to more effectively communicate face-to-face and telephonically. Community Connectors perform home visits and provide feedback to the care team to address health concerns before they become more serious.

Call Center. Molina maintains call centers during regular business hours, as well as a 24-hour Nurse Advice Line to ensure members always have access to a live person. Oral and written interpreter services are available for members whose primary language is not English. This includes all medical/non-medical points of contact. Interpreter services are available for many languages, including American Sign Language and TTY/TDD services for the deaf and hard of hearing.

Web Portal. Molina maintains a secure, HIPAA-compliant Web Portal available to members and providers, giving members access to the Provider Directory and a community resource guide, and allowing them to view and print their member Care Plan. Through this portal, the member may also provide feedback to the Case Manager, view the member's profile, including a list of prescriptions, and view a list of the member's Care Team members and contact information. The Web Portal also provides information on a range of health topics such as asthma, breast and cervical cancer, dental health, diabetes, high blood pressure, immunizations, nutrition, physical activity, postpartum depression, smoking cessation, stress management, and well-child checkups. Molina has established policies and procedures for ensuring its website is updated regularly and contains accurate information.

Mobile Technology. With the unprecedented shift toward mobile technology in today's business environment, Molina has developed a corporate Mobile Strategy and Roadmap to drive greater value to both its member and healthcare provider communities. The overall objective is to deliver improved levels of care to each and every member served. This can be achieved through the application of solutions that include:

- Mobile Applications ("Mobile Apps") accessible to smartphone users;
- SMS Text Messaging services to feature phone users;
- Employee-based mobile applications to assess, evaluate and communicate with members;
- Mobile web access into member, provider and corporate internet portals; and
- Sensor-based technologies (e.g. Machine-to-machine) for real-time healthcare status and information.

To identify, develop and deploy these types of mobile solutions, Molina is focused on creating the requisite infrastructure, systems and environment as follows:

- Communicate and prioritize mobile projects through an executive committee within the company;
- Create a mobile Center of Expertise (COE) to innovate, design and prototype business solutions enabled by mobile technology;

- Educate and adopt native, hybrid and/or web-based application tools and platforms to streamline development of mobile value-add services to members and providers; and
- Build an information technology infrastructure that readily supports deployment of mobile capabilities in the field.

Molina's Research and Innovation team is highly focused on working across the member "value chain" to create mobile solutions that are practical, economic and value-based. Implementing the company's Mobile Strategy and Project Roadmap in 2015 will enable the development and implementation of transformative mobile solutions for Molina's members.

2. Describe your plans to provide oral interpretation services and translated written information and how you intend to notify members of the availability of these services and how to obtain these services.

Molina ensures effective member communication by making information available in threshold languages and alternate formats, such as audio, Braille or large print. Communications developed in English, including the written scripts for video and audio productions, are translated by qualified translators into non-English languages in accordance with membership. English words and phrases that do not directly translate into a particular language are translated according to message concept and intent, keeping the objective of the communication in mind.

Molina also provides oral interpretation services for members who require additional language services beyond the translated member materials. Molina offers free interpreter services to all members. Interpreter services are available telephonically or in-person through a Molina-contracted translation service. The service provides interpretation in many languages, including American Sign Language and TTY/TDD services for the deaf and hard of hearing. Molina provides face-to-face interpreters to ensure quality care to all non-English speaking or Limited English Proficient members in situations where bilingual staff is not available and telephonic interpretation is not adequate. Member Services Representatives facilitate access to these services. Staff that is bilingual in English and Spanish answer Molina's Nurse Advice Line, 24 hours a day, 7 days a week. Members may also communicate electronically with Molina through the member Web Portal.

3. Describe your plans to provide all written materials in alternative formats and how you will identify members needing alternative formats.

When a member or family joins Molina, they receive a Welcome Packet and health education and promotion materials that provide comprehensive information about available services and how to access them. Recognizing that health plan information can be confusing, a Case Manager will call the member as part of the initial assessment process to ensure the member understands all of the provided materials and answer any questions. The Case Manager will determine if the member has special needs that will require material in an alternate format. The Case Manager will ask the member if email is a preferred means of receiving information, such as an audio file or large print document. The Case Manager will note preferences in the member's file so Molina will send all future communications in the necessary alternate format.

If a member develops a need for an alternate format after the initial assessment process and notifies Molina, a Case Manager will conduct a new assessment and update the member's file future communications.

Potential members considering joining Molina can learn about alternative formats on the Molina Healthcare website.

Targeted Education Information

Molina uses a variety of mechanisms to ensure that members with specific or special health care needs receive appropriate information about the services that are available to them. When members are behind on their preventive health screening, Case Managers and PCPs are notified and specific information is sent or provided to them offering reminders and information on accessing the necessary services. Molina also distributes health education materials during its preventive health screening events, health fairs and community outreach events.

Members identified as having special health care needs or who could benefit are also enrolled in disease management programs which provide additional member outreach, risk assessment, education and case management services.

General Health Promotion and Prevention Education

Molina's Community Outreach team conducts health education events within the community to promote and educate members and potential members about chronic health conditions and self-care. Molina continues to seek new locally relevant, convenient and culturally sensitive forums and locations, in addition to the traditional social service venues, to educate members and potential members about the benefits and services provided by managed care programs, including Service Coordination and Disease Management. Molina also distributes health education materials during its preventive health screening events, health fairs and community outreach events.

Molina engages in focused activities to assist members in obtaining preventive health services and ongoing chronic care/self-management through member health education that consists of:

- General reminder mailings;
- Targeted reminder mailings to those within the identified population not on schedule with preventive health or chronic care screenings and tests;
- Multiple outbound reminder calls;
- Telephonic reminders and health education; and
- Offering member incentives to increase compliance with needed services.

Each year, Molina Healthcare establishes annual program performance goals and measurable objectives for its health education programs. Molina then monitors its progress in achieving those priorities and goals. During the year, interventions are implemented, where necessary, to improve performance. At the conclusion of the year, the overall effectiveness of the program is evaluated, follow-up or new initiatives are developed, and new areas for analysis are identified.

Molina is committed to locating members. Members are initially engaged during the screening and comprehensive assessment commenced upon enrollment. Face-to-face comprehensive assessments are highly encouraged, and include caregivers and/or family members whenever possible. Special arrangements are available to conduct assessments in non-traditional settings such as a shelter for the homeless. In situations where a personal meeting is not feasible, a telephone assessment is conducted. If Molina cannot make contact after three attempts or if the individual refuses to meet, Molina will work with the member's PCP, community service agencies, and/or known pharmacy in an effort to contact the member.

Community Connectors are also used to conduct research with available data to locate members including but not limited to:

- Reviewing claims and care management databases;
- Contacting members' providers/caregivers;
- Traveling to last known addresses; and
- Traveling to community resource center locations such as homeless shelters or soup kitchens.

4. Describe your policies and procedures for ensuring materials are accurate in content and translation.

Molina staffs a Content Management department to ensure quality, consistency and compliance in all content intended for members. Molina writes all health education and outreach materials in accordance with Plain Language Guidelines and established criteria to ensure cultural sensitivity and readability. Molina follows policies and procedures to write member communications using language that does not exceed the 6th grade reading level per the Flesch-Kincaid index. Materials reflect best practices by limiting the amount of text presented, using photos or graphics to reinforce the message, and choosing fonts and layout designs that help to simplify the content. Molina field-tests many health education brochures and booklets, to verify their effectiveness with the target population. All materials contain information in English and Spanish to inform the member how to call and request materials in another language or special format. Upon member request, or identification of a member's special needs, Molina provides materials in alternate formats such as audio, Braille and large font.

Member materials are initially developed from government contract requirements and/or identified health education needs. Molina clinicians and the Quality department review all health education content to ensure it reflects the most current health information. Following internal review, which includes the Consumer Advisory Board, the Member/Provider Services Committee (MPSC), and the Quality Improvement Committee (QIC), Molina will submit all member materials to the state agency for review and approval prior to publishing and distributing it for use. The Content Management department tracks all materials through development and processes all print requests to ensure the state agency has approved the materials. Any revisions to approved content will result in resubmission to the state agency for approval.

Molina translates member materials into Spanish and other threshold languages as identified by the state agency. Molina utilizes highly qualified, experienced translators to translate all written member materials. All translated member materials are certified by a professional translator to ensure content is accurately expressed in the target language with the appropriate terminology and cultural nuance. Molina translates its member materials, such as the enrollment packet, the member ID card, the Member Handbook and health education materials, as well as other vital member documents.

5. Provide sample member enrollment materials as described in Section 8.2.6.

Molina understands, agrees and will comply with all requirements in Section 8.2 Member Communications and the requirements in Section 8.2.6 New Member Communications of Attachment 1 – Scope of Work, and will submit for DHS review and approval prior to distribution in accordance with the process established in Section 8.2.4 State Review and Approval of Member Communications of Attachment 1 – Scope of Work.

Molina ensures that it will distribute enrollment materials to each member within five business days of receipt of member enrollment information via the eligibility files provided by DHS. In accordance with Section 8.2.6 New Member Communications in Attachment 1 – Scope of Work, Molina's Member Handbook and Member Website will inform and educate members on how to access information about available Molina programs and services. Molina's Member Web site and Member Handbook inform and educate members on how to access information about available Molina programs and services:

- Preventive Health and Early Periodic Screening, Diagnosis, and Treatment Care;
- Disease Management and Health Education Programs;
- Nurse Advice Line Information;
- Member Rights and Responsibilities;

- Information on Grievance and Appeals Procedures;
- Patient Safety Information;
- Quality Measurement (HEDIS, CAHPS) and Survey Results; and
- Electronic Member Newsletters.

New Molina members also receive a Welcome Packet that includes information on benefits, services, the Quality Improvement Program and initiatives such as current immunization schedules. Molina has a variety of educational materials for new and existing members. All materials are written using language that does not exceed the 6th grade reading level, are available in English and Spanish and in other languages. Education materials are also produced in alternative formats such as large print, Braille and audio disks.

Molina's enrollment materials will meet the requirements of Section 8.2.6 New Member Communications of Attachment 1 – Scope of Work. See Attachment 8.2.5-1 Sample Member Enrollment Materials, which includes a sample Member Handbook from Molina Healthcare of Texas.

6. Describe your processes for identifying significant changes as described in Section 8.2.8 and notifying members of such changes.

Molina understands, agrees and will comply with all requirements for identifying significant changes in operation and notifying members of such changes in accordance with Section 8.2.8 of Attachment 1 – Scope of Work.

Molina understands the power of frequent and effective communications with members and other community stakeholders. Molina will actively keep members and community-based organizations up-to-date on changes to the Iowa High Quality Healthcare Initiative program standards and services to ensure that members continue to receive efficient and effective health care that results in positive health outcomes. Molina recognizes that keeping members and stakeholders informed contributes to overall satisfaction. Additionally, effective communication offers members and stakeholders the opportunity to provide feedback to improve operational efficiency that can impact care and services. Molina will establish a Community Advisory Committee comprised of individuals and community-based organizations who are interested in addressing access-to-care barriers, especially linguistic and cultural barriers, in order to provide quality health care for Molina's members. The committee will meet quarterly to help direct the development of programs and health education materials in ways that meet the needs and sensitivities of Molina's diverse communities, as well as review performance and improvement activities.

Molina utilizes multiple communication avenues to ensure member awareness. The communication format depends upon the content, and communication modalities consist of the following approaches:

- **Member Newsletter –** Molina will publish and mail a Member Newsletter on a routine basis. The newsletter will note recent changes impacting members, general information regarding the plan, updates on quality, health promotion and wellness initiatives, and upcoming community events.
- **Direct Mail –** Molina will also mail notifications to members to inform them of the Community Advisory Committee. Notification will occur in advance of the community meeting and will utilize a standard print communications service for member mass mailings.
- **Interactive Voice Response (IVR) –** Molina's telephony infrastructure is supported via VoIP Cisco technology. Molina has successfully expanded IVR services for members. Targeted interventions and messages are deployed through this communication system, including health outreach programs. The IVR system is used to communicate services and will be used to promote participation in the Community Advisory Committee.

- **The Molina Website –** The Molina website is another venue for communicating with members. The member website allows members to review available services and provides instructions on how to access and contact Molina. Several options for member and community feedback are posted in the Molina website. An interactive survey is available, and results may be presented to the Advisory Committee. The Molina website will be used to communicate Iowa High Quality Healthcare Initiative program changes and updates as well as to promote the Advisory Committee activities.
- **E-mail Distribution –** Molina will establish a database of provider e-mail addresses to facilitate electronic transmission of real time information to our members.

Molina will apply its standard and rigorous project management system to deploy a comprehensive communication plan to ensure thorough and broad promotion of the Advisory Committee. Molina will also notify DHS about the meetings or events. Molina will submit all promotional materials and the communication strategy to DHS for review and approval and will provide meeting minutes and reports to ensure the DHS is informed of progress and meeting deliberations.

8.3 Member Services Helpline

1. Describe your plans for the member services helpline, including the days and hours of operation.

Molina's operational Member Services Call Center meets all Member Services Helpline requirements of Section 8.3 Member Services Helpline of Attachment 1 – Scope of Work. Molina's Member Services Call Center Representatives provide competent and transparent information that helps members navigate the complex healthcare system. Molina makes every effort to provide personal assistance to all members to address their concerns and inquiries. Molina's toll-free Member Services Call Center has adequate staffing to respond to questions, comments and inquiries from members.

Molina's Member Services staff focus on helping members utilize resources to achieve optimal wellbeing, including preventive care, chronic care coordination, and dental, behavioral health and long-term service needs. It is through the Member Services department that Molina ensures prompt, courteous, positive and appropriate access to benefits and services. This front-line department provides the primary interface between every member and the Molina health plan. Representatives are equipped to assist members on a wide variety of issues, including access, enrollment and benefit inquiries. Member Services staff is available to:

- Help members navigate the health care system and explain managed care and the value of services available through Molina;
- Explain the role of the PCP and assist with PCP selection for new members or members needing to change their PCP;
- Provide assistance to members in arranging for services, including but not limited to urgent care, non-emergent transportation to medical appointments, or interpretive services for medical appointments, including sign language interpretation;
- Educate members on what to do in an emergency or health crisis;
- Specify members' rights and responsibilities and explain the grievances and appeals process;
- Give Molina providers including who is accepting new members or give member names of providers in the specialty of their need;
- Help members understand cost sharing and member liability and balance billing issues;
- Assist with understanding benefits, claims status and how to access services; and
- Connect with resources within Molina, such as Case Managers.

Member Services Representatives attempt to provide immediate resolution of member issues and concerns or facilitate resolution with the appropriate staff member. Molina's Member Services department reviews member input and feedback gleaned from the complaint/grievance process. Molina ensures that members have access to the grievance process by providing them with assistance through each step, ensuring their understanding and ease of use.

Molina's robust telephony infrastructure provides Interactive Voice Response services, which include ID card request, PCP change request, authorization status, claim status and eligibility verification. The Interactive Voice Response system is integrated with live QNXT data, and retrieves real-time information for providers and members on a 24/7 basis.

Molina provides all members access to a dedicated toll-free multilingual Nurse Advice Line operating 24-hours a day, 7 days a week, 365 days a year. The Nurse Advice Line is staffed by Registered Nurses (RNs) with an average of 5–20 years of acute care experience and 3–4 years of telephone triage experience. Nurses are also supported by other health professionals, such as on-call PCPs and other physicians. Nurse Advice Line staff provides culturally competent, comprehensive and personalized clinical and non-clinical telephone services with significant competence in behavioral health and crisis intervention and performs triage services to ensure members receive care in the proper settings.

All Molina health plans are supported by its Nurse Advice Line staff, who answers calls from members, confirms eligibility, provides general health information, and performs triage services to ensure members receive care in the proper settings. Nurse Advice Line staff is trained to provide culturally competent, comprehensive and personalized clinical and non-clinical telephone services and possess significant competence in behavioral health and crisis intervention. Physicians are on-call to support staff for situations not covered by established clinical or administrative protocols. Molina's Nurse Advice Line call center is accredited by URAC. Molina's Member Services department is the front-line department that provides the primary interface between members and the local Molina health plan. Member Services department staff ensures prompt, courteous, positive and appropriate access to benefits and services.

2. Describe the process you will utilize to answer, route, track and report calls and inquiries. Indicate if an Interactive Voice Response (IVR) system is proposed.

Molina offers an HIPAA-compliant, Cisco-based Interactive Voice Response (IVR) phone system, available 24 hours a day, 365 days a year, that allows members and providers to access various information over the phone, including eligibility verification, claim status, ID card requests, PCP change requests and authorization status. The IVR system uses touch tones to help route the member or provider to the proper member service representative queue or provide certain services automatically. The IVR system is integrated with live QNXT data, and retrieves real-time information for providers and members.

3. Describe your plans to provide services for the hearing impaired and non-English speaking population.

Molina exceeds DHS requirements in providing linguistically and culturally competent communications to recipients, including individuals who are hearing-impaired and non-English speaking. Molina is committed to recruiting and maintaining a diverse staff that is representative of the demographic characteristics of its service area.

Accommodations for Hearing-impaired Recipients

Molina staff effectively communicates with hearing-impaired recipients through use of the state 711 service. Recipients who are hard of hearing, deaf or speech-disabled can call in to this service. The service is available 24-hours per day and is offered free of charge in accordance with Title IV of the Americans with Disabilities Act.

All recipient-written materials are available in alternate formats, such as audio, Braille and large font.

Accommodations for Non-English Speaking Recipients

Molina's Member Services Representatives are local, and many are bilingual, so they are able to communicate with recipients in their native language. For languages not spoken by representatives, language interpreter services are also immediately available to assist non-English speaking recipients. Molina utilizes oral interpreter services through its partnership with a single interpreter vendor, CyraCom. Exclusively endorsed by the American Hospital Association for its interpretation and translation services, CyraCom specializes in language services for the health care industry. All CyraCom interpreters have advanced health care-focused training that enables them to clearly and effectively communicate with recipients, even when complex health-related information must be exchanged.

Molina develops written materials that are culturally and linguistically appropriate for each of its service areas. Molina ensures that these materials meet all current plan requirements and are readily available to recipients through a variety of different avenues. All standard written recipient materials are culturally sensitive and are generally produced in English, Spanish, and threshold languages. Recipient materials are developed in easy-to-read formats using simple and plain language, written at or below the Flesch-Kincaid sixth (6th) grade reading level.

As a Hispanic minority-owned company, Molina's parent, Molina Healthcare, Inc., has always known the importance of cultural respect and understanding as a basis for health care. Formed in 2006, the Molina Institute for Cultural Competency is a unique resource with years of experience in the evaluation and practical application of cultural concepts and provides its plans, including Molina Healthcare of Iowa, with research, evaluation, consultation, training and support materials, policy and procedure review, and recommendations to improve cultural competency.

4. Describe your training program curriculum and training process for call center staff.

During the Implementation Phase, Molina will conduct Member Services functions and will train its Member Services Representatives (e.g., Customer Service staff) upon hire and on an ongoing basis to ensure in-depth knowledge of Medicare-Medicaid Alignment Initiative benefits and services. New Member Services Representatives receive at least two weeks in classroom training and a week of on the job training to ensure sufficient exposure to all Iowa High Quality Healthcare Initiative program requirements. Member Services leadership and Quality Monitoring team monitor calls to ensure optimum member services support is consistently provided. This is reinforced by periodic training sessions on an individual or group basis. Training curriculum includes:

- Operations, policies and procedures;
- Regulatory and contractual requirements;
- Fraud, Waste and Abuse;
- Role of the PCP and the Medical Home concept;
- Benefits and unique services for members, including physical health, behavioral health, and long term care services;
- Health care access and delivery;
- Disease management programs, care coordination, screening and preventive services and wellness promotion services;
- Guidelines to document and address member complaints and appeals;
- Use of oral interpreter services from local resources and language line services;
- How to change PCPs; enrollment and disenrollment from the plan;

- How to quickly identify, process, and resolve quality of care issues;
- Incentive programs;
- Potential barriers to access;
- Definition of and appreciation of vulnerabilities during transitions in care;
- Claims and Coordination of Benefits (COB);
- Cost-sharing and member liability;
- Provider network practices and capacity (open or closed panels);
- How to assist members in a health crisis, including but not limited to suicidal callers;
- Coordination with other state health and human services programs; and
- Services Beyond Those Required.

Member Services Representatives all participate in mandatory company cultural diversity training and can direct members to appropriate resources to address their cultural and linguistic needs. Molina staff is trained on policies and procedures pertaining to the privacy and security of Protected Health Information (PHI) under HIPAA within 30 days of hire and additional training based upon job roles. All employees receive annual Fraud, Waste and Abuse training to make them aware of the detection, prevention, review, and reporting of illegal activity affecting the health plan and state.

5. Describe your call center monitoring process to ensure helpline performance metrics are achieved.

Molina uses information from QNXT Call Tracking and from the Cisco Unified Intelligence Center (CUIC) software integrated with the call center phone system to track call performance metrics for both internal operational performance management as well as for external reporting to DHS. Molina can report to DHS on metrics such as call volume (received and answered), abandonment rates, and percentage of calls answered within 30 seconds. The system is used to plan workforce needs around vacations and holidays to ensure that the standards for these metrics are continually met.

Additionally, Molina has a workforce management tool that allows call-volume forecasting based upon historical data. This ensures Molina member hotlines are staffed appropriately to adhere to required benchmarks during peak call periods.

6.Describe your plans for a backup solution for phone service in the event of a power failure or outage or other interruption in service.

Core IT systems are located in Molina's primary data center in Albuquerque, New Mexico, and protected by a co-location/disaster recovery (DR) data center located in Richardson, Texas. Near real-time storage replication ensures that critical production data is available at the DR site. Production data backups are also copied to the DR site, providing a secondary data protection measure.

In the event of a disaster preventing application functionality at the primary data center, the Disaster Recovery Team works with the IT infrastructure and application teams to coordinate the efforts needed to bring up the DR servers and connect them with the replicated data, according to the DR plan documentation.

Molina's Emergency Management Plan ensures an ongoing provision of health care services that will meet the following requirements: (a) all staff, including Case Managers that are designated to be involved in emergency measures will be informed of their duties and will be responsible for implementing the

emergency management plan; (b) If telephone service is not available during an emergency, Molina's contingency plan will support communication.

In the event of a diasaster, local staffing levels are determined based on the location of the disaster, level of disaster, and the safety and availability of staff to help serve members in need. If staffing needs cannot be met locally, calls and processes will be forwarded to another Molina Healthcare location. Molina will notify DHS when the phone system is inoperative or a back-up system is being utilized.

7. Describe if any separate member services lines or staff will be used to address member needs by service type (i.e., physical health, behavioral health and long-term care services).

The Member Services Representatives are fully trained to assist members with all inquiries types, including but not limited to physical health, behavioral health, and long term care services. The training curriculum ensures Member Services Representatives are fully trained to assist members with all calls. If additional assistance is needed, the Representatives are trained to warm transfer the members to the correct area, such as a case manager.

8. Describe proposed entities to which you will be capable of warm transferring member calls.

Member Services Representatives have the ability to warm transfer members within and outside of Molina. Member Services Representatives attempt to provide immediate resolution of member issues or facilitate resolution by escalating to the appropriate staff member based on appropriate clinical or administrative protocols. When a member needs to speak to staff in a specific department, call routing is handled with a warm transfer by the Member Services Representative.

When a call comes into the Member Services Hotline with a question relating to a member's health care needs that is outside of regular customer support service inquiries, the Member Services Representative can warm transfers the call to the member's Service Coordinator, back-up Service Coordinator, or other qualified clinical member of the Service Coordination Team. Member Services Representatives also have the ability to communicate with supervisors real-time via instant messaging or phone call to obtain additional instructions or information to facilitate resolving the member's concerns.

In the event call volume creates a backlog, Molina can seamlessly route calls to other cross-trained Molina call centers to handle overflow and provide quality service, such as in the event of a natural disaster.

8.4 Nurse Call Line

1. Describe how the Nurse Call Line will be publicized to members.

Molina will provide all members with a dedicated toll-free multilingual Nurse Advice Line staffed by Registered Nurses 24-hours a day, 7 days a week. Members will be notified of the availability of the Nurse Advice Line service through the Welcome Call made at enrollment, through the member's Welcome Packet and in the Member's Handbook. Molina maintains a secure electronic portal (Web Portal) for customer interactions and dissemination of information to members and providers. The Web Portal provides general and up-to-date information, as well as available services, about Molina's Plan, including the Nurse Advice Line, Provider Network, Customer Services and the Grievance Systems and Complaint Process. Molina's Web Portal handles more than two million transactions per month across various Molina health plans.

2. Describe the credentials Nurse Call Line staff must possess.

The Nurse Advice Line is staffed with Registered Nurses with an average of 15-20 years acute care experience and 3-4 years telephone triage experience. The nurses are supported by other health professionals, such as on-call PCPs and other physicians. The Nurse Advice Line nurses have immediate access to licensed behavioral health professionals when necessary for added consultation or dispatch of crisis stabilization intervention through mobile unit teams provided through contracted providers. The Nurse Advice Line works in collaboration with guidelines for behavioral health crisis situations; health plans are notified of any activity with their member regarding any action taken.

3. Describe processes and protocols for when a physician must be consulted.

Nurse Advice Line staff refers members they identify as eligible for special services and coordinates medical care with the member's primary care physician. Physicians are on-call to support staff for situations not covered by established clinical or administrative protocols.

8.5 Electronic Communications

1. Describe how technology will be leveraged to communicate with members.

Molina maintains a secure electronic portal (Web Portal) for customer interactions and dissemination of information to members. The Member Web Portal provides general and up-to-date information about Molina's Plan, including the Provider Network, Customer Services, Program Service Line, and the Grievance Systems and Complaint Process. Molina's Web Portal handles more than two million transactions per month across various Molina health plans.

2. Describe how information on member's preferred mode of receipt of communications will be collected and how information will be sent in accordance with such selection.

Molina has a Member Portal for all members to select a physician, order an ID card, and read educational materials to facilitate taking ownership of their own health care services. Molina provides members with education and assistance to use the Member Portal through the Member Newsletter and during Member Services or other telephone calls.

Molina's eligibility/enrollment process is completely automated including processes such as PCP auto assignment, ID card and welcome packet generation. Molina's inbound eligibility/enrollment process leverages a custom-developed, highly-integrated technology solution utilizing .NET and Microsoft BizTalk to provide extensibility and scalability for managing and processing inbound eligibility data before it is loaded into QNXT, Molina's core administration system. Molina can accept HIPAA-standard 834 enrollment data files as well as files based on proprietary formats.

The whole life cycle of member enrollment is ultimately recorded and managed out of QNXT. This includes enrollment lapses, disenrollments, changes in family composition, changes in eligibility category which may determine access to certain benefits or cost-sharing requirements and movement in and out of an Iowa region. When applicable, Molina also transmits member eligibility/enrollment data securely to the File Transfer Protocol sites of its subcontractors.

3. Describe how electronic communications will be received.

The enrollment process begins when Molina receives the Enrollment Files from DHS. The file is downloaded and runs through initial validation procedures that confirm the file layout, record counts and

HIPAA compliance. Any anomalies in the initial validations will immediately be reported to DHS. Upon receipt and loading of these files, eligibility data is securely transmitted to the FTP sites of Molina's subcontractors. Provider rosters are produced and made available to providers after receipt of the monthly and daily enrollment roster. Any anomalies in initial validations will immediately be reported to DHS.

Exhibit 8.5.3-1 Data Processing Flowchart and Interfaces Diagram provides a high-level progression of inbound and outbound data flows for data and process flows for all key business processing functions, including member information, as well as the interaction with MIS applications and subsystems. These major functions include Membership, Provider/Service Coordination and Encounter/Claims. The following are the highlights of each function:

Membership

- Process and load HIPAA-compliant standard 834 enrollment; tracking members covered services in the QNXT system. The Membership function processes electronic data transmission, which adds, deletes or modifies membership records with accurate begin and end dates
- QNXT provides a single source for eligibility updates/status;
- Updated eligibility to Web Portal and Interactive Voice Response (IVR) system within 24 hours;
- Partnerships with various clearinghouses including Emdeon for receipt of data from providers; and
- HIPAA compliant Electronic Data Interchange (EDI) for clearinghouse and direct EDI and Web Portal data submissions.

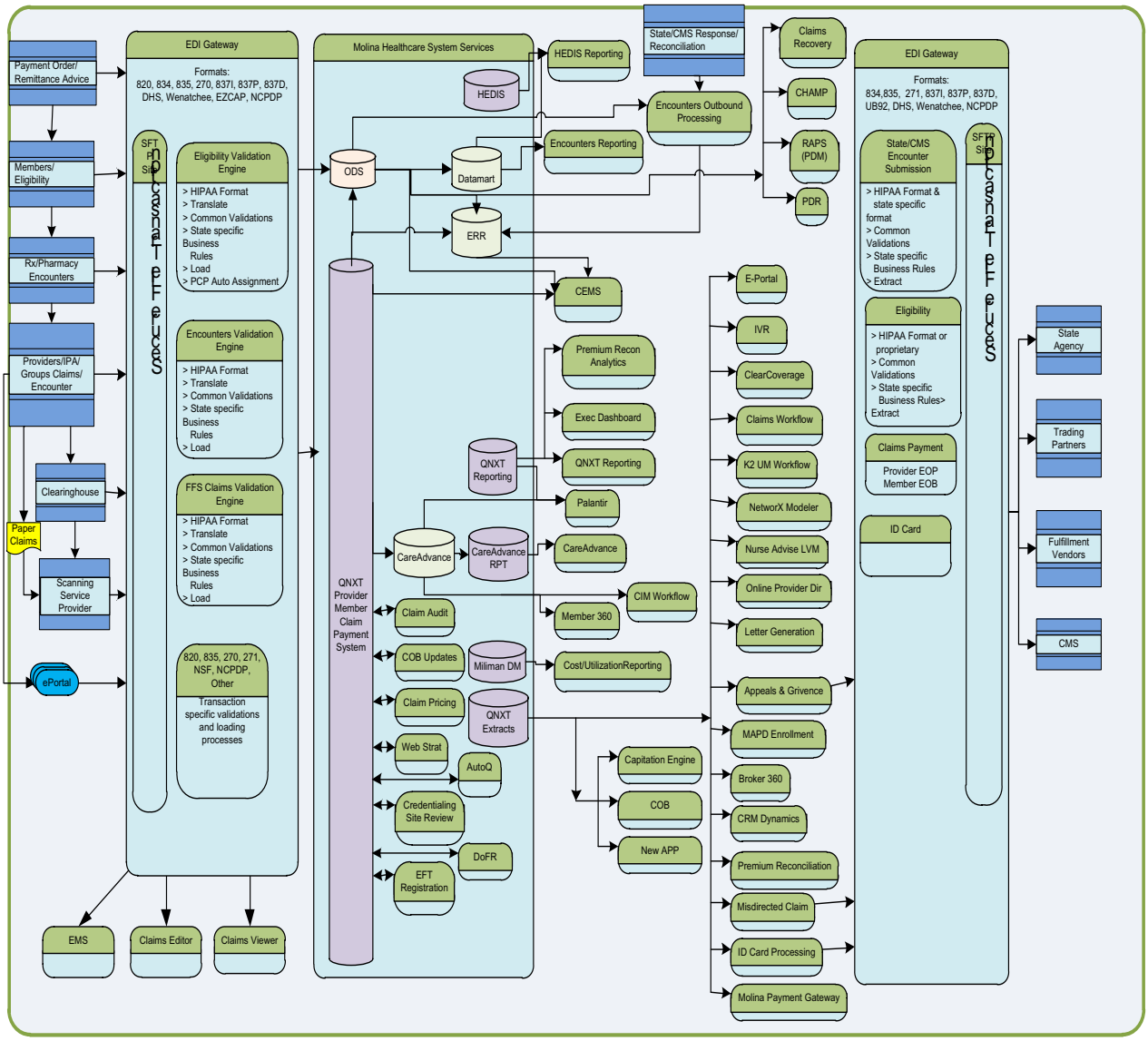
Provider

- Provider data submissions and reference are provided through Emdeon/Empower, IVR, and the Web Portal in addition to the formulary and other references, and provider specific reporting;
- Provider Credentialing through Visual Cactus System, Laserfiche, National Provider Data Bank (NPDB), and the Council for Affordable Quality Healthcare (CAQH);
- UM/K2 Prior Authorization System for prior authorization and referral management, including integration to QNXT for authorization claims matching and processing, as well as paperless processing of inbound fax requests;
- Molina is working on an initiative to give providers the ability to submit prior authorization request electronically and receive immediate, real-time responses (approvals or denials) to their requests utilizing McKesson's ClearCoverage, a web-based decision tool used as the point of care, available in Q1 2015; and
- QNXT exports data feeds to Care Advance for identification and referral of eligible members for Care Management, Service Coordination and Disease Management programs.

Encounter/Claims

- Variety of methods for claims submission including clearinghouse, Web Portal (as per 8.1.20.3 providing a no-cost alternative to bill without the use of a clearinghouse), and via paper;
- Solid claims and Encounter Processing from data load (via BizTalk) including QNXT;
- Integration of QNXT with other claim focused systems to enhance claim processing accuracy including K2 Claim Workflow, Claim Viewer, QC Audit Pro, Claim Editor, HMS for coordination of benefits, HCI (fraud and abuse evaluation), and WebStrat to support advanced DRG pricing; and
- Encounter tracking and reporting through the Operational Data Store.

Exhibit 8.5.3-1 Data Processing Flowchart and Interfaces Diagram



8.6 Member Website

1. Describe your plan to develop a member website and mobile applications in English and Spanish, and the kinds of information you will make available to members in these formats.

Molina has a secure Member Web Portal for members to access the plan benefits and the dissemination of information. Molina's Member Portal provides a HIPAA-compliant secure site that offers 24 hours a day, 7 days a week access and allows members, members authorized representatives a repository of customized information. Molina's Member Portal system is the web channel into Molina's dynamic QNXT information core management system and contains the following key functionalities:

- Access to the member's handbook and benefits at a glance document;
- Ability to view their ID Card and request or print a temporary ID card;

- Change their Primary Care Physician;
- Change demographic information such as mailing address, phone number and email;
- View Health Record information such as service history, service request/authorizations, labs, medication, allergies and care plan (if applicable). Also print a copy of the health record or care plan;
- Access to case manager information such as case manager name, phone number and ability to send messages to assigned case managers;
- View Available Molina services (Example: Transportation, Nurse Advice Line);
- Access to helpful Health Education information and videos;
- Access to a searchable Provider Directory that Molina updates within three business days of a change to the Provider Network;
- Participate in a Post Appointment Survey; and
- Available in English and Spanish ("Mi Molina").

The Molina Member Portal has the following features available for Marketplace members:

- Premium Payment and Auto Payment functionality;
- Payment History and view monthly premium statements;
- Accumulator information;
- Explanation of Benefits and Summary of Benefit documents;
- Authorize a person to access member's account and make payment for Marketplace members;
- Provide ability for CA members to route to DentaQuest website; and
- Provide ability for members to access VSP website for vision benefits.

The Molina Member Portal also offers the following features for Interdisciplinary Care Team:

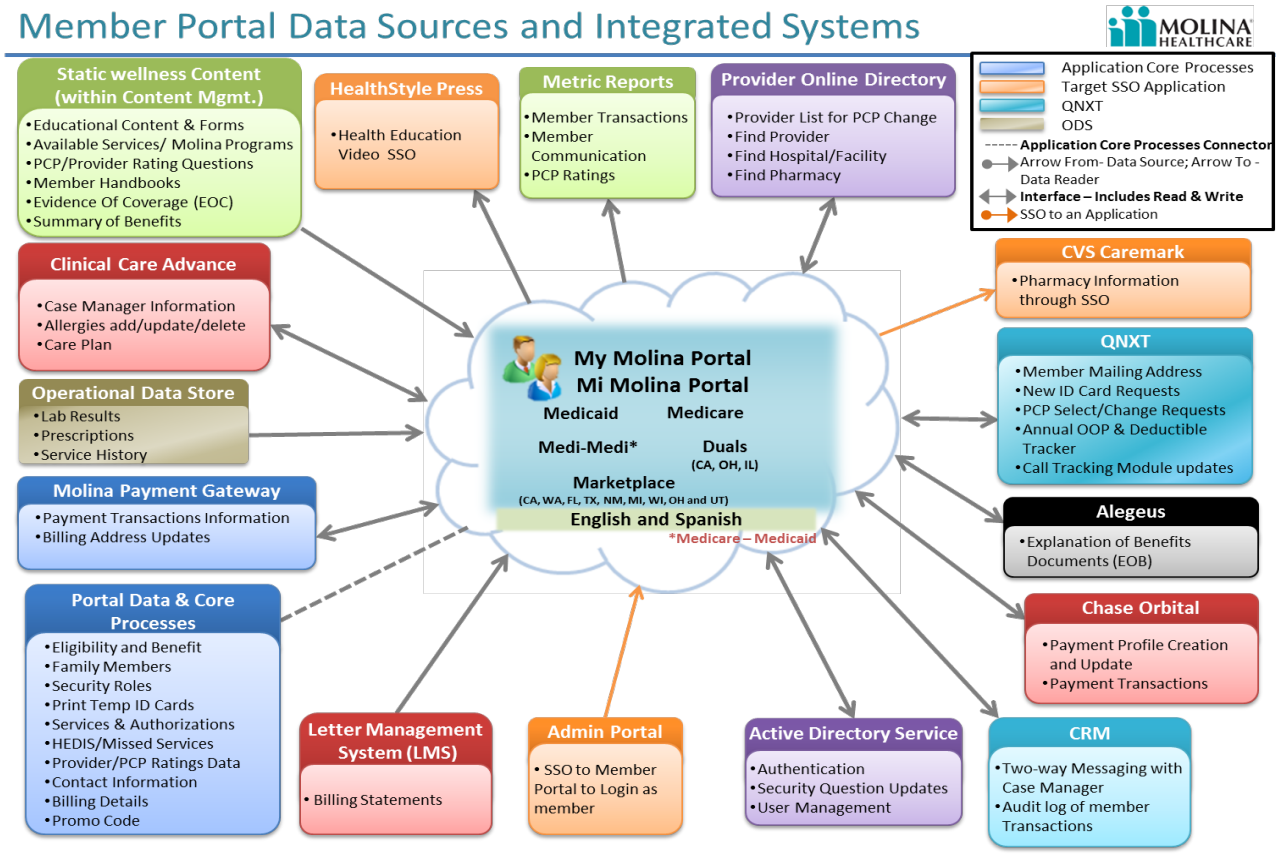
- Ability to view and provide electronic consent to Interdisciplinary Care Team access to Health records;
- Provides ability to access member's health record including – service history, service authorizations, lab results, medications, allergies, inpatient admissions and emergency department visits, care plan, assessments and HEDIS missed service alerts;
- Provides ability to register, login and view Member PHR for Interdisciplinary Care Team;
- Ability to view a member's Case Manager name and contact information and communicate with the Molina Case Manager; and
- Provides ability for member's to complete 'Health Risk Assessments' online.

Systems Integration:

Molina Member Portal Connects to multiple backend systems including its QNXT information core management system, Case Management and Disease Management platform - Clinical Care Advance, Operational Data Store, Molina's Payment Gateway, Chase Orbital, Letter Management System and Alegeus, among other systems.

Exhibit 8.6.1-1 illustrates a systems integration snapshot of Molina Member Portal.

Exhibit 8.6.1-1 Member Portal Systems Integration



8.7 Health Education and Initiatives

1. Describe your proposed health education initiatives including topic areas and strategies for communication. Provide sample materials.

Molina is committed to improving the health education of its members and recognizes the importance of active participation of the member, provider/practitioner and the health plan to ensure that members receive the benefits of preventive care, early identification of health problems, and aggressive intervention on a personal and focused basis to improve health. Molina takes this concept and uses different avenues for health education and health promotion of its members.

New Molina members receive a Welcome Packet that includes information on benefits, services, and the Quality Improvement Program. Additionally, educational materials on the importance of obtaining regular well checks and getting immunized according to current immunization schedules, as well as Health Education and Disease Management program information, are also provided. The Disease Management program supports practitioner practices by providing education and other resources to members to assist them in achieving optimal self-management knowledge and skill.

To meet each member's unique health needs, Molina has developed a variety of educational materials for new and existing members. All materials are written using language that does not exceed the 6th grade reading level, and are available in English, Spanish and other languages upon request. Education materials are also produced in alternative formats, such as large print, Braille and audio disks. Molina employs bilingual staff to assist members in understanding health education materials.

Molina distributes health education materials to members throughout the year via mail or Member website that provide important information about specific health topics. Interactive Voice Response and text messages may be used as an additional resource to communicate health education information and reminders, if available. When appropriate, Molina will also utilize promotoras or Community Connectors to conduct outreach and education activities. Examples of member materials include:

- *Health & Family Newsletter* – This member newsletter contains timely information on health and public health-related issues such as flu shots, the importance of wellness and preventive services, cultural competency issues and other appropriate health information.
- *Health Management Newsletters* – Molina sends biannual health management newsletters to members participating in disease management programs such as asthma/COPD, and heart disease/diabetes.
- *Health education brochures* – Molina's health education brochures are available to Members through a variety of health management programs. Molina's Content Management department developed standard packets of health education brochures to support all health education programs and meet the needs of Case Managers. Topics include stress reduction, nutrition, exercise, weight management, diabetes, cholesterol, asthma, smoking cessation, oral/dental health, wellness and injury prevention. Molina also distributes health education brochures to members through targeted quality improvement interventions.
- *Clear & Easy Booklets* – Molina developed the Clear & Easy series of booklets to address 17 common health topics, including chronic disease conditions. Extensive field-testing demonstrated that the target audience found them useful and easy to read. Molina mails the Clear & Easy booklets to all members who participate in a disease management program. They also support our Motherhood Matters® program for pregnancy and postpartum. Molina occasionally sends them to a target population to address utilization of services.

See Attachment 8.7.1-1 Molina Health Education Materials.

2. Describe how you would propose to participate and interface with the Healthiest State Imitative.

To illustrate Molina's commitment to Iowa's Healthiest State Initiative, we are a proud sponsor at the "Healthiest in the Nation Sponsor Level" for the June 18 Healthiest State Conference "Taking Back Our Health." Molina's practices are also aligned with the Healthiest State Initiative's "Focus 5" priority areas. For example, Molina provides members with health education materials about increasing the consumption of fruits and vegetables and conducts outreach to members in various modalities to increase the percentage of preventive services completed, including an annual dental exam.

Wellness programs aimed at promoting self-management and quality of life, such as smoking cessation, healthy eating, weight loss and preventive health screenings, will be offered based on member's individualized needs and preferences. Molina has extensive experience in developing wellness programs and in working with community-based organizations, local government agencies, and state and federal programs to successfully implement them.

Molina prides itself for being a company that supports not only healthy living for our members but also our staff. Improvements in health and quality of life are realized by addressing not only physical health but also the social and emotional factors that are crucial to overall well-being. Molina encourages all staff to complete an annual health risk assessment. In addition, gyms are available in most Molina locations.

Molina demonstrates all of the ten characteristics of a socially responsible employer as outlined in Iowa's Healthiest State Initiative. For example, Molina is committed to community service and has established a vibrant corporate social responsibility initiative to support the communities we serve and to help those most in need. The Molina Helping Hands volunteer program provides volunteer opportunities to employees and facilitates this by offering time off for volunteer activities. Molina's Community Champions Awards recognize and affirm the contributions of everyday community heroes across the

country. In addition, Molina trains for success by offering training programs and career growth. Molina also believes in employee recognition for contributions and encourages work/life balance. These combined efforts help to engage employees leading to employee satisfaction, and improvements in mental and emotional well-being.

Post-implementation, an important role of the Community Engagement Director will be evaluating opportunities to further integrate the elements of Iowa's Healthiest State Initiative in Molina's operations.

8.8 Cost and Quality Information

1. Describe proposed strategies to provide price and quality transparency to members.

Molina Healthcare, Inc. has NCQA accredited plans in nine states: Michigan, California, Florida, New Mexico, Ohio, Texas, Utah, Washington and Wisconsin. Molina Healthcare, Inc.'s health plans have been nationally ranked by NCQA for the last ten years, making Molina a national leader in quality among Medicaid focused plans.

Commitment to Accreditation goes hand in hand with a commitment to transparency. Accordingly, Molina has a long history of publicly sharing results of our quality scores. Molina's website includes HEDIS and CAHPS scores, as do Molina newsletters. We will continually evaluate opportunities to enhance the information provided to our members. Additionally, Member Services Representatives training includes price and quality curriculum. The Representatives are able trained to respond to members' inquiries regarding price and quality inquiries.

2. Provide sample EOBs as an exhibit or attachment.

See Attachment 8.8.2-1 Sample Explanation of Benefits (EOB).

3. Describe processes for making provider quality information available to members.

Molina publishes information on provider quality in our provider directory, including our online provider directory. This includes board certification, hospital privileges, and in the case of facilities, Joint Commission accreditation status. In addition, we discuss the Leapfrog Group patient safety practices on the member section of the Molina website, including a link to the Leapfrog Group website. We will continually evaluate opportunities to enhance the information provided to our members.

8.10 Member Rights

1. Describe your process for ensuring member rights as described in Section 8.10.

Molina will comply with federal and State of Iowa laws and regulations that pertain to the rights of members in accordance with Section 8.10 Member Rights of Attachment 1 – Scope of Work. Members will be free to exercise their protected rights. Molina will provide extensive training to call center staff on covered services for the Iowa High Quality Healthcare Initiative program requirements and on issues such as Member Rights, Cultural Competency, identification of emergency needs and the different populations in the program.

Additionally, the Molina Member Web portal includes information on valuable resources, such as a description of members' rights and responsibilities, the online provider directory, list of covered benefits and health and wellness program information. The *Member Handbook* will include a copy of the member rights.

Molina has written policies in place regarding the protected member rights listed below and will provide them to DHS upon request. Members are free to exercise protected member rights. Molina does not discriminate against a member that chooses to exercise his or her rights. In accordance with 42 CFR 438.100, Molina guarantees the following rights to members:

- Receipt of Information – The right to receive information in accordance with 42 CFR 438.10;
- Dignity and Privacy – The right to be treated with respect and with due consideration for his or her dignity and privacy;
- Receive Information on Available Treatment Options – 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;
- Participate in Decisions – The right to participate in decisions regarding his or her health care, including the right to refuse treatment;
- Freedom From Restraint or Seclusion – The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;
- Copy of Medical Records – The right to request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164;
- Treatment Setting – The right to treatment in the least restrictive setting;
- Community Participation – The right to fully participate in the community and to work, live and learn to the fullest extent possible; and
- Health Care Services – The right to be furnished health care services in accordance with 42 CFR 438.206 through 438.210.

8.11 Redetermination Assistance

1. Describe in detail your plans to assist members in the eligibility redetermination process and control against prohibited activities.

The Service Coordinator will complete the annual reassessment at least 90 days prior to the Individualized Service Plan expiring. Should the Service Coordinator encounter any issues that may result in the member not being determined eligible for the upcoming year, the Service Coordinator will inform his/her manager and director, who will contact DHS immediately to discuss the concern and develop a plan to ensure the member does not experience any gaps in services. Services are continued until an appropriate plan is developed in cooperation with DHS and the member or legally authorized representative.

8.12 Member and Stakeholder Engagement

1. Describe in detail your member and stakeholder engagement strategy.

To ensure member and stakeholder engagement, Molina has established a Member and Stakeholder Advisory Board that provides a forum for consumer input on program-related plan policies and benefits, and solicits input on access and availability of care and services.

To ensure participating members selected for the Stakeholder Advisory Board are engaged, the Member Services, Quality and Care Coordination departments develop a list of candidates who are high utilizers of Molina's Care Coordination programs, and reflect the diverse demographics of its member population.

The candidates are also informally assessed for health literacy. Board members advise Molina on issues concerning service delivery and quality of all covered services, member rights and responsibilities, grievance and appeal recommendations for resolution and the needs of the groups represented by members regarding the enrolled population.

Stakeholder Advisory Board meetings are incorporated in program through a formal system to log, assign and track requests and suggestions. The meetings will occur once per quarter and will be regionally based, thereby being conveniently located for members in each county Molina serves. Transportation to and from each meeting will be provided for members if needed, including members with disabilities and functional limitations. The primary functions of the Stakeholder Advisory Board will be to:

- Offer Plan strategies to improve member satisfaction;
- Offer members information about the grievance and appeals process;
- Provide Molina council on development of new member materials, including availability in alternate formats;
- Provide Molina with information regarding general and specific concerns which may include but are not limited to physician and clinical sensitivity issues, physical and communication access challenges, interpreter services, etc. Member input plays a key role in quality improvement activities; and
- Act as a focus group to assist with evaluation of health plan service improvement.

After each meeting, the Community Outreach Director or designee logs each idea, suggestion and request, then presents new entries to the appropriate functional area manager along with recommended follow-up. The functional area manager determines appropriate follow up, assigns tasks to appropriate Molina personnel, and sets workable deadlines. Outcomes are documented in the meeting log.

The Community Outreach Director reports back to the committee on the outcomes of requests and suggestions. If a request or suggestion is not fulfilled, the Community Outreach Director explains the rejection and solicits feedback from the member. The Stakeholder Advisory Board reports to Molina's Quality Improvement Committee. Minutes and other reports from the committee are shared with Molina's Board of Directors. This provides the Board, the ultimate policy-making entity in the company, the opportunity to see the member's feedback. By establishing a formal system to track requests and suggestions, Molina ensures that ideas and opportunities for improvement are not just discussed, but actually incorporated into programs.

2. Submit your Stakeholder Advisory Board strategy and discuss how meaningful representation from member stakeholder groups will be ensured.

To local stakeholders who play an active role to support innovative and effective programs through the effective use of medical home and community-based services, Molina solicits input from community stakeholders through the operation of a Stakeholder Advisory Board consisting of key representatives from hospitals, regional centers, disability advocates and safety net providers.

Throughout the implementation phase and on an ongoing basis, Molina solicits input from community stakeholders through the operation of advisory boards consisting of enrolled members and key representatives from hospitals, regional centers, disability advocates and safety net providers. This ensures local stakeholders play an active role to support innovative and effective programs that remove barriers to member access and continuity of care.

3. Describe how feedback obtained from the Stakeholder Advisory Board will be utilized.

Feedback from the Stakeholder Advisory Board will be reported to the Quality Improvement Committee and the Board of Directors. When appropriate, the feedback and information may lead to staffing changes,

program changes, revisions to policies and procedures and/or revisions of consumer materials to ensure the information is easily understood and relevant to Molina's membership.

To ensure Molina maintains an appropriate range of covered services as well as a sufficient number, mix and geographic distribution of providers (including subcontractors), Molina will establish an accountable, oversight body, the Network Operations Committee. The Network Operations Committee is responsible for overseeing the network development and management plan to deliver a sufficient network that provides the full continuum of behavioral health, physical health, and long-term care and services. The Network Operations Committee ensures continuous evaluation, monitoring and improvement of the network; solicits continuous feedback from stakeholders and experts in the community; and leverages existing relationships and innovative approaches with network partners.

8.13 Stakeholder Education

1. Describe your plan for stakeholder education including proposed timelines and topics.

Molina conducts training for all stakeholders. Because this is a new program, Molina will begin training stakeholders and their staff no later than 90 days prior to go live on all aspects of the contract including the unique needs of the population. Molina will emphasize training for stakeholders in the 90-day period leading up to implementation and then immediately following go-live when stakeholders and members tend to have the most questions about new programs. Molina will provide training using multiple modalities including in person training, in group or individual settings, training through Webinars for stakeholders who have Internet access, and materials posted to Molina's website.

Molina's training program ensures stakeholders understand and respond to the needs of the members. In addition to core operational topics, training includes training on cultural competency, requirements of the Americans with Disabilities Act, Person First Language, and challenges encountered by Individuals with Developmental Disabilities.

Additionally, Molina has dedicated Provider Services Representatives in each service that can provide in-person or telephonic training for individual providers on specific topics. Molina makes the Provider Manual available to newly contracted providers within five working days from inclusion of the provider into the network. The Provider Manual serves as a working document for the training session. The Provider Manual, developed by Molina and approved by DHS, is the core training tool and reference for any provider process or policy associated with Molina.

Molina also periodically makes additional training available to stakeholders on specific topics via multiple modalities including in-person, telephonic, and web-based training. Molina also partners with community organizations and stakeholders to provide education to Molina providers and staff.

2. Describe how you will identify and outreach to stakeholders.

Molina has a grass roots approach to developing relationships and identifying stakeholders within a state's communities. The approach includes attending community events, as well as reaching out to key state advocacy groups and provider organizations. Over the past 6 months, Molina has established relationships with many Iowa stakeholders and will also utilize those connections to continue to identify additional stakeholders. Molina's stakeholder relationships are designed to include and represent all member populations. Molina will work proactively with stakeholders to maintain a comprehensive and successful communication program focused on soliciting input; providing timely, accurate and useful information; and communicating significant program changes that may impact members, providers or stakeholders.

The following is a list of examples of how Molina will proactively work with stakeholders:

- Molina's Outreach staff will hold town hall meetings throughout the state for existing and prospective recipients in preparation for the Iowa High Quality Healthcare Initiative contract. For these events, Molina will develop and disseminate multiple written and web-based communication pieces.
- Molina will provide written notice to members and providers of changes to prior authorization requirements, formulary changes, and/or benefit changes. Members and/or providers will be notified of these changes at least 30 days prior to the change.
- Molina will hold quarterly Provider Office Manager Meetings (POMMs) in high-profile regions of the state. These POMMs have proven to be an effective way of providing education and updated information to providers and their staffs. Molina will also conduct Provider Councils and Joint Operations Committees. These are organized by specialty (behavioral health, long-term care, primary care, etc.) and/or by facility or provider organization and will provide another opportunity to inform and educate providers based on their particular needs.
- Molina will aid in addressing stakeholders concerns and acts on opportunities for improvement. Molina believes that the stakeholder-centered Advisory Committee meetings will play a vital role in ensuring effective and efficient program administration for all Iowa High Quality Healthcare Initiative program recipients.

8.14 Implementation Support

1. Describe proposed strategies to support members during program implementation.

Molina's Member Services provides competent and transparent information that helps members navigate the complex healthcare system. Whether a new or existing members, Molina makes every effort to provide personal assistance to address all member concerns and inquiries.

Molina provides a single, toll-free Member Services hotline and adequate staffing to respond to questions, comments and inquiries from members. Members will be able to obtain support and ask questions during the implementation of the Iowa High Quality Healthcare Initiative, including how to contact Molina and the Ombudsman.

Molina's Member Services staff focuses on helping the member utilize resources to achieve optimal well-being, including preventive care, chronic care coordination, dental and behavioral health needs. It is through the Member Services department that Molina ensures prompt, courteous, positive, appropriate access to benefits and services. This front-line department provides the primary interface between every member and the Molina health plan. Representatives are equipped to assist members on a wide variety of issues, including access, enrollment and benefit inquiries.

Molina's New Member Orientation materials are designed to provide members with easy-to-understand information about covered services and information necessary for the member to efficiently and effectively access health services. The information covers member issues, which includes the role of the primary care provider, Health Homes, Individualized Care Plans and Care Management. The Molina Member Handbook for Iowa High Quality Healthcare Initiative program members and the Molina website will also include information about these topics as well as contact information for the Ombudsman and Molina's toll-free Member Services hotline.

Community Outreach Team

Molina's Community Outreach team will be dedicated to educating Iowa High Quality Healthcare Initiative members about Molina services and benefits while providing information regarding preventive care. The Community Outreach team receives comprehensive training upon hire and periodically

throughout the year to ensure full compliance with all marketing and enrollment requirements. Molina understands that its Community Outreach team is the "face of Molina" in the community and with members. Therefore, Molina takes this charge very seriously, and enforces strict adherence to appropriate outreach activities that reflect positively upon and accurately represent Molina and DHS.

Molina's Community Outreach team is active in the local community in which members live. Molina seeks locally relevant, convenient and culturally sensitive forums and locations to educate members and potential members about Molina and its services. Molina is committed to educating the community on managed care, healthy behaviors, use of benefits, and access to PCPs and other health information through its participation in many venues such as, health fairs, festivals, school nurse associations, evening parent meetings, various church- and community-center sites, provider partnerships, and many more.

8.15 Grievances, Appeals, and State Fair Hearings

1. Describe in detail your system for resolving inquiries, grievances, and appeals, including how your system ensures all policy and processing requirements are met.

Molina has established an appeals and grievances process in accordance with Section 8.15 Grievance Appeals and State Fair Hearings of Attachment 1 – Scope of Work. The appeals and grievances process for members and authorized representatives define their rights regarding matters of dissatisfaction including disputing a denial of coverage, payment or medical assistance. Molina's Appeals and Grievances Department has oversight and responsibility for all grievances and appeals received. The Appeals and Grievance staff serve as advocates guaranteeing that all members have access to the benefits and care to which they are entitled and easy access to the grievance process. Members are informed of their grievance, appeal, and state fair hearing rights in the member enrollment materials in compliance with the requirements in Section 8.2 Member Communications of Attachment 1 – Scope of Work.

Members or their authorized representative may file a standard appeal in writing via mail, fax or e-mail, within 30 calendar days from the date on the notice of Action. Members may also submit a request through the member portal of Molina's website. Member Service Representatives and Appeals and grievances Coordinators are available to assist members with the filing, notice and resolution timeframes. Members may also utilize translation assistance, toll-free calling or TTY capability. Oral appeal requests must be followed up with a written request. Any appeals requests made on behalf of the member must have the member's written consent. Standard appeals are acknowledged in writing within three business days of receipt, taking into consideration an oral notice will constitute the date of receipt. All appeals will be determined as expeditiously as possible; but no later than 45 calendar days from the date of receipt. This timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c). If the timeframe is extended, for any extension not requested by the member, Molina will give the member written notice of the reason for the delay. Members have the right to a state fair hearing; however, members must first exhaust Molina's internal appeal process.

All grievances and appeals are date stamped and documented in Molina's operating system, QNXT, and are also automatically captured in Molina's Appeals and Grievances Application, which is a web-based database that houses all appeals and grievances information. When a grievance or appeal is coded in QNXT, it automatically maps to the Appeals and Grievances Application where it is assigned a case number. Grievances that are resolved by the Member Services Representative are closed in QNXT (yet still captured in the Appeals and Grievances Application). Grievances that are not fully resolved at the time of the initial call are left in an "open" status and forwarded, via the Call Tracking module in QNXT, to the Appeals and Grievance Department. An Appeals and Grievances Coordinator is assigned to the case and is responsible for resolving the grievance.

Members or their authorized representative may file a grievance related to any dissatisfaction with Molina other than an Action. Any grievances filed on behalf of a member must have the member's written consent. All grievances are acknowledged in writing within three business days from receipt. Molina Member Services representatives and Appeals and Grievances Coordinators are available to assist members with the filing, notice and resolution timeframes. Members may also utilize translation assistance, toll-free calling and/or TTY capability. Grievances are resolved as expeditiously as possible and every effort is made to resolve grievances at the time of the initial call to the Call Center. Members will be provided written notice of the disposition of their grievance within 30 calendar days. This timeframe may be extended up to 14 calendar days, pursuant to 42 CFR 438.408©. If the timeframe is extended, for any extension not requested by the member, Molina will give the member written notice of the reason for the delay. There is no right to appeal a grievance decision.

Expedited appeals may be requested by the member or a provider acting on the member's behalf, within 30 calendar days from the date of Action notice. Written consent from the member is not required for expedited appeal requests. Molina will dispose of expedited appeals within three business days after Molina receives the expedited request, unless this timeframe is extended pursuant to 42 CFR. Members are informed of the limited time available to present evidence and allegations of fact or law. Punitive action will not be taken against any provider who requests an expedited resolution or supports an enrollee's appeal.

In accordance with 42 CFR 438.410, if Molina denies the request for an expedited resolution of a member's appeal, the expedited appeal will be transferred to a standard appeal and a decision must be made within the standard 45 calendar day timeframe. The member will be provided written notice of the denial within two business days of the expedited appeal request. Molina will also make reasonable attempt to give the member prompt oral notice.

Molina's Appeals and Grievance Coordinators fully investigate the substance of all appeals to ensure that the information is complete and determine whether it is clinical or non-clinical in nature. The member is granted the opportunity to present evidence and allegations of fact or law, examine their case, and consider all authorized or legal representatives as parties. Molina guarantees that the individuals who make decisions have not participated in previous levels of review or decision-making. Molina ensures that decisions are made by healthcare professionals, with the appropriate clinical expertise in treating the member's condition or disease for all appeals related to medical necessity and as well as any grievance concerning a denial of expedited resolution of an appeal; or a grievance that has any clinical issues.

Members will be provided written notice of the appeal disposition including appropriate Iowa Code and/or Iowa Administrative Code section citations. For all appeals that are not wholly in the member's favor, the appeal disposition letter, in accordance with 42 CFR 438.408, must be provided with their right to file a state fair hearing. The member will be informed that they may file a state fair hearing within 90 calendar days of the date of notice from Molina on the appeal decision. The parties to the state fair hearing shall include Molina, as well as the member and his or her representative or the representative of a deceased member's estate. A provider may request a state fair hearing on behalf of a member with the member's written consent. This information is also provided in the member handbook.

In certain member appeals, Molina shall continue the member's benefits pending the appeal, in accordance with 42 CFR 438.420. Members are notified throughout all phases that Molina will continue the member's benefits provided that all of the following conditions apply:

- The member or authorized representative files an appeal with Molina on or before the later of the following: within 10 business days after the notice of the adverse action is mailed, or within ten business days after the intended effective date of the action, whichever is later;
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment;

- The services were ordered by an authorized provider;
- The time period covered by the original authorization has not expired; and
- The member or authorized representative requests an extension of services.

If benefits are continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:

- The member withdraws the request;
- Ten (10) business days pass after the Molina has mailed the notice of an adverse decision, unless a State Fair hearing has resolved the matter; or
- The time period or service limits of a previously authorized service has been met.

If the final resolution of the appeal is adverse to the member, Molina may recover the cost of the services furnished to the members while the appeal is pending, to the extent that they were furnished solely because of the requirements to maintain benefits in accordance with 42 CFR 431.230 and 42 CFR438.420.

Molina's Grievance and Appeals System is capable of identifying and categorizing complaints, grievances, and appeals, in accordance with NCQA and state category requirements. Molina currently tracks and reports data related to grievances and appeals in compliance with NCQA reporting guidelines using the following categories: Quality of Care, Access, Attitude and Service, Billing and Financial Issues, and Quality of Provider Office Site in order to identify opportunities for improvement and implement appropriate interventions. Appeal and grievance data is analyzed on a regular basis in order to stay on top of trends. A thorough analysis is conducted and presented to the Member Provider Satisfaction Committee and Quality Improvement Committee on a quarterly and annual basis. Goals and performance thresholds are established based on this analysis. The results of the analysis are compared to previous measurements and established goals. Root-cause analysis and barrier assessments are conducted to provide insight into issues that may have contributed to the causes and performance gaps in achieving established goals while opportunities for improvement are developed and implemented. In addition, internal departmental audits are performed to ensure all processes and written communications comply with state, Federal, and NCQA requirements.

Additionally, as part of the standard grievance resolution process, various departments such as Provider Services, Quality Improvement, Case Management and the Member Services Call Center work closely with the Appeals and Grievances Department in order to resolve an issue.

2. Describe your proposed exception to Contractor policy process.

Molina follows all policies as written. However, on a case by case basis, some exceptions may be made for members if it is in their best interest. For example, if a member does not meet the criteria for a certain service based on the criteria used; however, there may be some other extenuating circumstances involved that were not taken into account during the PA review process and would warrant approving the service.

MOLINA HEALTHCARE
Your Extended Family.

Molina Healthcare of Iowa

[Proposed method of marketing the plan]

1.0 EXECUTIVE SUMMARY

Marketing Plan | March 2014

This plan outlines the planned marketing, outreach and education programs that will accompany the implementation of Molina Healthcare's health plan in Iowa. The plan is the result of our research into the current environment in Iowa's market, combined with 35 years of experience working with low-income populations. Molina has a proven record of success utilizing outreach and marketing programs targeted at the government-sponsored health care population, and expects to continue this success to the benefit of this same population in Iowa –those who are eligible for the state's government-funded programs including Iowa Medicaid, Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (hawk-i) programs.

Molina Healthcare of Iowa (MHIA) is a wholly owned subsidiary of Molina Healthcare, Inc., a publicly-traded, multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid. Molina is an innovative health care leader providing quality care and accessible services in an efficient and caring manner.

This Marketing Plan follows our guiding mission and core values

- We strive to be an exemplary organization
- We provide quality service
- We are health care innovators and respond quickly to change
- We respect each other and value ethical business practices
- We are careful in the management of our financial resources
- We care about the people we serve

The primary goal of the MHIA Marketing Plan is to promote and facilitate an awareness of MHIA's commitment to high quality health care standards, helpful and engaging health education and medical advice programs, and other benefits associated with being a member of MHIA.

Molina's focus in targeting the Medicaid market will be centered on patient outreach and will include educating prospective members and beneficiaries about four major concepts:

- The managed care process implemented by the Iowa Department of Health Services (DHS)
- The role of Molina Healthcare in the regions it will operate
- The enrollment process
- The rights and responsibilities of patients as members of the plan and participants in Iowa's government-sponsored programs

As the health care environment changes, Molina Healthcare continues to integrate and incorporate best practices in order to provide the best programs for the Medicaid population. While we have previously integrated many of the outreach programs in this plan with success in other markets, we continue to learn from our other health plans and will incorporate those lessons learned into our ongoing outreach in Iowa.

1.1 Overall Goal

The ultimate objective of Molina Healthcare's marketing and outreach effort is to provide Medicaid-eligible beneficiaries with accurate information so they can make informed decisions concerning their health care needs and the health care needs of their families.

1.2 Marketing Objectives

In general terms, marketing objectives can be defined as the goals set forth by a business when promoting a project to potential consumers of that product. Marketing goals are specific, and quantifiable, and can be assigned a particular timeframe for achievement.
The goals of Molina Healthcare's marketing and outreach programs in Iowa are as follows:

- Promote maximum enrollment of eligible individuals, including those with subsidized coverage and those without.
- Utilize resources already in place, encouraging close partnerships with state and local agencies, community organizations and businesses that embrace a common mission
- Identify areas for maximum impact – select appropriate channels of communication for each population based on geographic areas of residence, recreation and work for targeted audiences

- Embrace population diversity to create specific product messaging, utilizing multi-language messaging
- Provide program outreach that reflects the target population and create trusted relationships upon which beneficiaries can depend

2.0 MARKET ANALYSIS

2.1 Situational Analysis

The Iowa Department of Human Services ("Agency") intends to contract for delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa (hawk-i) programs. The Agency intends to contract on a statewide basis with two (2) to four (4) successful bidders with a demonstrated capacity to coordinate care and provide quality outcomes for the Medicaid and Children's Health Insurance Program (CHIP) populations. The program will enroll the majority of the Iowa Medicaid and CHIP populations and will also provide services for individuals qualifying for Iowa Department of Public Health (IDPH) funded substance abuse services. Also includes Duals and LTC.

Medicaid in Iowa currently provides health care assistance to about 560,000 people statewide through the following programs:

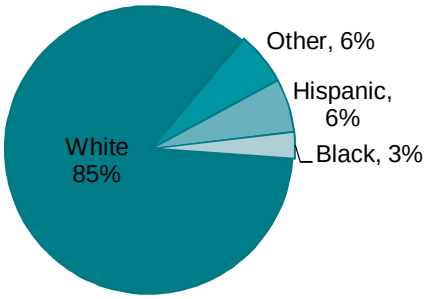
- Managed Care
    - MediPass – physician managed population
    - Health Maintenance Organization (HMO)
    - Iowa Health & Wellness Plan
    - Dental Wellness Plan
    - Iowa Plan
    - Non-Emergency Medical Transportation (NEMT)
    - Program of all inclusive care for the elderly (PACE)
    - Children's Health Insurance Program (CHIP)
    - Fee-for-Service (FFS) – currently the vast majority of enrollees is in a fee-for-service model

As a new entrant into the Iowa market, Molina Healthcare will incorporate the best features of the DHS program model into our managed-care framework, creating a market-specific health care program that best serves the target population.

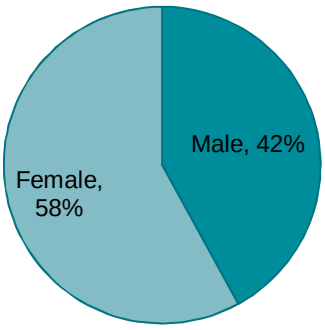
2.2 Target Market for Health Plan Enrollment

The 2010 U.S. Census counted 3.1 million people living in Iowa, with the population being predominately White. However, demographics are transitioning and the shift is contributed to new health patterns and disparities throughout the state, such as aging population, medically underserved rural communities, influx of newcomers and rapid ethnic diversification. These will all be areas of focus for MHIA.

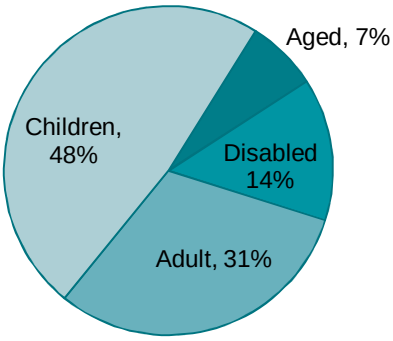
Iowa Population by Ethnicity



Medicaid Enrollment by Gender

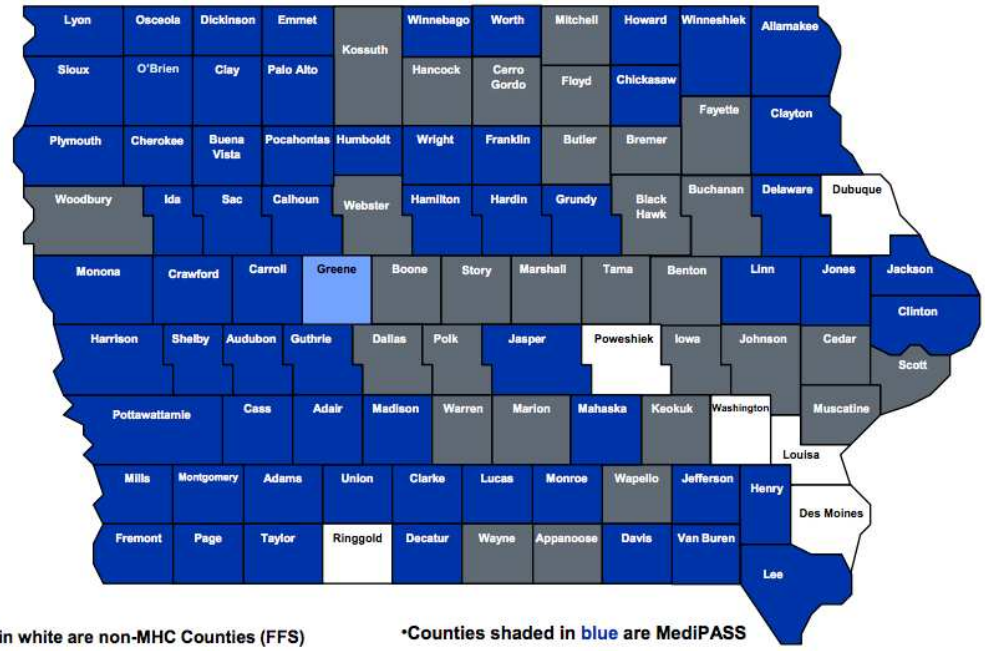


Medicaid Enrollment by Type



2.3 Geographic Area to be served

Molina Healthcare of Iowa will establish an office and operate from a presence in Iowa. While initial expectations for membership will be statewide, area-specific expansion will be assessed periodically in accordance with MHIA's internal business plan.



2.4 Target Audience

Molina Healthcare will combine its current successful programs with other public health programs to target all eligible populations for education, awareness and outreach. Outreach and marketing efforts will focus on providing education and awareness for the currently eligible population residing in the Molina regions and potential beneficiaries, especially with:

- Counties/regions with high member ratios
- Rural residents, newcomers, minorities (predominantly Hispanic, African American and Asian), and the elderly

2.5 Current Managed Care Enrollment and Competitor Analysis[1]

MediPASS, Iowa's first managed care program, serves 75 counties and provides pregnant women, children and parents with a designated provider for primary care, case management, referrals and specialty services. While Iowa currently enrolls a portion of the Medicaid

[1] https://dhs.iowa.gov/sites/default/files/IDA%20PRM%202014.pdf

population in managed care plans, the vast majority of enrollees are still served in a fee-for-service model. Moreover, none of the managed care plans provide a comprehensive benefit plan.

- In 2012, Iowa also offered beneficiaries the option to enroll in a single MCO instead of MediPASS (Meridian Health Plan of Iowa)
- Meridian Health Plan of Iowa
    - Covers all primary, acute and some specialty services
    - Available to Medicaid recipients in Benton, Black Hawk, Clinton, Linn, Muscatine, Polk and Webster counties.

Molina Healthcare has a distinct advantage in serving the Medicaid population, thanks to more 35 years of care focused strictly on underserved and vulnerable populations. Our consistent focus through Molina's extensive growth has been on providing excellent service and preventive health care to traditionally overlooked populations. This unwavering focus will benefit the Iowan Medicaid population.

2.6 Health Care Delivery System

Iowa has a strong and stable infrastructure of health care providers. The provider infrastructure in the Iowa is more than adequate for Molina to develop a network to serve the projected enrollment. MHIA shall maintain and manage a network of appropriate providers that is supported by written agreements and is sufficient to provide timely and adequate access to all services covered under the DHS contract.

3.0 Molina's Health Care Model

3.1 Key Strengths

Some of the key strengths of MHIA's parent, Molina Healthcare, Inc., which will be adopted by MHIA and will set it apart from the competition, include the following:

- **Commitment to Medicaid:** Molina Healthcare, Inc.'s focus is exclusively on patients that receive health benefits from government-sponsored programs; Molina Healthcare,

Inc. does not operate any commercial lines of business outside of those that target low-income populations.

- **Focus on Preventive Medicine and Wellness:** Molina focuses much of its patient outreach around educating patients to partner in their own health care. Successful programs have included our Smoking Cessation Program, which combines counseling, self-help materials and nicotine replacement medication, patches and gum; and our Motherhood Matters™ program, which educates mothers about perinatal care of both mother and child. Molina also offers a variety of disease management programs to help those living with chronic conditions to prevent deterioration of health conditions and enjoy the best quality of life possible.

- **Care Management:** Molina Healthcare provides care management programs to promote improved health care outcomes by providing our members with the assistance and resources they need to take control of their health. We use an integrated team approach that encourages enhanced provider collaboration and may include face-to-face interaction with patients making it easier to address issues, wellness and prevention. We focus on interventions that involve transitions of care and disease protocol as opposed to discharge planning only.

- **Disease Management:** Molina Healthcare offers programs and services to help our members manage chronic diseases and take care of their health. Examples of chronic condition programs include Molina Breathe with Ease® (Asthma) Program, Molina Healthy Living with Diabetes Program®, Chronic Obstructive Pulmonary Disease (COPD) and Heart Healthy Living®. Members may be automatically enrolled in a program depending on their health needs. Molina sends educational material to newly identified members with chronic conditions. Molina sends newsletters bi-annually to remind members to see their provider and offer tips on managing their condition. Molina writes all health education materials at a 4th grade reading level as tested by Flesch-Kincaid readability test. Members may receive material in English or Spanish. If members speak another language, Molina offers interpreter services so that materials may be read to the member. Upon member request, Molina will provide materials in

special formats, including Braille, large print (18 point font) or audio. Occasionally, Molina offers incentives for members to receive services in a timely manner.

Molina also offers preventive health management programs such as Weight Management and Quit Smoking. All health management programs provide education materials and support.

- **Patient Outreach / Education:** Access to Molina Healthcare's multilingual free 24-hour Nurse Advice Line is available to all Molina members. Accredited by URAC, the Advice Line provides medical information to members in over 20 world languages. Members may speak directly with a registered nurse and receive a medical opinion about a physical or emotional problem. Molina owns and self-operates a nurse advice line and also requires all of its staff nurses to be fluent in both English and Spanish.

- **Value-Driven Health Care:** Molina believes that thorough health management means staying in communication with our patient population – not only when they are sick. Increased focus on preventive health care and education results in more informed and engaged patients and lower health care costs. The benefits of this model are enjoyed by patients, providers and ultimately the state.

- **Case Management Services:** Finding a doctor or understanding the health care system can be intimidating for many, but for the most vulnerable in our society, it can be confusing and overwhelming. When a member joins Molina, a case manager is assigned to help identify what the member needs – whether it is transportation to the doctor, a reminder call to take his/her insulin, assistance with social services, or help with housing. Our case managers help our members navigate the health care system to make sure they get the right health care in the right setting at the right time.

- **Quality Healthcare**: Molina Healthcare is committed to providing quality health care to low-income individuals and families in all the states where Molina operates. As such, 9 out 11 of its health plans are accredited by the National Committee for Quality

Assurance (NCQA), making Molina a leader in quality care. NCQA is an independent, not-for-profit organization dedicated to measuring the quality of America's healthcare.

- **Molina Institute for Cultural Competency:** Through the Molina Institute, we develop strategies and programs to reduce barriers to health care access for underserved and diverse populations. One example of how Molina closes the gap in cultural barriers in California is our partnership with Latino Counseling at Santa Clara University. Molina's donation to the University helped to fund financial assistance for students enrolled in the Latino Counseling emphasis. The money helps develop bilingual/bicultural therapists to address the mental health needs of the underserved Latino population.

- **Multicultural Planning:** The ethnically diverse populations of the states where we operate require specific and targeted outreach efforts that are both language-appropriate and culturally sensitive to the specific needs of these communities. Language barriers, cultural differences, health literacy and socio-economic circumstances all have contributed to the challenges of securing and maintaining health coverage. Multicultural outreach is not a "niche" or add-on part of Molina's plan. In fact, it has been integral to all planning, including critical paid media, earned media, the grant program, and more. The descriptions in the following sections give specific target examples of this outreach, outlining key considerations for the Hispanic audience that is prevalent in Iowa.

- **35 Years of Experience:** Molina Healthcare, Inc. was founded as a provider organization – providing insights into the challenges faced by Medicaid providers. Three decades later, it remains a physician-led organization with J. Mario Molina, MD as its chief executive officer. Molina Healthcare also offers a robust direct delivery system that includes 25 company-owned and operated primary care clinics in California, New Mexico, Florida, Utah and Washington and the management and operation of three county-owned primary care clinics in Fairfax County, Virginia through a contract with Fairfax County.

- **Community Engagement:** Being involved in the community has been a significant part of Molina Healthcare's mission for 35 years in the various states where we operate. It

will be no different in Iowa where we will strive to make an impact on the local community and help those most in need. For example, Molina HOPE focuses on giving micro-grants directly to community partners that serve our common mission: caring for the underserved. Since the inception of Molina HOPE, we have invested more than a million dollars into the local communities. We offer scholarships to educate the future physicians and health care providers that our communities so desperately need, and we write grants to help fund programs to increase individuals' and families' access to quality health care. For example, Molina funded National Hispanic Health Foundation scholarships, and Molina Healthcare of California helped fund scholarships at Western University of Health Sciences. In addition, we contribute human resources in the form of employee volunteer work through our companywide volunteer time-off program, Helping Hands.

- **Community Champions:** Created in 2006, the Community Champions program honors individuals in the community who inspire others through selfless contributions that positively affect the health and wellbeing of others. The Community Champions Awards were named in honor of Molina Healthcare's physician founder, Dr. C. David Molina, and recognizes those unsung heroes who inspire and serve others. Nominated by other community members for their work, winners are chosen by a committee of Molina and community members. Winners are then honored at a dinner and awards ceremony where they receive a trophy and a $1,000 grant to be awarded on behalf of each winner. That way, a winner can "pay it forward" to an organization of their choice in the local community.

- **Faith-Based Partnerships:** A significant percentage of the Iowan population reports themselves as religious (56%), with Catholic being the leading faith. Our experience indicates that when the church pastor and other church leaders are early adopters of external programs and projects, the chances of the congregation embracing the initiatives increase. As part of our outreach in the community, we will engage these faith-based organizations to reach our potential members.

4.0 Experience and Accolades

In 35 years, Molina Healthcare has accrued significant experience in our field and garnered awards and accolades that support our success:

- Molina Healthcare, Inc. has been honored with the 2011 Alfred P. Sloan Award for Business Excellence in Workplace Flexibility for a workplace strategy that increases business and employee success. This honor ranks Molina Healthcare in the top 20 percent of employers nationally in terms of its programs, policies and culture for creating an effective and flexible workplace.
- Molina Healthcare's nine NCQA-accredited plans place Molina Healthcare among the national leaders in quality Medicaid accreditations.
- For 10 years in a row, Molina Healthcare plans have been ranked among America's 100 top Medicaid plans by NCQA.
- Molina Healthcare has been listed FORTUNE magazine's ranking of the 500 largest U.S. companies since 2012.
- Molina Healthcare was named among the 100 best corporate citizens by Business Ethics magazine.
- Time magazine recognized Dr. J. Mario Molina, CEO of Molina Healthcare, as one of the 25 most influential Hispanics in America.
- Recognized for innovation in multi-cultural health care by The Robert Wood Johnson Foundation, NCQA and CHCS.
- Ranked among Forbes 400 Best Big Companies in America.
- Ranked largest Hispanic-owned business in the nation by Hispanic Business magazine in 2010.

5.0 MARKETING METHODS

Molina Healthcare of Iowa's goal is to provide access to DHS beneficiaries, increase overall health, create health awareness through education, and to remove barriers to service (be they physical, linguistic or cultural) facilitated through our marketing and outreach efforts. The primary goal of the Molina Marketing Plan is to promote and facilitate an awareness of MHIA's commitment to high quality health care standards, helpful health education and medical advice

programs and other benefits associated with being a member of MHIA. Specifically, this will be accomplished by educating beneficiaries and prospective members about the managed care process implemented by the agency, the role MHIA performs in providing services, the enrollment process, and their rights and responsibilities as members of the Plan and participants in the Medicaid program.

5.1 Messaging and Creative Development

Molina recognizes that all markets are different, and we anticipate language and messaging challenges that are unique to Iowa as we develop materials and concepts for use in our outreach efforts. We will rely on our extensive library of successful materials from other markets as a baseline, making our development of new materials as efficient as possible. Government agencies and other organizations will play a major role in assisting Molina with the distribution of materials through existing channels and outreach methods.

In addition to the development of appropriately targeted materials, Molina will continue to collaborate with our extensive national network. This allows us to share best practices nationwide, ultimately lowering costs to all. We embrace partnership with local agencies and sponsors in this collaborative effort.

5.2 Materials Development: Outreach and Education

Educational materials will be developed to raise awareness, ensure consistency of care and motivate action where needed. All materials will work in concert – ensuring a uniformity of messaging to intended Iowa audiences. Each piece will be culturally and linguistically relevant, written in simple language, and will provide a clear call to action. All of our materials will be available in English and Spanish.

Under Medicaid program rules, Molina Healthcare of Iowa may not and will not charge enrollees for health care services. Furthermore, in accordance with DHS regulations, all applicable marketing guidelines will be followed.

5.3 Outreach Locations

MHIA will conduct outreach activities in the regions where it serves beneficiaries through its direct contract with DHS. All MHIA marketing materials and activities utilized in operations will be developed in accordance with guidelines and parameters set forth in MHIA's contract with DHS, manuals and documents per the contract, Molina's Marketing Plan, and MHIA's cultural and linguistic standards.

Iowa's evolving demographic profile and populations new to managed care will require specific and targeted outreach that is language-appropriate and culturally sensitive to the needs of those communities. Challenges that must be overcome in outreach efforts will include: language barriers, cultural differences, health literacy and socio-economic circumstances.

5.4 Outreach Activities and Tactics

Securing the assistance of public and private sponsors within Iowa will be a critical element in reaching the underserved populations that Molina Healthcare can benefit. By recruiting established local champions into public awareness, outreach and education campaigns, Molina can build on the already existent trust that residents have in these organizations. These organizations will play a crucial partnership role as credible sources of information and counsel to target communities.

Molina Healthcare's outreach activities will be conducted with the full partnership and approval of DHS. MHIA will provide all materials to DHS for approval prior to any event, including all schedules, plans and informational material for community education, networking and outreach activities. Ethnic and multicultural events, holiday celebrations, health fairs, events surrounding health awareness programs, recreational sporting events, etc. all provide opportunities for outreach to our targeted audiences.

A narrative description of these potential activities follows:

- **Sponsorship/Co-sponsorship of Community Events** – Either alone or in conjunction with community leaders and/or community-based organizations, upon request, MHIA will make formal group and one-on-one presentations to Medicaid beneficiaries and the

larger public. Possible sites for these events include community centers, social service agencies, schools, places of worship, and other appropriate public-gathering locations.

These presentations may focus on a particular population's common health prevention issues (e.g., nutrition, breast cancer, diabetes, etc.), cultural and linguistic experiences and traditions. DHS-approved marketing materials such as pamphlets, promotional items and fliers may be available to the public at these events, as they relate to these factors for Medicaid and MHIA.

- **Participation in Third-Party Event**s **–** MHIA's participation will generally consist of the placement of a table or booth at the event site; the table may be adorned with a MHIA banner, plan-awareness materials and health-related presentation materials applicable to the event. In addition to such approved collateral items, promotional items may be available to the visiting public such as balloons, bottled water, etc. Some of these items will relate to current MHIA health-related campaigns to raise awareness of common health concerns. An example is childhood immunizations, for which MHIA will make available items such as childhood immunization schedules.

  Third-party events are so named because an outside party, not MHIA, is primarily responsible for the event organization. Examples include health fairs, holiday celebrations, and other community events where MHIA may play a positive role in raising awareness of Medicaid, health-related interests or issues, and MHIA's health care services, in a responsible and positive manner.

- **Presentations or "In-Services" with CBO's (Community-based Organizations)** – Coordinators will make presentations about the Medicaid program to community-based organizations such as the WIC program. Coordinators will use a standard presentation that focuses primarily on the nuts and bolts of the Medicaid program, including: who is eligible, how individuals determine their eligibility and enrollment in the Medicaid programs, and how individuals choose a managed care organization. The goal of the presentation is to help intermediaries explain the program to potential enrollees.

- **Collaboration with Provider Services Staff in Provider Partnerships** – Outreach and Retention staff will accompany Provider Services representatives to provider offices, providing additional information about MHIA activities, enabling providers to help members maximize the benefits they receive from their health plan and helping to develop partnerships that result in better member health outcomes as well as stronger membership numbers for the plan. Additionally, Molina Healthcare of Iowa will offer one Continuing Education seminar per quarter to strengthen provider partnerships. This strategy will help providers be ambassadors for Molina Healthcare of Iowa.

- **Follow-up of Beneficiary Inquiry –** Molina may have referral cards available to the general public at third-party events and other locations. Beneficiaries, or any members of the public who express an interest in learning more about MHIA or a health-related issue related to Medicaid services, can fill out this card and mail it to MHIA. Once MHIA receives the card, a MHIA staff member will call the individual in response to his/her request for information.

- **Media Advertising** – MHIA's media advertising campaign may include the use of television commercials, radio spots, billboards, bus shelters, print advertisements, and an internet home page for public accessibility at www.molinahealthcare.com. All Medicaid media advertising campaigns and plan-awareness materials will be culturally and linguistically appropriate.

5.5 Outreach Materials

All MHIA outreach materials will be submitted to DHS for approval prior to use. These materials will be designed so that they are culturally sensitive and linguistically appropriate, in accordance with all regulatory guidelines, including material available in alternative formats and foreign languages. These materials could be distributed by MHIA or in partnership with provider partners and community organizations. Some potential MHIA outreach materials may include:

- Health Education Materials
- Print Advertisements

- Magazine/Newspaper Advertisements
- Informational Brochures
- Event Fliers
- Promotional Cards
- Posters
- Direct Mail
- Other Media Advertisements
    - Television Advertisements
    - Radio Advertisements
    - Managed Care and Plan Informational Videos
- Online Advertisements – Online ads will be published on websites that target specific demographic and psychographic criteria. This information has been added to the marketing plan.
- Out-of-Home: Outdoor advertising is a persistent and unobtrusive way to reinforce messages in places where people live, play and work. This type of advertising will allow Molina to create a constant dialogue with target audiences, becoming a presence in communities, and might include:
    - Billboards
    - Bus Shelters
    - Retail Posters

5.6 Outreach Distribution Methods

In addition to the above-referenced plan awareness and health promotions, MHIA will distribute DHS-approved materials to members primarily through two means, which are in the Health Plan's entire Service Area. Done in accordance with all application regulatory guidelines and concurrent with DHS oversight and direction:

- **Molina Member Services:** Member informational materials such as MHIA Provider Directories, Member Handbook, and Solicitation Brochure will be disseminated to member and beneficiary households by MHIA's Member Services Department.

- **Health Education / Cultural and Linguistics:** Other DHS- approved materials such as health-campaign awareness and promotional collateral items may also be sent to MHIA members, as approved by DHS.

- **Provider Partners/Sub contractors:** As needed, MHIA will develop strategic, cobranding partnerships with provider partners and other subcontractors. This could include the development of cobranded DHS-approved fliers, posters, direct mail, and other marketing and/or health education collateral.

5.7 Community Outreach Staff Recruitment

Any Community Outreach Department vacancies that may occur will be filled according to MHIA's policies and procedures governing recruitment and employment of staff. Related provisions of these policies are included below:

- **Equal Employment Opportunity:** MHIA is committed to equal employment opportunity for all applicants and employees. It is the employer's policy to employ, retain, promote, terminate, and otherwise treat all employees and job applicants on the basis of merit, qualifications, and competence. This policy shall be applied without regard to any qualified individual's sex, race, color, religion, national origin, ancestry, citizenship, pregnancy, age, marital status, medical condition, or physical or mental disability. Subcontractors of MHIA will be required to affirm commitment to same, as evidenced by non-discrimination clause compliance provisions in all contracts with MHIA. All solicitations and/or advertisements for applicants and employees will affirm this policy by stating that the employer is an Equal Opportunity Employer (EOE).

- **Non-Discrimination on Basis of Disability**: In furtherance of our nation's commitment to end discrimination on the basis of disability, and in accordance with the provisions of Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 (ADA), Code of Federal Regulations (CFR), Part 84, CFR, Part 36, and all regulations properly issued thereunder, it is the employer's policy that no program or activity administered by the employer shall exclude from participation, deny benefits to or subject any qualified individual to discrimination, based solely on, or by reason of, his or

her disability. Equal employment opportunity will be extended to all qualified disabled persons in all aspects of the employer-employee relationship, including recruitment, hiring, upgrading, training, promotion and reasonable accommodation to the known physical or mental limitations of an otherwise qualified disabled employee or applicant. Subcontractors of MHIA will be required to affirm commitment to same as evidenced by non-discrimination clause compliance provisions in all contracts with MHIA.

- **Recruitment & Employment:** The Human Resources Department maintains a centralized recruitment service that is coordinated by the local office. Human Resources will recruit normally from within the company first by announcing open positions through the intranet, pre-screening and referring the most qualified applicants to interviewing supervisors/managers. External candidates will be recruited if the internal efforts are unsuccessful.

  All applicants are subject to pre-employment investigation of work and educational background. In some cases, a security background check may be conducted based upon the position being applied for. If references are found to be unsatisfactory, applicants may be rejected for employment. In addition, falsification or omission on the employment application or related documents will result in rejection for employment or termination of employment if the employee is already employed.

  When engaging in marketing, MHIA shall have a designated person, qualified by training and experience, to adhere to the marketing requirements.

  All employment with MHIA is for no definite period of time and may be terminated at the will of the employee or MHIA, at any time, with or without cause.

- **Staff Development & Training:** MHIA will train and develop our Community Outreach Representatives to conduct positive and responsible interactions with all Medicaid beneficiaries. Any guidelines established by DHS will be strictly construed and adhered to by the Plan and its Representatives.

All such representatives of Molina will be trained to understand and adhere to these parameters and be licensed / certified as required by DHS.

5.8 Community Needs Assessments and Outreach Research

The MHIA Marketing Department may utilize several methods to determine the needs of the communities served. These methods are employed in compliance with all applicable regulatory guidelines and include, but are not limited to, the following:

- Conducting Group Needs Assessments
- Conducting Member Focus Groups
- Conducting Membership Quantitative Research
- Conducting Member Satisfaction Surveys
- Implementing and maintaining a Cultural and Linguistic Services Plan
- Maintaining an active Member Participation Committee
- Maintaining an active Community Advisory Committee
- Establishing regular communication between Molina and community leaders/organizations (through processes approved by DHS)

MHIA Marketing, Outreach, and Health Education departmental staff will review all information collected from these assessment methods. Informative feedback will be collected and studied by MHIA staff to assist in the development and formulation of all future health promotion and plan-awareness campaigns, Medicaid member informational materials, community-based activities, outreach efforts, plan-sponsored distribution methods and internal staff recruitment practices.

MHIA's Community Needs Assessments will assist the Plan to function efficiently in communicating with our beneficiary population. In turn, this will serve MHIA's objective of ensuring that beneficiaries receive clear, complete and accurate information to facilitate their process of making well-informed choices concerning their health care needs.

6.0 CONTROLS

6.1 Monitoring & Reporting

MHIA will apply diligence and good judgment in the internal approval of all marketing activities associated with the Plan. In an effort to ensure regulatory compliance all activities will be monitored and tracked by the Community Outreach Department, in conjunction with Molina's Corporate Compliance Department. Guidelines set forth by DHS will be strictly construed and adhered to by the Plan and its representatives.

The MHIA Marketing Department will maintain an accurate inventory of printed materials and will provide materials based on the needs for events and presentations. The Marketing Department will review inventory on a monthly basis to ensure that all materials are approved by DHS, and are up-to-date. Materials will be updated and replaced when applicable.

7.0 MANAGEMENT TEAM

In accordance with the contract, MHIA will notify in writing the Department of changes in key staff positions and anyone key to the Contractor's operations.

Welcome to the Molina family

Molina Healthcare Member Handbook

STAR

Dallas, El Paso, Harris, Hidalgo, Jefferson

September 2014

(866) 449-6849

MolinaHealthcare.com

MOLINA HEALTHCARE®

Your Extended Family.

NEW HEALTH PLAN NCQA ACCREDITATION ACCREDITED

TEXAS STAR PROGRAM

Your Health Plan ■ Your Choice

Important Phone Numbers

Molina Member Services Department Toll Free: 1-866-449-6849

We are open Monday through Friday from 8:00 am to 5:00 pm, local time except on holidays. If you call when this department is closed, you can leave a message on our answering machine. Someone will call you back by the next business day. You also have a service called the Nurse Advice Line that you can call. The Nurse Advice Line is available to you 24 hours a day. They can help you with general information about your health or help you decide where to go for care after-hours.

We can help you in English and Spanish. We have interpreter service agents that can help with any other language. Members who are deaf or hard of hearing can call Relay Texas TTY at 1-800-735-2989 or dial 711 (English) or 1-800-662-4954 (Spanish).

Molina Member Services Department Toll Free: **Member Advocates** Dallas, El Paso, Harris, Hidalgo, and Jefferson Service Areas	**1-866-449-6849**
Nurse Advice Line Call for basic health questions or if you want information on how to get after-hours care	1-888-275-8750 (English) 1-866-648-3537 (Spanish)
Relay Texas TTY For members who are deaf or hard of hearing	1-800-735-2989 or dial 711 (English) 1-800-662-4954 (Spanish)
Eye Care Services Call for information on routine eye care	1-866-449-6849
Disease Management	1-866-449-6849
Prescription Drugs	1-866-449-6849
Behavioral Health Services • Behavioral Health Service employees are ready to help you 24 hours a day, 7 days a week • You do not need to ask your doctor to get behavioral health services; you can call member services • Get help with finding a provider that best meets your needs • We can help you in English and Spanish • Interpreter service will be used for any other language • Members who are deaf or have a hard time hearing can call the Relay Texas TTY number above If you are in a critical situation, go to an emergency room that is close to where you are.	
Behavioral Health Services **(Includes mental health and substance abuse) other than Dallas**	1-866-449-6849
Behavioral Health Services **(Includes mental health and substance abuse) – Dallas** Dallas Service Area (Value Options/North Star Service Center)	1-888-800-6799

Dental Services for Members **under** age 21 DentaQuest MCNA Dental	 1-800-508-6775 1-800-494-6262
Medicaid Managed Care Helpline: Call if you have questions about the STAR program or about your health plan. This line does not give medical advice.	 1-866-566-8989 TTY# 1-866-222-4306
STAR Program Helpline Call if you have questions on enrollment, plan changes, your primary care provider or health plan.	 1-800-964-2777 TTY# 1-800-267-5008
Medical Transportation Services:	
Call **Medical Transportation Management** to set up a ride for health care visits in the **Houston-Beaumont Area**.	1-855-687-4786
Call this number to set up a ride for health care visits in the **Dallas Area**.	1-855-687-3255
Call this number to set up a ride for health care visits in **other areas** (El Paso, Hidalgo and Jefferson).	1-877-633-8747 (1-877-MED-TRIP)

Dear Member,

Welcome to the Molina family. We know picking a health plan that is right for you and your family is important.

Since 1980 the Molina family has worked for better access to healthcare. We work with doctors, clinics and hospitals to get you the care you need, when you need it. We work with your community to help you with disease prevention and health education activities.

Molina has health plans in ten states. Molina has six offices in Texas. Molina also has an award for good quality. This shows that Molina offers good care to their members.

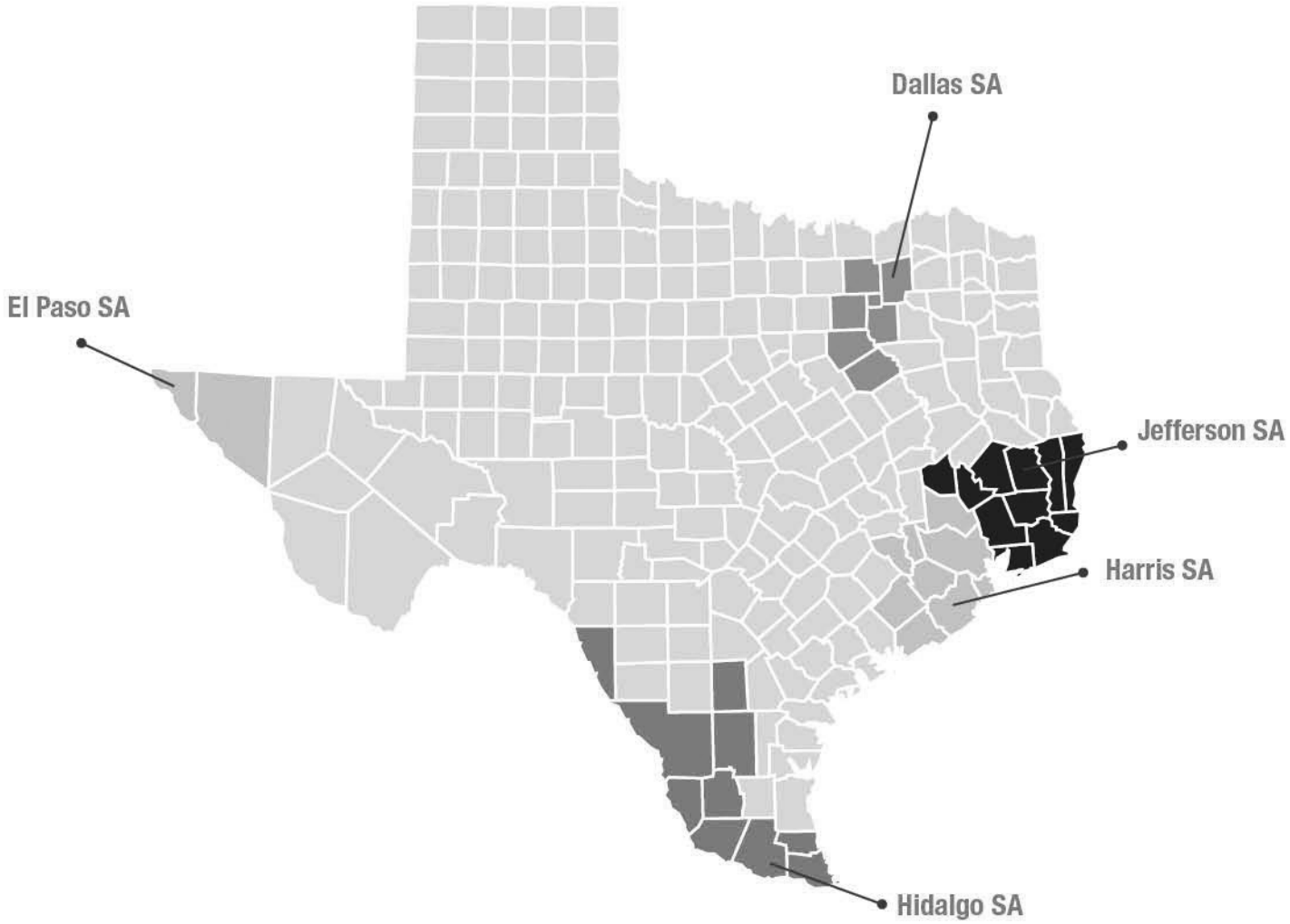
It is important that you understand how your health plan works. This Member Handbook has all the information you need about the benefits that Molina gives you. Please take a moment to read it.

We look forward to serving you. Thank you for picking Molina.

Sincerely,

Craig Bass,
President, Molina Healthcare of Texas

Service Areas



STAR Service Areas	Counties Served
Dallas	Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall
El Paso	El Paso, Hudspeth
Harris	Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton
Hildalgo	Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata
Jefferson	Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker

Table of Contents

Important Phone Numbers ..... **i**
Molina Member Services Department i
Behavioral Health Services (Includes mental health and substance abuse) i
Dental Services i
Eye Care Services i
Introduction **1**
Welcome to Molina! 1
Molina Member Services is Here for You! 1
What do I do in an Emergency? 1
What if I need hospital care? 1
Molina ID Cards **2**
Sample ID Card (ID) 2
How to read your card 2
How to use your ID card? 2
How to replace a lost or stolen ID card? 3
Primary Care Provider (PCP) **4**
What is a Primary Care Provider? 4
What do I need to bring with me to my doctor's appointment? 4
How can I change my Primary Care Provider? 4
Can a clinic be my Primary Care Provider? (FQHC/RHC) 4
How many times can I change my/my child's Primary Care Provider? 4
When will my Primary Care Provider change become effective? 5
Are there reasons why my request to change a Primary Care Provider may be denied? 5
Can my Primary Care Provider ask to move me to another Primary Care Provider for non-compliance? 5
What if I want to go to another doctor who is not my Primary Care Provider? 5
How do I get medical care after my Primary Care Provider's office is closed? 5
What is the Medicaid Lock-in Program? 5
Physician Incentive Plans **6**
Changing Health Plans **6**
What if I want to change health plans? When will my health plan change become effective? 6
Who do I call for information on how to change my plan? 6
How many times can I change health plans? 6
Can Molina request that I be dropped from their plan (for non-compliance, etc.)? 6
Benefits **7**
What are my health care benefits? 7
How do I get these services? 7
Are there any limits to any covered services? 7
What services are not covered benefits? 7
Value Added Benefits **8**
What extra benefits does a member of Molina Healthcare get? 8
How can I get these benefits? 9
What health education classes does Molina Healthcare offer? 9
Disease Management **9**
What other services can Molina help me with? 9
Health Care and Other Services **10**
What does Medically Necessary Mean? 10

What is routine medical care? 10
How soon can I expect to be seen for routine medical care? 10
What is urgent medical care? 11
What should I do if my child or I need urgent medical care? 11
How Soon Can I Expect to Be Seen? 11
What is Emergency Medical Care? 11
How soon can I expect to be seen? 12
Are Emergency Dental Services Covered? 12
What do I do if my child needs Emergency Dental Care? 12
What is Post-Stabilization? 12
What if I get sick when I am out town or traveling? What if I am out of State? 12
What if I am out of the country? 12
Specialist Care 13
What if I need to see a special doctor? (Specialist) 13
How soon can I expect to be seen by a specialist? 13
Can a specialist ever be considered a Primary Care Provider? 13
What is a referral? 13
What Services Do Not Need A Referral? 13
Second Opinion 13
How can I ask for a second opinion? 13
General Health Care Tips 14
Behavioral Health, Mental Or Substance (Drug) Abuse 14
How do I get help if I have behavioral (mental) health or drug problems? 14
Do I need a referral for behavioral health or substance abuse care? 14
What are mental health rehabilitation services and mental health targeted case management? How do I get these services? 14
Prescription Drugs 15
How do I get my medications? 15
Which drug stores can I use? How do I find a network drug store? 15
Can I go to a drug store not in the network? 15
What do I bring with me to the drug store? 15
What if I need my medications delivered to me? 15
Who do I call if I have problems getting my medications? 15
What if I can't get the medication my doctor ordered approved? 15
What if I lose my medication(s)? 15
What if I need durable medical equipment (DME) or other products normally found in a pharmacy? 16
What is the Limited Home Health Supply (LHHS) List? 16
Family Planning Services 16
How do I get family planning services? 16
Do I need a referral for this? 16
Where do I find a family planning service provider? 16
Case Management For Children And Pregnant Women (CPW) Program 16
What is Case Management for Children and Pregnant Women (CPW)? 16
Texas Health Steps 17
What is Texas Health Steps? 17
What services are offered by Texas Health Steps? 17
How and when do I get Texas Health Steps medical and dental checkups for my child? 18
Does my child's doctor have to be part of the Molina network? 19

Do I have to have a referral? 19
What if I need to cancel an appointment? 19
What if I am a Migrant Farm Worker? 19
Transportation 19
What is HHSC's Medical Transportation Program (MTP)? 19
What services are offered by MTP? 19
Who do I call for a ride to a medical appointment? 20
Vision 20
How do I get eye care services for myself or my child? 20
Dental Services 20
How do I get dental services for myself or my child? 20
Interpreter Services at Doctor's Visits 21
Can someone interpret for me when I talk with my doctor? Who do I call? 21
How far in advance do I need to call to get an interpreter? 21
How can I get a face-to-face interpreter in the provider's office? 21
OB/GYN Care 21
What if I need OB/GYN care? Do I have the right to pick an OB/GYN? 21
How do I pick an OB/GYN? 21
If I do not pick an OB/GYN, do I have direct access? Will I need a referral to see an OB/GYN? 21
How soon can I be seen after contacting my OB/GYN for an appointment? 21
What if I am pregnant? What if I become pregnant after joining Molina? 22
If I am pregnant when I join Molina, can I stay with an OB/GYN who is not with Molina? 22
Who do I need to call for more information? 22
What other services/activities/education does Molina offer pregnant women? 22
Where can I find a list of birthing centers? 22
Can I pick a Primary Care Provider for my baby before the baby is born? 22
How do I sign up my newborn baby? 22
How and when do I tell Molina about the birth of my baby? 22
How and when do I tell my caseworker? 23
How and when can I switch my baby's Primary Care Provider? 23
Can I switch my baby's health plan? 23
Other Important Information 23
Who do I call if I have special health care needs and need someone to help me? 23
What if I am too sick to make a decision about my medical care? 23
What are Advance Directives? 23
How do I get an Advance Directive Form? 23
What happens if I lose my Medicaid coverage? 23
What if I get a bill from my doctor? Who do I call? What information will they need? 24
What do I have to do if I move? 24
What if I have other health insurance in addition to Medicaid? 24
MEMBER RIGHTS and RESPONSIBILITIES 24
What are my rights and responsibilities? 24
Complaint Process 26
What should I do if I have a complaint? 26
Can someone from Molina help me file a complaint? 27
How long will it take to process my complaint? 27
What are the requirements and timeframes for filing a Complaint? 27
Do I have the right to meet with a complaint appeal panel? 27

Appeal Process **28**
How will I find out if services are denied? 28
What can I do if my doctor asks for a service or medicine for me that is covered but Molina denies it or limits it? 28
Can I continue getting the services that were already approved? 28
What are the timeframes for the appeal process? 28
How soon do I need to ask for an appeal? 28
Does my request have to be in writing? 28
Can someone from Molina help me file an appeal? 29
Can I ask for a State Fair Hearing? 29
Expedited Appeals **29**
What is an expedited appeal? 29
How do I ask for an expedited appeal? Does my request have to be in writing? 29
Who can help me in filing an expedited appeal? 29
What are the time frames for an expedited appeal? 29
What happens if Molina denies the request for an expedited appeal? 30
State Fair Hearing **30**
Can I ask for a State Fair Hearing? 30
Waste, Abuse and Fraud Information **31**
Do you want to report Waste, Abuse, or Fraud? 31
To report waste, abuse, or fraud, choose one of the following: 31
To report waste, abuse, or fraud, gather as much information as possible. 31
Information Available On a Yearly Basis **32**
Your Privacy **32**
Why does Molina use or share your PHI? 32
When does Molina need your written authorization (approval) to use or share your PHI? 32
What are your privacy rights? 33
How does Molina protect your PHI? 33
What must Molina do by law? 33
What can you do if you feel your privacy rights have not been protected? 33
New Medical Procedures Review **33**

Introduction

Welcome to Molina!

Welcome to Molina Healthcare of Texas (Molina). Thank you for picking us as your health plan. You are now a member of a health plan also known as the STAR program.

We want to do all we can to help you with your medical needs. We will work with you and your doctor to make sure you get the care you need. We want to help remove any difficulties you have getting health care. We have employees ready to help you with questions or concerns; do not hesitate to call us.

This member handbook can help you with questions you have about how to get health care, what your benefits are, and many other topics. If you need help with this handbook, you can call us toll free at 1-866-449-6849.

You can also ask for this handbook in other forms, which include audio, large print, Braille, and other languages. Member Services can help you get one of these handbooks. Just call us and tell us which kind you need.

You can also find information about us on the Internet. Our web site is: www.molinahealthcare.com.

On the web site, you can:

- Find a copy of the Member Handbook
- Find a list of Molina providers
- Change your primary care provider
- Order a temporary verification form

Molina Member Services is Here for You!

We are open Monday through Friday from 8:00 am to 5:00 pm, (local time) except on holidays. We have employees that are ready to help you in English and Spanish. If you speak a language other than English, call Member Services. We have an interpreter service that can help with any other language.

Member Services Toll Free: 1-866-449-6849

What do I do in an Emergency?

Call 911 or go to the nearest hospital/emergency facility if you think you need emergency care and help getting to the emergency room. If you get emergency care, call your doctor to schedule a follow up visit. Call Molina at 1-866-449-6849 and let us know of the emergency care you received.

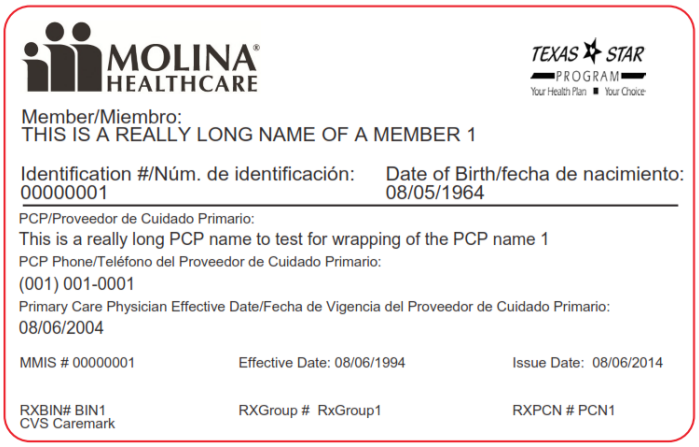
What if I need hospital care?

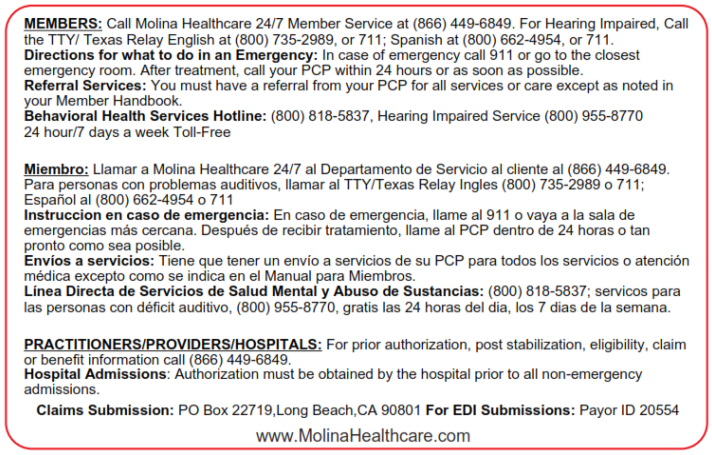
Sometimes you need hospital care. Sometimes hospital care is not an emergency. If this happens, call your doctor. Your doctor will need to arrange for hospital care that is not an emergency. Molina may need to approve this. Emergency care does not need approval from Molina. Emergency care does not need to be approved by your doctor.

Molina ID Cards

STAR Member Identification Card (ID)

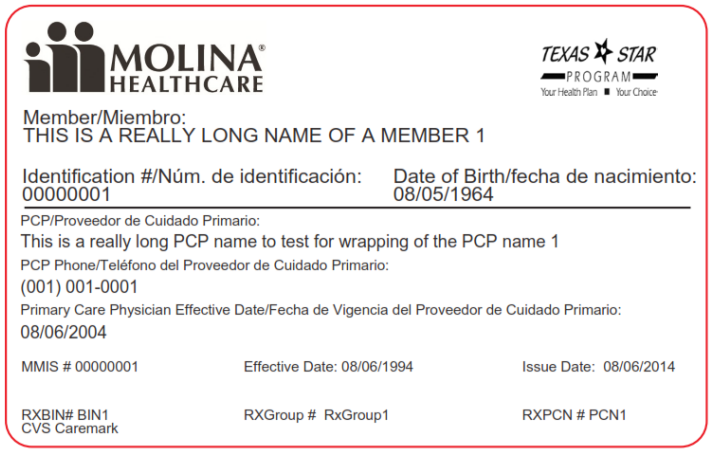
El Paso, Harris, Hidalgo, and Jefferson Service Areas

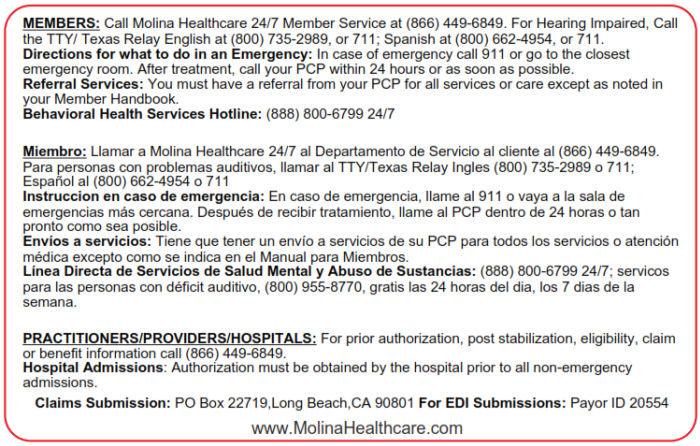




STAR Member Identification Card (ID)

Dallas Service Area





How to read your card

Front	Back
Name of Health Plan	Effective Date of Primary Care Physician
Program Name — STAR	Date the ID Card was issued
Member Name	Member Services Contact Information
Member Identification Number/Date of Birth	What to do in an emergency
Name of Primary Care Physician	Referral Service Information
Phone Number for Primary Care Physician	Behavioral Health Contact information

How to use your ID card?

Show your ID card whenever you are getting health care services. You will also need to show Your Texas Benefits Medicaid Card. You should carry it with you all the time. You do not need to show your ID card before getting emergency care.

How to replace a lost or stolen ID card?

If your ID card has been lost or stolen, call Molina Member Services for a new ID Card. Call Member Services toll free at 1-866-449-6849. You can get a new ID Card.

Your Texas Benefits Medicaid Card

When you are approved for Medicaid, you will get a Your Texas Benefits Medicaid Card. This plastic card will be your everyday Medicaid ID card. You should carry and protect it just like your driver's license or a credit card. The card has a magnetic strip that holds your Medicaid ID number. Your doctor can use the card to find out if you have Medicaid benefits when you go for a visit.

You will only be issued one card, and will only receive a new card in the event of the card being lost or stolen. If your Medicaid ID card is lost or stolen, you can get a new one by calling toll-free 1-855-827-3748.

If you are not sure if you are covered by Medicaid, you can find out by calling toll-free at 1-800-252-8263. You can also call 2-1-1. First pick a language and then pick option 2.

Your health history is a list of medical services and drugs that you have gotten through Medicaid. We share it with Medicaid doctors to help them decide what health care you need. If you don't want your doctors to see your health history through the secure online network, call toll-free at 1-800-252-8263.

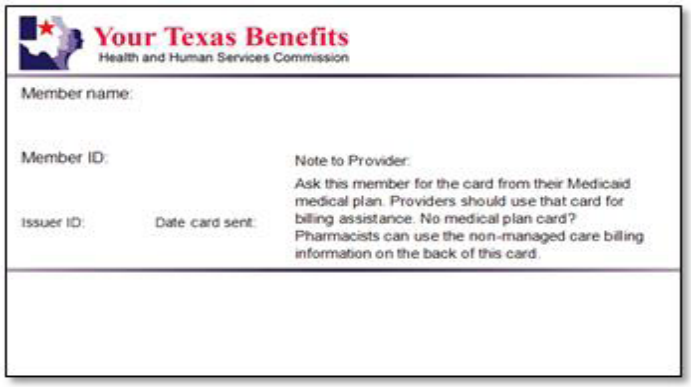
The Your Texas Benefits Medicaid card has these facts printed on the front:

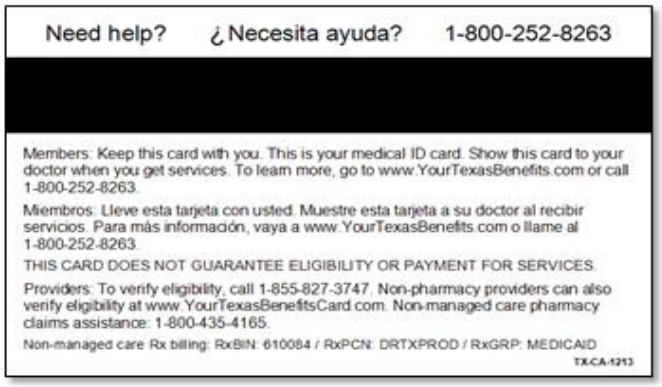
- Your name and Medicaid ID number.
- The date the card was sent to you.
- The name of the Medicaid program you're in if you get:
  - Medicare (QMB, MQMB)
  - Texas Women's health Program (TWHP)
  - Hospice
  - STAR Health
  - Emergency Medicaid, or
  - Presumptive Eligibility for Pregnant Women (PE).
- Facts your drug store will need to bill Medicaid.
- The name of your doctor and drug store if you're in the Medicaid Lock-in program.

The back of the Your Texas Benefits Medicaid card has a website you can visit (www.YourTexasBenefits.com) and a phone number you can call toll-free (1-800-252-8263) if you have questions about the new card.

If you forget your card, your doctor, dentist, or drug store can use the phone or the Internet to make sure you get Medicaid benefits.

Sample of Your Texas Benefits Medicaid Card:


Your Texas Benefits
Health and Human Services Commission
Member name:
Member ID:
Issuer ID:
Date card sent:
Note to Provider:
Ask this member for the card from their Medicaid medical plan. Providers should use that card for billing assistance. No medical plan card? Pharmacists can use the non-managed care billing information on the back of this card.


Need help? ¿Necesita ayuda? 1-800-252-8263
Members: Keep this card with you. This is your medical ID card. Show this card to your doctor when you get services. To learn more, go to www.YourTexasBenefits.com or call 1-800-252-8263.
Miembros: Lleve esta tarjeta con usted. Muestre esta tarjeta a su doctor al recibir servicios. Para más información, vaya a www.YourTexasBenefits.com o llame al 1-800-252-8263.
THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR PAYMENT FOR SERVICES.
Providers: To verify eligibility, call 1-855-827-3747. Non-pharmacy providers can also verify eligibility at www.YourTexasBenefitsCard.com. Non-managed care pharmacy claims assistance: 1-800-435-4165.
Non-managed care Rx billing: RxBIN: 610084 / RxPCN: DRTXPROD / RxGRP: MEDICAID
TX-CA-1213

Temporary Verification Form - Form 1027-A

If you lose Your Texas Benefits Medicaid card you will have to visit your local Health and Human Services Commission (HHSC) Benefits Office or call 1-800-252-8263 or call 2-1-1. HHSC will provide you with a temporary verification form called a Form 1027-A. You can use this form until you receive Your Texas Benefits Medicaid Card.

Primary Care Provider (PCP)

What is a Primary Care Provider?

A primary care provider is your main doctor. It can also be nurse or clinic. This doctor knows you well. Your main doctor will treat most of your healthcare needs. If he cannot, you will be referred to a provider who can. Your doctor's name and telephone number are on your ID card.

What do I need to bring with me to my doctor's appointment?

You must take your Molina ID card and Your Texas Benefits Medicaid Card whenever you go to the doctor or get any health care services.

How can I change my Primary Care Provider?

If you want to change your primary care provider, just call Member Services toll free at 1-866-449-6849. Molina can help you find a new primary care provider.

Can a clinic be my Primary Care Provider? (FQHC/RHC)

Yes, a primary care provider can also be a clinic, such as a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC).

How many times can I change my/my child's Primary Care Provider?

There is no limit on how many times you can change your or your child's primary care provider. You can change primary care providers by calling us toll free at 1-866-449-6849 or writing to:

Molina Healthcare of Texas
Attn: Enrollment Department
5605 N. MacArthur Blvd., Suite 400
Irving, TX 75038-2617

When will my Primary Care Provider change become effective?

Your primary care provider change will be effective on the first day of the month following the month you made the request.

Are there reasons why my request to change a Primary Care Provider may be denied?

Yes, your request to change a doctor may be denied if:

- The primary care provider you want is not taking new patients.
- The primary care provider you want is no longer with Molina.

Can my Primary Care Provider ask to move me to another Primary Care Provider for non-compliance?

Yes, your primary care provider may request a change if:

- You often miss visits and don't call your primary care provider to say you will not be there.
- You do not follow your primary care provider's advice.
- You and the primary care provider do not get along.

What if I want to go to another doctor who is not my Primary Care Provider?

You may go to any doctor who is not your primary care provider if you need:

- 24-hour emergency care from an emergency room
- Behavioral Health Care
- OB/GYN Care
- Texas Health Step Services

You should go to your primary care provider for most other services. If your primary care provider does not give a service, you will be referred to one that does.

How do I get medical care after my Primary Care Provider's office is closed?

Your primary care provider will have someone help you after your primary care provider's office is closed. Only call after hours if you have an urgent care need. If it is an emergency, go to the nearest emergency room or call 911.

Your primary care provider's phone number is on the front of your Molina ID card. You can also call our 24-hour Nurse Advice Line. When you call them, tell them what your medical problem is. They will help you decide the best way to get your medical needs taken care of. The Nurse Advice Line phone number is also on the back of your Molina ID Card.

What is the Medicaid Lock-in Program?

You may be put in the Lock-in Program if you do not follow Medicaid rules. It checks how you use Medicaid pharmacy services. Your Medicaid benefits remain the same. Changing to a different MCO will not change the Lock-In status.

To avoid being put in the Medicaid Lock-in Program:

- Pick one drug store at one location to use all the time.
- Be sure your main doctor, main dentist, or the specialists they refer you to are the only doctors that give you prescriptions.
- Do not get the same type of medicine from different doctors.

To learn more call Molina Member Services toll free at 1-866-449-6849.

Physician Incentive Plans

A physician incentive plan rewards doctors for treatments that reduce or limit services for people covered by Medicaid. Right now, Molina Healthcare of Texas does not have a physician incentive plan.

Changing Health Plans

What if I want to change health plans? When will my health plan change become effective?

You can change your health plan by calling the Texas STAR or STAR+PLUS Program Helpline at 1-800-964-2777. You can change health plans as often as you want, but not more than once a month. If you are in the hospital, a residential Substance Use Disorder (SUD) treatment facility, or residential detoxification facility for SUD, you will not be able to change health plans until you have been discharged. If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take place on June 1.

Who do I call for information on how to change my plan?

Call the STAR Program Helpline at1-800-964-2777.

How many times can I change health plans?

You can change plans as many times as you want, but not more than once a month.

Can Molina request that I be dropped from their plan (for non-compliance, etc.)?

Yes, Molina can ask that you be disenrolled from the health plan if:

- You let someone else use your Molina Healthcare of Texas ID card
- You let someone else use your Texas Benefits Medicaid Card or
- You make it difficult for your doctor to help you

The Texas Health and Human Services Commission will make the final decision on all disenrollment requests. If there is a change in your health plan, you will be sent a letter.

Benefits

What are my health care benefits?

Here is a list of ***some*** of the medical services you can get from Molina. Some of your benefits do have limits. Call Molina Member Services toll free at 1-866-449-6849 for more information.

Benefit	Limit
Services in your primary care provider's office when medically necessary	No limit
Services in a specialist office when referred by your primary care provider and medically necessary	No limit
Medically necessary inpatient and outpatient medical hospital services	No limit
Family planning service done by any qualified health care provider	No limit
Coverage for pregnancy and newborn baby services	No limit
Ambulance services in an emergency	No limit
Chiropractic services treatment period	12 visits in 12 months
Emergency room and urgent care services	No limit
Outpatient behavioral health services (mental health)	30 visit per year
Outpatient behavioral health services(chemical dependency)	No limit
Inpatient behavioral health (mental health and chemical dependency)	135 hours per year
Routine Medical Care	No limit
Audiology (hearing exam)	No limit on exam
Audiology (hearing aids)	1 fitting per hearing aid per 5 rolling year period
Vision: Exam & glasses (<21 yrs old)	1 every 12 months
Vision: Exam & glasses (>21 yrs old)	1 every 24 months
Prescription Drugs	No limit

How do I get these services?

Your Primary care provider will do most services. If your primary care provider does not give you a service, you will be sent to a provider that can. If you have an emergency, go to the nearest Emergency Room.

Are there any limits to any covered services?

Some of the covered services may have limitations. For questions about a specific service, call Member Services Toll Free at: 1-866-449-6849.

What services are not covered benefits?

Services that are not covered by Medicaid will not be covered by your Molina health plan. Some of the services that are not covered are listed below. You can call Member Services for a complete list of services that are not covered.

- All services or supplies that are not medically necessary
- Experimental services, including drugs and equipment, not covered by Medicaid
- Organ transplants that are not covered by Medicaid
- Paternity Testing

- Abortions except in the case of a reported rape, incest or when medically necessary to save the life of the mother
- Infertility services, including reversal of voluntary sterilization procedures
- Voluntary sterilization if under 21 years of age or legally incapable of agreeing to the procedure
- Cosmetic surgery
- Shots for travel outside the United States
- Services for treatment of obesity unless it is medically necessary
- Custodial or supportive care
- Sex change surgery and related services
- Sexual or marriage counseling
- Court ordered testing
- Education testing and diagnosis
- Acupuncture and biofeedback services
- Comfort items

If you have a question about a service being covered, call Molina Member Services at 1-866-449-6849 and ask for help. If you have a service done that is not covered, you may have to pay for it.

Value Added Benefits

What extra benefits does a member of Molina Healthcare get?

Value Added Services are extra services you get from Molina. Call Member Services to get more information on these benefits.

Value Added Benefit	How does it work?
24 – Hour Nurse Advice Line	You can talk to a nurse 24 hours a day, 365 days a year. The phone numbers are: English: (888AskUs50) 888-275-8750 Spanish: (866Mi TeleSalud) 866-648-3537
School/Sports Physical	Members 5 to 19 years of age will get a once a year physical for school or sports.
Weight Watchers® program	Members who are 15 or older and have a BMI (Body Mass index) of 30 or above can get coupons for Weight Watchers® meetings.
$20 Gift Card for getting all childhood vaccinations on time*	Members under the age of 21 who get all of their childhood vaccinations on time can receive a $20 gift card.
Stop-Smoking Program	Molina uses a national stop-smoking program, called Quit for Life® This benefit is for members who are age 18 or older and all STAR members of any age, who are pregnant and want to stop smoking.
$20 Gift Card for Yearly Texas Health Steps check-ups for members under 21*	Members under the age of 21 who get all of their Texas Health Steps check-ups every year and infants who get all their 6 visits in the first 16 months of life can get a $20 gift card.
$20 Gift Card for early pregnancy exam*	Pregnant members, who have an exam in the first three months of pregnancy or within 42 days of enrolling with Molina, can get a $20 Gift card.
$20 Gift Card for Post-partum exam*	Members who complete a post-partum exam within 21– 56 days of delivery can get a $20 Gift Card.
Car Seat for Newborns (**STAR EL PASO only**)	Members can receive an infant car seat for newborns up to six months of age.
Adult Dental Services	Up to $250 for dental exams, x-rays and cleaning per year for members age 21 or older
Allergy-Free Bedding for Members with Asthma	Members with Asthma who have completed the 3-month "Breathe with Ease®" Asthma Disease Management Program can receive allergy-free bedding. Bedding includes allergy-free pillowcases and mattress cover.

How can I get these benefits?

Call Molina's Member Services at 1-866-449-6849 and we will help you get these services.

What health education classes does Molina Healthcare offer?

Molina wants to help keep you and your family healthy. We can help you find health education classes near your home. Call Member Services to find out about these classes.
Some of the classes are:

- Quitting Smoking
- Losing weight
- Pregnancy and Childbirth
- Infant care
- Parenting

Disease Management

We also have programs to help you manage certain health conditions. Some of these conditions are Asthma, Cardiovascular Disease, Congestive Heart Failure, COPD and Diabetes; we also have a special program to help you if you are pregnant. The programs offer learning materials, telephonic calls, and advice. You can take part in a way that best manages your needs.

You will be enrolled if you have any of the health conditions listed above. You will begin to receive learning materials and newsletters. If you or your child's condition is more severe, you may receive a telephone call by a Case Manager. The Case Manager will work with you and your doctor to help make sure you have what you need to stay well. If you would like to know more about any of these programs, please call Member Services at 1-866-449-6849.

What other services can Molina help me with?

Molina can help you get some services covered by fee-for-service Medicaid instead of Molina. Below are some of those agencies that cover service that Molina can help you get:

- Texas Health Steps dental (including orthodontia);
- Texas Health Steps environmental lead investigation (ELI);
- Early Childhood Intervention (ECI) Program;
- Medical Transportation Program (MTP);
- Texas School Health and Related Services (SHARS);
- Texas Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program;
- Food Stamps,
- Women, Infants, and Children's (WIC) Program,
- Case Management for Children and Pregnant Women

Call Member Services Toll Free at 1-866-449-6849 for information about these services or how to get these services.

Health Care and Other Services

What does Medically Necessary Mean?

Medically Necessary means:

1. For Members birth through age 20, the following Texas Health Steps services:
   a. Screening, vision, and hearing services; and
   b. other Health Care Services, including Behavioral Health Services, that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:
      i. must comply with the requirements of the Alberto N., et al. v. Janek, et al. partial settlement agreements; and
      ii. may include consideration of other relevant factors, such as the criteria described in parts (2)(b-g) and (3)(b-g) of this definition.
2. For Members over age 20, non-behavioral health related health care services-that are:
   a. reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a member, or endanger life;
   b. provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;
   c. consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
   d. consistent with the diagnoses of the conditions;
   e. no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
   f. not experimental or investigative; and
   g. not primarily for the convenience of the member or provider; and
3. For Members over age 20, behavioral health services that:
   a. are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
   b. are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
   c. are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
   d. are the most appropriate level or supply of service that can safely be provided;
   e. could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;
   f. are not experimental or investigative; and
   g. are not primarily for the convenience of the member or provider.

What is routine medical care?

Routine medical care is when you go to your primary care provider for a check-up, without being sick. This care is important to keep you in good health. Some of the things that can be done on these visits are well woman exam, Texas Health Steps medical check-up for your child or a full routine physical.

How soon can I expect to be seen for routine medical care?

When you call your primary care provider for routine medical care, you will get an appointment within 14 days from the day you call.

What is urgent medical care?

Another type of care is urgent care. There are some injuries and illnesses that are probably not emergencies but can turn into emergencies if they are not treated within 24 hours. Some examples are:

- Minor burns or cuts
- Earaches
- Sore throat
- Muscle sprains/strains

What should I do if my child or I need urgent medical care?

For urgent care, you should call your doctor's office even on nights and weekends. Your doctor will tell you what to do. In some cases, your doctor may tell you to go to an urgent care clinic. If your doctor tells you to go to an urgent care clinic, you don't need to call the clinic before going. You need to go to a clinic that takes Molina Medicaid. For help, call us toll-free at 1-866-449-6849. You also can call our 24-hour Nurse Advice Line at 1-888-275-8750 for help with getting the care you need.

How Soon Can I Expect to Be Seen?

You should be able to see your doctor within 24 hours for an urgent care appointment. If your doctor tells you to go to an urgent care clinic, you do not need to call the clinic before going. The urgent care clinic must take Molina Medicaid.

What is Emergency Medical Care?

Emergency medical care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions.

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

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child.

Emergency Behavioral Health Condition means:
Any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson, possessing average knowledge of medicine and health:

1. requires immediate intervention or medical attention without which the Member would present an immediate danger to themselves or others; or
2. which renders the Member incapable of controlling, knowing, or understanding the consequences of their actions.

Emergency Services and Emergency Care means:
Covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition or Emergency Behavioral Health Condition, including post-stabilization care services.

How soon can I expect to be seen?

You should be seen as soon as possible. The emergency room staff will decide based on your condition. If you need help getting to the emergency room, call 911.

Are Emergency Dental Services Covered?

Molina covers limited emergency dental services for the following:

- Dislocated jaw.
- Traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Treatment and devices for craniofacial anomalies.
- Drugs for any of the above conditions.

Molina also covers dental services your child gets in a hospital or ambulatory surgical center including other services your child might need, like anesthesia.

What do I do if my child needs Emergency Dental Care?

During normal business hours, call your child's Main Dentist to find out how to get emergency services. If your child needs emergency dental services after the Main Dentist's office has closed, call us toll free at 1-866-449-6849 or call 911.

What is Post-Stabilization?

Post-stabilization care are services covered by Medicaid that keep your condition stable following emergency medical care.

What if I get sick when I am out town or traveling? What if I am out of State?

If you need medical care when traveling, or if you are out of the state, call us Toll Free at 1-866-449-6849 and we will help you find a doctor. If you need emergency services while travelling, go to a nearby hospital, then call us Toll Free at 1-866- 449-6849.

If you have an urgent care need, you should call your primary care provider's office. You can also call our 24-hour Nurse Advice Line for direction on care. Your primary care provider's phone number and the Nurse Advice Line's phone number are on your Molina ID card.

What if I am out of the country?

Medical services performed out of the country are not covered by Medicaid.

Specialist Care

What if I need to see a special doctor? (Specialist)

Your primary care provider will help you if you need to see a special doctor or if you need a special service. Your primary care provider will make sure you get the special health care you need.

How soon can I expect to be seen by a specialist?

When you call to make an appointment with a specialist, you will be seen within (30) days. If your medical need is urgent you will be seen within (24) hours.

Can a specialist ever be considered a Primary Care Provider?

Yes, if you would like a specialist to be your primary care provider and the doctor agrees, you can call member services toll-free at 1-866-449-6849 for help.

What is a referral?

A "Referral" is an approval for you to get certain medical services. This may include when you need to see a special doctor or need a special service. Your primary care provider will help you to get a referral.

What Services Do Not Need A Referral?

You don't need a referral for:

- Emergency services
- Qualified Family Planning services
- OB/GYN services
- Certified Nurse Midwife services
- Certified Nurse Practitioner
- Federally Qualified Health Care (FQHC) services
- Rural Health Care (RHC) service
- Behavioral Health Service
- Routine Vision Care

If you go for a service without a referral and you need one, you may have to pay for the service yourself. If you are not sure if a service needs a referral, call Member Services.

Second Opinion

How can I ask for a second opinion?

To ask for a second opinion, call Member Services. They will help you. Your doctor can also call and ask that you have a second opinion.

Listed below are some of the reasons why you may want to have a second opinion:

- You are not sure if you need the surgery your doctor is planning to do
- You are not sure of your doctor's diagnosis or care plan for a serious or difficult medical need
- Your doctor is not sure of a diagnosis because your condition is confusing
- You have done what the doctor has asked, but you are not getting better
- When a doctor does a second opinion, he or she will give a written report to you and your first doctor

General Health Care Tips

- Be active in your health care: Plan ahead
- Schedule your visits at a good time for you
- Ask for your visit at a time when the office is least busy if you are worried about waiting too long
- Keep a list of questions you want to ask your doctor
- Refill your prescription before you run out of medicine

Make the most of your doctor's visit

- Make a list of questions you want to ask before you go to your appointment
- Ask your doctor questions.
- Ask about possible side effects of any medicines you have been prescribed.
- Tell your doctor if you are drinking any teas or taking herbs. In addition, tell your doctor about any vitamins or over-the-counter medicines you are using.

Visiting your doctor when you are sick:

- Try to give your doctor as much information as you can.
- Tell your doctor if you are getting worse or if you are feeling about the same.
- Tell your doctor if you have taken anything
- Remember to take your medications with you to all appointments with your doctor

Behavioral Health, Mental Or Substance (Drug) Abuse

How do I get help if I have behavioral (mental) health or drug problems?

If you live in Harris, Jefferson, El Paso or Hidalgo Service area:
Call our 24-hour Behavioral Health Line at 1-800-818-5837. Someone will always be there to help you. You do not need to call your primary care provider to get an approval for these services. If you have an emergency or crisis care need, you do not need to call first, go to the nearest emergency care center or call 911.

If you live in the Dallas service area:
If you live in the Dallas Service Area, you will receive treatment for mental health, alcohol, and drug use through NorthSTAR. NorthSTAR provides these types of behavioral health services to members who live in the following counties: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall. If you have behavioral health issues, call the NorthSTAR program toll-free at 1-888-800-6799 to receive services in your area. You do not need a referral from a Primary Care Physician but you may want to talk to your Primary Care Physician about the issue. If you have an emergency or crisis care need, you do not need to call first. Go to the nearest emergency care center or call 911.

Do I need a referral for behavioral health or substance abuse care?

No, you do not need to get a referral from your primary care provider for these services.

What are mental health rehabilitation services and mental health targeted case management? How do I get these services?

Mental Health Rehabilitation and Targeted Case Management services are available to adult Medicaid recipients who are assessed and determined to have a severe and persistent mental illness (SPMI) illness (such

as Schizophrenia, Major Depression, Bipolar Disorder), as well as children and adolescents ages 3 through 17 years with a diagnosis of a mental illness who exhibit a severe emotional disturbance (SED) (such as Conduct Disorder). For more information, call Molina Member Services at 1-866-449-6849.

Prescription Drugs

How do I get my medications?

Medicaid pays for most medicine your doctor says you need. Your doctor will write a prescription so you can take it to the drug store, or may be able to send the prescription for you.

Which drug stores can I use? How do I find a network drug store?

You have to go to a Molina network pharmacy. You can get your prescription filled at most drug stores in Texas, including Walgreens, Kroger, HEB, Randall's, Target, Wal-Mart, CVS. If you need help with finding a pharmacy, just call Member Services toll free at 1-866-449-6849. You can also go to the internet. Our website is www.molinahealthcare.com. You can click on the find a pharmacy link. This will show you the list of pharmacies.

Can I go to a drug store not in the network?

No, you have to go to a Molina pharmacy, and we can help you find one. Just call Member Services toll free at 1-866-449-6849.

Call us if you are out of state and need emergency prescriptions. We can help you find a Molina pharmacy. If there are no Molina pharmacies, we may be able to work with the pharmacy to pay for the medicaion or you may have to pay for your prescription. You will have to send us the receipt so Molina can pay you back.

What do I bring with me to the drug store?

You have to take your Molina ID card, Your Texas Benefits Medicaid Card, and the prescription your doctor wrote for you.

What if I need my medications delivered to me?

If you cannot leave home, Molina can provide you with mail order pharmacy. This is done by CVS Caremark Mail Services. Please call Molina Member Services Toll Free at 1-866-449-6849.

Who do I call if I have problems getting my medications?

We can help you. Call Member Services at 1-866-449-6849.

What if I can't get the medication my doctor ordered approved?

If your doctor cannot be reached to approve a prescription, you may be able to get a three-day emergency supply of your medication. Call Molina at 1-866-449-6849 for help with your medications and refills.

What if I lose my medication(s)?

If your medication is lost or stolen, have your pharmacy call Molina Member Services at 1-866-449-6849 for help.

What if I need durable medical equipment (DME) or other products normally found in a pharmacy?

Some durable medical equipment (DME) and products normally found in a pharmacy are covered by Medicaid. For all members, Molina pays for nebulizers, ostomy supplies, and other covered supplies and equipment if they are medically necessary. For children (birth through age 20), Molina also pays for medically necessary prescribed over-the-counter drugs, diapers, formula, and some vitamins and minerals.

Call Molina 1-866-449-6849 for more information about these benefits.

What is the Limited Home Health Supply (LHHS) List?

You may be able to get basic home health supplies from your pharmacy. To get more information call Member Services at 1-866-449-6849.

1. Diabetic insulin syringe with needle 1cc or less
2. Diabetic insulin needles
3. Diabetic blood glucose test strips
4. Diabetic lancets
5. Diabetic blood glucose monitor with integrated voice synthesizer
6. Diabetic home glucose disposable monitor packaged with test strips
7. Aerosol holding chamber
8. Oral electrolyte
9. Orally administered iron salts
10. Hypertonic saline solution

Family Planning Services

How do I get family planning services?

Family planning services like birth control and counseling are private; you do not need to ask your doctor to get these services. You can go to any family planning provider who takes Medicaid.

Do I need a referral for this?

No, you do not need to ask your primary care provider to get these services.

Where do I find a family planning service provider?

You can find the locations of family planning providers near you online at http://www.dshs.state.tx.us/famplan/locator.shtm or you can call Molina at 1-866-449-6849 for help in finding a family planning provider.

Case Management For Children And Pregnant Women (CPW) Program

What is Case Management for Children and Pregnant Women (CPW)?

CPW gives service to children with a health need or risk, birth through 20 years of age and to high-risk pregnant women of all ages.

Case Management for Children and Pregnant Women

Need help finding and getting services? You might be able to get a case manager to help you.

Who can get a case manager?
Children, teens, young adults (birth through age 20) and pregnant women who get Medicaid and:

- have health problems, or
- are at a high risk for getting health problems.

What do case managers do?
A case manager will visit with you and then:

- Find out what services you need.
- Find services near where you live.
- Teach you how to find and get other services.
- Make sure you are getting the services you need.

What kind of help can you get?
Case managers can help you:

- Get medical and dental services.
- Get medical supplies or equipment.
- Work on school or education issues.
- Work on other problems.

How can you get a case manager?
Call the Texas Health Steps at 1-877-847-8377 (toll-free), Monday to Friday, 8 a.m. to 8 p.m.
To learn more, go to: www.dshs.state.tx.us/caseman

Texas Health Steps

What is Texas Health Steps?

Texas Health Steps is a Medicaid program for children from birth through 20 years old. The Texas Health Steps program is very important for your children and helps them get the health care they need to stay healthy.

Regular Checkups help children stay healthy. Texas Health Steps gives free medical and dental checkups to children, including immunizations. Your Member Advocate will help you make your child's appointment.

They can also help you with getting transportation services. You can call your member advocate at 1-866-449-6849 Ext. 752054.

What services are offered by Texas Health Steps?

Texas Health Steps is the Medicaid health-care program for children, teens, and young adults, birth through age 20.

Texas Health Steps gives your child:

- Free regular medical checkups starting at birth.
- Free dental checkups starting at 6 months of age.
- A case manager who can find out what services your child needs and where to get these services.

Texas Health Steps checkups:

- Find health problems before they get worse and are harder to treat.
- Prevent health problems that make it hard for children to learn and grow like others their age.
- Help your child have a healthy smile.

When to set up a checkup:

- You will get a letter from Texas Health Steps telling you when it's time for a checkup. Call your child's doctor or dentist to set up the checkup.
- Set up the checkup at a time that works best for your family.

If the doctor or dentist finds a health problem during a checkup, your child can get the care he or she needs, such as:

- Eye tests and eyeglasses
- Hearing tests and hearing aids
- Dental care
- Other health care.
- Treatment for other medical conditions.

Call Molina at 1-866-449-6849 or Texas Health Steps 1-877-847-8377 (1-877-THSTEPS) (toll-free) if you:

- Need help finding a doctor or dentist.
- Need help setting up a checkup.
- Have questions about checkups or Texas Health Steps.
- Need help finding and getting other services.

If you can't get your child to the checkup, Medicaid may be able to help. Children with Medicaid and their parent can get free rides to and from the doctor, dentist, hospital, or drug store.

- Houston/ Beaumont area: 1-855-687-4786.
- Dallas/ Ft. Worth area: 1-855-687-3255.
- All other areas: 1-877-633-8747 (1-877-MED-TRIP).

How and when do I get Texas Health Steps medical and dental checkups for my child?

Make sure you take your child to their doctor or another Molina Texas Health Steps provider to get their Texas Health Steps medical checkups. These checkups are important and should be set up within 45 days of your child joining the health plan. The list below shows when your child will need a checkup.

Texas Health Steps Medical Checkups Schedule				
3 – 5 days old	12 months old	4 years old	10 years old	16 years old
2 weeks old	15 months old	5 years old	11 years old	17 years old
2 months old	18 months old	6 years old	12 years old	18 years old
4 months old	2 years old	7 years old	13 years old	19 years old
6 months old	30 months old	8 years old	14 years old	20 years old
9 months old	3 years old	9 years old	15 years old	

You can get these services by calling your child's primary care provider and/or dental provider to make a visit. Tell the person on the telephone that you want to schedule a "Texas Health Steps" appointment.

If you need help setting up an appointment, you can call Molina at 1-866-449-6849 for help.

Molina will help you:

- find a doctor, dentist, or case manager
- make an appointment for a checkup
- get a ride or money for gas

Does my child's doctor have to be part of the Molina network?

Your child may go to any Texas Health Steps Medicaid doctor for Texas Health Steps services. Most of Molina's doctors who treat children also provide Texas Health Steps services. You may want to talk to your child's doctor first. Be sure to show your Molina ID card and Your Texas Benefits Medicaid Card to the doctor.

Do I have to have a referral?

No, you do not need a referral for Texas Health Steps services for your child. Talk to your doctor if you plan to go to a non-Molina doctor for these services.

What if I need to cancel an appointment?

Call your doctor if you cannot keep your child's appointment. Many primary care providers want to be called 24 hours before the appointment time. When you call, be sure to setup a new time for your child to be seen.

What if I am out of town and my child is due for a Texas Health Steps checkup?

When you return, setup a visit as soon as you can. It is very important that your child get these services.

What if I am a Migrant Farm Worker?

You can get your checkup sooner if you are leaving the area.

Transportation

What is HHSC's Medical Transportation Program (MTP)?

MTP is an HHSC program that helps with non-emergency transportation to healthcare appointments for eligible Medicaid clients who have no other transportation options. MTP can help with rides to the doctor, dentist, hospital, drug store, and any other place you get Medicaid services.

What services are offered by MTP?

- Passes or tickets for transportation such as mass transit within and between cities
- Air travel
- Taxi, wheelchair van, and other transportation
- Mileage reimbursement for enrolled individual transportation participant (ITP). The enrolled ITP can be the responsible party, family member, friend, neighbor, or client.
- Meals at a contracted vendor (such as a hospital cafeteria)
- Lodging at a contracted hotel and motel
- Attendant services (responsible party such as a parent/guardian, etc., who accompanies the client to a healthcare service)

Who do I call for a ride to a medical appointment?

If you live in the counties of Collin, Dallas, Denton, Ellis, Hood, Hunt, Johnson, Kaufman, Navarro, Parker, Rockwall, Tarrant, and Wise:

Call LogistiCare
Phone Reservations: 1-855-687-3255
Phone Ride Help Line: 1-877-564-9834
Hours: LogistiCare takes requests for routine transportation by phone Monday through Friday from 8:00 a.m. to 5:00 p.m. Routine transportation should be scheduled 48 hours (2 business days) before your appointment.

If you live in the counties of Austin, Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller and Wharton.

Call MTM
Phone Reservations: 1-855-687-4786
Where's My Ride: 1-888-513-0706
Hours: 7am to 6pm, Monday-Friday/ Call (855) MTP-HSTN or (855) 687-4786 at least 48 hours before your visit. If it's less than 48 hours until your appointment and it's not urgent, MTM might ask you to set up your visit at a different date and time.

If you live in any other county

Call MTP
Phone Reservations: 1-877-633-8742.
All requests for transportation services should be made within 2-5 days of your appointment. Exceptions may be authorized in the event of an emergency.

Vision

How do I get eye care services for myself or my child?

You can get routine eye care. You have to go to a vision care provider. The provider list is in the Vision Section of your Provider Directory. You will not need a referral from your primary care provider for routine vision care. If you have a medical problem with your eyes, you will need to call your primary care provider first. If your doctor cannot treat your medical problem, you will be referred to a special eye doctor who can. Adult members age 21 years and older get a vision exam and medically necessary frames and certain plastic lenses every 24 months.

Dental Services

How do I get dental services for myself or my child?

Your child's Medicaid dental plan provides dental services including services that help prevent tooth decay and services that fix dental problems. Call your child's Medicaid dental plan to learn more about the dental services they offer.

Molina covers emergency dental services your child gets in a hospital or ambulatory surgical center. This includes services the doctor provides and other services your child might need like anesthesia.

Interpreter Services at Doctor's Visits

Can someone interpret for me when I talk with my doctor? Who do I call?

When you set up a medical visit, tell the provider you need an interpreter. If the provider does not have someone to interpret for you, call Molina Member Services at 1-866-449-6849; we will help you.

How far in advance do I need to call to get an interpreter?

Call as soon as you make a doctor's appointment.

How can I get a face-to-face interpreter in the provider's office?

When you call to set up your visit, tell the person you are talking to that you need an interpreter with you during the visit. If they cannot help, call Member Services.

OB/GYN Care

What if I need OB/GYN care? Do I have the right to pick an OB/GYN?

Attention Female Members

Molina Healthcare of Texas allows you to pick any OB/GYN, whether that doctor is in the same network as your Primary Care Provider or not.

You have the right to pick an OB/GYN without a referral from your Primary Care Provider. An OB/GYN can give you:

- One well-woman checkup each year.
- Care related to pregnancy.
- Care for any female medical condition.
- Referral to other special doctors within the network.

How do I pick an OB/GYN?

You can pick any OB/GYN listed in the Molina Provider Directory. Your OB/GYN will set up an appointment within two (2) weeks of your call.

If I do not pick an OB/GYN, do I have direct access? Will I need a referral to see an OB/GYN?

You have direct access to see an OB/GYN without a referral from your primary care provider. You can go to any OB/GYN provider listed in the Provider Directory.

How soon can I be seen after contacting my OB/GYN for an appointment?

You will be seen within two (2) weeks from the day you called to set up your visit.

What if I am pregnant? What if I become pregnant after joining Molina?

Please call Molina as soon as you know you are pregnant. Molina will help you get the care you need.

Our educational pamphlets, and other information, will answer any questions you may have about the pregnancy.

If I am pregnant when I join Molina, can I stay with an OB/GYN who is not with Molina?

You can see a doctor who is not part of Molina's network if:

- You are pregnant when you start your coverage with Molina and you are seeing a doctor that is not a Molina doctor, you can still see that doctor if you are in the last three months of your pregnancy.
- You can also see that doctor if you have a health problem that would make changing to a new doctor unsafe. If not, you will need to see a Molina doctor.

Who do I need to call for more information?

Call Member Services toll free at 1-866-449-6849 for information on benefits for pregnant moms.

What other services/activities/education does Molina offer pregnant women?

Molina has a program just for pregnant women. This program gives you information on having a healthy pregnancy. It will tell you important things to do for you. It will tell you important things to do for your baby. You will work with someone that will help you during the time you are pregnant. This person will help you with what to do after your baby is born.

Where can I find a list of birthing centers?

Call Member Services at 1-866-449-6849 for help with finding a center. You can go to www.Molinahealthcare.com to find a provider in your area.

Can I pick a Primary Care Provider for my baby before the baby is born?

Yes, you can pick a primary care provider for your baby before your baby is born. You can find a listing of primary care providers in your provider directory. You can also find a listing of primary care providers on our website at www.molinahealthcare.com. You can also call Molina's Member Services at 1-866-449-6849 for help with finding a primary care provider for your unborn child.

How do I sign up my newborn baby?

It is important to sign your baby up for Medicaid soon after your baby is born. To get more information on how to sign your baby up call the Medicaid Helpline at 1-800-964-2777. The Helpline staff will tell you what you need to do to keep your baby covered under Medicaid. Check with the hospital social worker before you go home to make sure the application is complete. You can also call 2-1-1 to find your local HHSC office to make sure your baby's application has been received.

How and when do I tell Molina about the birth of my baby?

You need to call Molina's Member Services at 1-866-449-6849 to let us know that you had your baby as soon as you can.

How and when do I tell my caseworker?

Call your local HHSC benefits office to let them know that your baby has been born.

How and when can I switch my baby's Primary Care Provider?

If you need to change your baby's primary care provider, you can call Molina's Member Services at 1-866-449-6849 for help. We can change your baby's primary care provider on the same day that you request a change.

Can I switch my baby's health plan?

For at least 90 days from the date of birth, your baby will be covered by the same health plan that you are enrolled in. You can ask for a health plan change before the 90 days is up by calling the Enrollment Broker at 1-800-964-2777.

You cannot change health plans while your baby is in the hospital.

Other Important Information

Who do I call if I have special health care needs and need someone to help me?

You can call Member Services. We will help you get more information on how to get help with special health care needs. We can tell you about services that Molina has in your area. We can tell you of community resources in your area. It is important to tell your primary care provider that you have special health care needs. Call your primary care provider to make an appointment to talk about your special needs.

What if I am too sick to make a decision about my medical care?

You can write a letter that is called an Advance Directive that tells people what you want to happen if you get very sick. For more information on how to write an Advance Directive, call Member Services at 1-866-449-6849. We can send you forms to fill out that tell others the kind of health care you want if you are too sick to tell them.

What are Advance Directives?

An Advance Directives is a letter that you write to tell others the type of health care you want if you are too sick. You can also use this letter to give someone else the right to make these decisions for you, if you become too ill to make the decisions yourself.

How do I get an Advance Directive Form?

You can get forms to write advance directives by calling Member Services at 1-866-449-6849. They will help you get the information you need to complete these forms.

What happens if I lose my Medicaid coverage?

If you lose Medicaid coverage but get it back again within six (6) months you will get your Medicaid services from the same health plan you had before losing your Medicaid coverage. You will also have the same primary care provider you had before.

What if I get a bill from my doctor? Who do I call? What information will they need?

Your doctor should not bill you for a covered service. If you do get a bill from a doctor, call the doctor's office and make sure they have your Medicaid information and any other insurance policy information available. All of the information your doctor needs to bill Molina for the service is on your ID card.

You can also get help by calling Molina's Member Services. A team member will help you with your doctor bill. To help you, they will need:

- The name of the patient
- The patient's Medicaid ID number
- The date of service
- The name of the doctor sending you the bill
- The amount you are being billed for

What do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office and Molina Member Services Department at 1-866-449-6849. Before you get Medicaid services in your new area, you must call Molina, unless you need emergency services. You will continue to get care through Molina until HHSC changes your address.

What if I have other health insurance in addition to Medicaid?

You are required to tell Medicaid staff about any private health insurance you have. You should call the Medicaid Third Party Resources hotline and update your Medicaid case file if:

- Your private health insurance is canceled.
- You get new insurance coverage.
- You have general questions about third party insurance.

You can call the hotline toll-free at 1-800-846-7307.

If you have other insurance you may still qualify for Medicaid. When you tell Medicaid staff about your other health insurance, you help make sure Medicaid only pays for what your other health insurance does not cover.

IMPORTANT: Medicaid providers cannot turn you down for services because you have private health insurance as well as Medicaid. If providers accept you as a Medicaid patient, they must also file with your private health insurance company.

MEMBER RIGHTS and RESPONSIBILITIES

What are my rights and responsibilities?

MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect.
   b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:

a. Be told how to choose and change your health plan and your primary care provider.
b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
c. Change your primary care provider.
d. Change your health plan without penalty.
e. Be told how to change your health plan or your primary care provider.

3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
   b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you.
   b. Say yes or no to the care recommended by your provider.
5. You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, appeals and fair hearings. That includes the right to:
   a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan.
   b. Get a timely answer to your complaint.
   c. Use the plan's appeal process and be told how to use it.
   d. Ask for a fair hearing from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   b. Get medical care in a timely manner.
   c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

MEMBER RESPONSIBILITIES:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   a. Learn and understand your rights under the Medicaid program.
   b. Ask questions if you do not understand your rights.

   c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
   a. Learn and follow your health plan's rules and Medicaid rules.
   b. Choose your health plan and a primary care provider quickly.
   c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
   d. Keep your scheduled appointments.
   e. Cancel appointments in advance when you cannot keep them.
   f. Always contact your primary care provider first for your non-emergency medical needs.
   g. Be sure you have approval from your primary care provider before going to a specialist.
   h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your primary care provider about your health.
   b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
   c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:
   a. Work as a team with your provider in deciding what health care is best for you.
   b. Understand how the things you do can affect your health.
   c. Do the best you can to stay healthy.
   d. Treat providers and staff with respect.
   e. Talk to your provider about all of your medications.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at. www.hhs.gov/ocr

Complaint Process

What should I do if I have a complaint?

We want to help. If you have a complaint, please call us toll-free at 1-866-449-6849 to tell us about your problem. A Molina Member Services Advocate can help you file a complaint. Just call 1-866-449-6849 Ext. 752054. Most of the time, we can help you right away or at the most within a few days.

Once you have gone through the Molina Healthcare complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

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

If you can get on the Internet, you can send your complaint in an email to HPM_Complaints@hhsc.state.tx.us

Can someone from Molina help me file a complaint?

Yes, we want to help you with the complaint process. When you have a complaint, you can call Member Services and ask for help with your complaint. Member Services Toll Free at 1-866-449-6849 ext 752054.

How long will it take to process my complaint?

Your complaint will be handled within (30) calendar days from the date Molina receives your complaint. It could take less than 30 days. You will get a letter that tells you how your complaint was resolved. This letter will explain the complete complaint and appeal process. It will also tell you about your appeal rights. If the complaint is for an emergency for inpatient hospital or on-going care, Molina will resolve your complaint within one (1) business day.

What are the requirements and timeframes for filing a Complaint?

When we get your complaint, we will send you a letter within five days telling you we have your complaint. We will look into your complaint and decide the outcome. We will send you a letter telling you the outcome. We will not take more than 30 days to complete this process.

If I am not satisfied with the results, who else can I contact once I have gone through Molina's complaint process?
You can call the Texas Health and Human Services Commission toll free at 1-800-566-8989.

You can write to:

Texas Health and Human Services Commission
Health Plan Operations-H-320
P.O. Box 85200
Austin, Texas 78708-5200
ATTN: Resolution Services
If you can get on the Internet, you can send your complaint in an email to
HPM_Complaints@hhsc.state.tx.us.

Do I have the right to meet with a complaint appeal panel?

Yes, if you are not happy with the results of your complaint, call Member Services. They will help you set up a meeting with the Complaint Appeal Panel. Molina's appeal panel includes a doctor, a Member and an employee of Molina. The providers will be familiar with your kind of complaint. Members of the panel have not been involved in your case before. We will let you know we received your appeal. A letter will let you know the complete complaint and appeal process. This letter will tell you about your appeal rights.

Appeal Process

How will I find out if services are denied?

If Molina denies your services, we will send you a letter.

What can I do if my doctor asks for a service or medicine for me that is covered but Molina denies it or limits it?

If you do not agree with Molina's decision to deny or limit your services, you can ask for an appeal. An appeal is when you or your representative asks Molina to look again at the services or medicines that we denied or limited.

If you ask someone to be your representative and to file an appeal for you, you must also send a letter to Molina to let us know you have chosen a person to represent you. We must have this information in writing for your privacy and security You can send the letter to:

Molina Healthcare of Texas
Attn: Member Complaints & Appeals
P. O. Box 165089
Irving, TX 75016

Can I continue getting the services that were already approved?

Yes, to keep getting the services that were approved but are now being denied or limited, you must file your appeal within 10 days from the day you get a letter telling you a service was denied or limited or from the date the services will end. If you ask to keep the services while your appeal is pending, you need to know that you may have to pay for these services.

What are the timeframes for the appeal process?

We will send you a letter within five (5) business days from when we get your request for an appeal. The letter will tell you that we got your appeal and we are working on it. We will make the final decision within 30 days after we get your appeal, unless we need more information from you or your representative. If we need more information, we may take up to 14 more days to complete your appeal. If we extend the appeals process, we will send you a letter. The letter will let you know the reason for the delay. You can also ask us to extend the process up to 14 days if you have more information that we should consider. Molina will send you and your doctor a letter with the final decision.

You can ask for an expedited appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision. We will make our decision within 1 day after getting your request.

How soon do I need to ask for an appeal?

The appeal needs to be filed within 30 days from the date on the letter telling you that all or part of your services were denied or limited.

Does my request have to be in writing?

You can request an appeal by telephone. You can call a Molina Member Advocate or someone in Member Services can help you file your appeal. After your phone call, you or your representative must follow up with a signed written request, unless an expedited appeal is requested. Just ask for help when you call to file your appeal.

Toll free number: 1-866-449-6849

You can also write your appeal and send it to:

Molina Healthcare of Texas
Attn: Member Complaints & Appeals
P. O. Box 165089
Irving, TX 75016

Can someone from Molina help me file an appeal?

Yes, a Molina Member Advocate or someone in Member Services can help you file your appeal. Just ask for help when you call to file your appeal.

Can I ask for a State Fair Hearing?

You can also request a State Fair Hearing any time during or after Molina's appeal process, unless you have asked for an expedited appeal. For more information, see the section on Expedited Appeals and State Fair Hearing below.

Expedited Appeals

What is an expedited appeal?

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

How do I ask for an expedited appeal? Does my request have to be in writing?

You can call a Member Advocate or Member Services and ask to file an expedited appeal. We will help you. You can ask for an expedited appeal by calling or in writing.

Who can help me in filing an expedited appeal?

You can call a Molina Member Advocate or Member Services to file an expedited appeal. When you call, just tell them you would like to file an expedited appeal, they will know to work on it very quickly.

Toll free number: 1-866-449-6849

If you send the expedited appeal in writing, send it to:

Molina Healthcare of Texas
Attn: Member Complaints & Appeals
P. O. Box 165089
Irving, TX 75016

What are the time frames for an expedited appeal?

Molina will make a decision within one (1) business day. For expedited appeals, we will send a letter telling you your appeal has been handled. We will send your provider a letter telling him/her that your appeal has been resolved.

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

Molina may make a decision that your appeal should not be expedited. If this decision is made, we will follow the standard appeal process. As soon as this is decided, we will call you to let you know that the standard appeal process will be followed. We will also let you know by sending you a letter within 2 days from the date you asked for the expedited appeal.

Denied request for an expedited appeal
If you disagree with the decision, you have the right to request an expedited Fair Hearing from the State.

State Fair Hearing

Can I ask for a State Fair Hearing?

If you, as a member of the health plan, disagree with the health plan's decision, you have the right to ask for a fair hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A doctor or other medical provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the fair hearing within 90 days of the date on the health plan's letter with the decision. If you do not ask for the fair hearing within 90 days, you may lose your right to a fair hearing. To ask for a fair hearing, you or your representative should either send a letter to the health plan at:

Molina Healthcare of Texas
Attention Complaint & Appeal Dept.
P. O. Box 165089
Irving, TX 75016

Or call Members Services Toll Free at: 1-866-449-6849

You have the right to keep getting any service the health plan denied or reduced, at least until the final hearing decision is made if you ask for a fair hearing by the later of: (1)10 calendar days following the MCO's mailing of the notice of the Action, or (2) the day the health plan's letter says your service will be reduced or end. If you do not request a fair hearing by this date, the service the health plan denied will be stopped.

If you ask for a fair hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most fair hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied.

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

Waste, Abuse and Fraud Information

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

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

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

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

- Call the OIG Hotline at 1-800-436-6184;
- Visit https://oig.hhsc.state.tx.us/ Under the box labeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:

Molina Healthcare of Texas
Attention Compliance Officer
5605 N. MacArthur Blvd. Ste 400
Irving, Texas, 75038
1-866-606-3889

To report an issue online, visit: https://molinahealthcare.AlertLine.com

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

When reporting about a provider (a doctor, dentist, counselor, etc.) include:

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

When reporting about someone who gets benefits, include:

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

Information Available On a Yearly Basis

As a member of Molina you can ask for and get the following information each year:

- Information about network providers – at a minimum primary care doctors, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients.
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, appeal, and fair hearing procedures.
- Information about benefits available under the Medicaid program, including amount, duration, and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
- How you get benefits including authorization requirements.
- How you get benefits, including family planning services, from out-of-network providers and limits to those benefits.
- How you get after hours and emergency coverage and limits to those kinds of benefits, including:
  - What makes up emergency medical conditions, emergency services, and post-stabilization services.
  - The fact that you do not need prior authorization from your primary care provider for emergency care services.
  - How to get emergency services, including instructions on how to use the 911 telephone system or its local equivalent.
  - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid.
  - A statement saying you have a right to use any hospital or other settings for emergency care.
  - Post-stabilization rules.
- Policy on referrals for specialty care and for other benefits you cannot get through your primary care provider.
- Molina's practice guidelines.

Your Privacy

Your privacy is important to us. We respect and protect your privacy. Molina uses and shares your information to provide you with health benefits. Molina wants to let you know how your information is used or shared. PHI means *"protected health information."* PHI is health information that includes your name, member number or other identifiers, and is used or shared by Molina.

Why does Molina use or share your PHI?

- To provide for your treatment
- To pay for your health care
- To review the quality of the care you get
- To tell you about your choices for care
- To run our health plan
- To use or share PHI for other purposes as required or permitted by law

When does Molina need your written authorization (approval) to use or share your PHI?

Molina needs your written approval to use or share your PHI for purposes not listed above.

What are your privacy rights?

- To look at your PHI
- To get a copy of your PHI
- To amend your PHI
- To ask us to not use or share your PHI in certain ways
- To get a list of certain people or places we have given your PHI

How does Molina protect your PHI?

Molina uses many ways to protect PHI across our health plan. This includes PHI in written word, spoken word or in a computer. Below are some ways Molina protects PHI:

- Molina has policies and rules to protect PHI.
- Molina limits who may see PHI. Only Molina staff with a need to know PHI may use it.
- Molina staff is trained on how to protect and secure PHI.
- Molina staff must agree in writing to follow the rules and policies that protect and secure PHI.
- Molina secures PHI in our computers. PHI in our computers is kept private by using firewalls and passwords.

What must Molina do by law?

- Keep your PHI private.
- Give you written information, such as this on our duties and privacy practices about your PHI.
- Follow the terms of our Notice of Privacy Practices.

What can you do if you feel your privacy rights have not been protected?

- Call or write Molina and complain.
- Complain to the Department of Health and Human Services.

We will not hold anything against you. Your action would not change your care in any way.

The above is only a summary. Our Notice of Privacy Practices has more information about how we use and share our Members' PHI. Our Notice of Privacy is included in your Molina Welcome Packet. It is on our website at: www.molinahealthcare.com. You may get a copy of our Notice of Privacy Practices by calling our Member Services Department toll free at: 1-866-449-6849.

New Medical Procedures Review

As a member of the Molina health plan, one of your covered benefits includes the fact that we look at new medical advances, like new equipment, tests, and surgery. Each situation is looked at on a case-by-case basis, and sometimes we use a special review to make sure that it is right for you. For more information, call Member Services.

INTENTIONALLY LEFT BLANK

Molina Healthcare of Texas
Member Complaint/Appeal Request Form

Instructions for filing a complaint/appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit. (Do Not Send Originals).
3. If you have someone else submit on your behalf, you must give your consent below.
4. You may submit the completed form through one of the following ways:
   a. Send to the address listed below.
   b. Fax to the number below, or
   c. Present your information in person. To do this, call us at the number listed below.

   We will send a written acknowledgement letter of your request. It will be mailed to you within five (5) working days after the request is received.

Member's name: _____ Today's date: _____

Name of person requesting complaint/appeal, if other than the Member: _____

Relationship to the Member: _____

Member's ID #: _____ Daytime telephone #:_____

Specific issue(s): _____

_____

_____

_____

_____

_____

_____

(Please state all details relating to your request including names, dates and places. Attach another sheet of paper to this form if more space is needed)

By signing below, you agree that the information provided is true and correct. If someone else is completing this form for you, you are giving written consent for the person named above to submit on your behalf.

Member's Signature: _____ Date: _____

If you would like help with your request, we can help. Please call 1-866-449-6849 with any questions.

Molina Healthcare of Texas
Attn: Member Complaints & Appeals
6999 McPherson, Suite 212
Laredo, TX 78041

Or Fax to (877) 816-6416

MHTMemACReq.072012

Molina Healthcare of Florida, Inc
8300 NW 33rd Street
Suite 400
Miami, FL 33122

Welcome to Molina Healthcare of Florida. An ID card will be sent separately. The card is good as long as you are with Molina. If you lose your membership and regain it within 180 days you will be a Molina member. Please carry this card with you when you get health care. When you get your ID card, please look at it. Your Primary Care Provider (PCP) is listed on your ID card.

Call Member Services at 1 (866) 472-4585:

- **If the PCP on your ID card is not the one you are seeing**
- **If you wish to change the PCP**

Your Welcome packet includes:

- Member Handbook
- Provider Directory
- Medical Release Form
- Over the Counter (OTC) Flyer

The Member handbook gives information about the following:

- Your coverage
- How to get services
- How to file a complaint
- Other important information

The Provider Directory lists all of our PCPs. It also lists other care givers you can see.

The OTC Flyer explains how to get over the counter medicine or medical supplies. It gives directions how to use it and lists items that are covered.

Please sign the medical release form and return it in the envelope provided.

Call Member Services at 1 (866) 472-4585 if you have questions about:

- Changing your PCP
- Your health benefits (what is paid for)
- Molina Healthcare
- Interpreters
- How to file a complaint

Call Member Services if you change your address or telephone number.

Member Services is open Monday through Friday, 8:00 a.m. to 7:00 p.m.

The TTY/TDD number (for people who have trouble with hearing or speech) is 1 (800) 955-8771. You can also learn more about Molina Healthcare or contact us through our website at www.molinahealthcare.com.

Member Services
Molina Healthcare of Florida

If you need this information in another format, call Molina Healthcare Member Services Department at 1-866-472-4585.

Molina and You

MOLINA HEALTHCARE

Vaccinations

What are vaccinations?

Vaccinations are shots given to children to prevent harmful diseases.

What diseases do these shots prevent?

These shots protect against harmful diseases like:

- Measles
- Mumps
- Rubella
- Influenza (flu)
- Hepatitis A & B
- Polio
- Tetanus
- Pertussis (whooping cough)
- Chickenpox

Why is it important for me to get my child vaccinated?

It is important for your child to receive vaccinations to prevent serious diseases. These diseases can cause breathing problems, seizures, brain damage and deafness. In some cases, these diseases can cause death.

Are vaccinations safe?

Vaccines are safe. The government tests every vaccine before approving it for use. They monitor its safety as long as the vaccine is in use.

How do I know when to take my child in for shots?

Your provider should remind you when your child is due for his or her next shot. If you are not sure, call your clinic or provider's office to find out when you should bring your child back.

What if my child isn't a baby anymore? Is it too late for my child to get shots?

No. Although it is best to have your child vaccinated as a newborn, it's never too late. If your child hasn't received any or all of his or her shots, now is the best time to start.

What if my child does not get the shots?

- Your child is at greater risk of catching one of diseases that could be prevented by shots.
- If your child becomes ill, he or she can infect others.
- Your child may miss school or childcare to prevent others from getting sick.

Your extended family.

Molina and You

MOLINA HEALTHCARE

Body Mass Index (BMI)

What is BMI?

Body Mass Index (BMI) is a number based on your height and weight. This number can show if your body fat is in a healthy range. Providers use BMI for males and females of all ages. It is a reliable source to see if you are at a healthy weight.

Why should you measure your BMI?

- The BMI test will tell you if you are overweight or at risk of becoming overweight or obese.
- Obesity can cause many health problems, such as high blood pressure, type 2 diabetes and high cholesterol.
- Obesity can affect your mood and your self-image.

What can I do if my child is overweight or at risk of becoming overweight?

Promote healthy eating. Your child should:

- Eat five servings of fresh fruits and vegetables per day.
- Drink 5 to 8 cups of water per day. Your child may need more or less depending on activity level.
- Limit drinks that are high in sugar, such as soda.
- Limit foods that are high in sugar and fat, such as ice cream.

Encourage exercise. Your child should:

- Stay active for at least 60 minutes per day.
- Limit TV and video game time to two hours per day or less.

Be a good example for your child.

Keep good eating and exercise habits for your whole family. Talk to your child's provider often to ask questions and to record your child's progress.

Your extended family.

Molina is here to help you.

You are not alone. Research shows that almost one in ten people suffer from depression. That is 15.8 million adults.

Medicine and "talk therapy" can help you get better.

Take your medicine as prescribed by your provider. Talk to your provider before you stop taking your medicine. This will lower your risk of having depression come back.

MOLINA HEALTHCARE
Your Extended Family.

Distributed by Molina Healthcare. All material in this brochure is for information only. It does not replace your provider's advice.

www.MolinaHealthcare.com

To get this information in other languages and accessible formats, please call Member Services. The number is on the back of your ID card.

Do you have questions?

Call our 24-hour Nurse Advice Line.
We are here to help you.

English: (888) 275-8750
Spanish: (866) 648-3537
TTY (English and Spanish): 711

40717DM0414

Behavioral Health

Taking Depression Medication

MOLINA HEALTHCARE
Your Extended Family.

Take Your Depression Medicine Every Day

Your medicine can take 4-6 weeks before it makes you feel better.

Most medicine therapy for depression lasts 6 to 9 months. If you stop taking your medicine before that time, you are at risk of having the depression return. Talk with your provider about issues you may have with taking your medicine.

What should you do if you have side effects?

Call your provider to talk about the side effects. Your provider might do one or more things to manage the side effects. Your provider may:

- Ask you to take the medicine longer to see if the side effects go away
- Ask you to take a lower dose of medicine
- Give you different medicine to try
- Suggest ways to lessen the side effects
- Suggest ways to help you cope with the side effects

Healthy Snack Ideas

Plan ahead. Pack healthy snacks for the day. Try to **sit at a table** when eating a snack. You're less likely to eat too much if you are paying attention to what you are eating.

Ideas for Fruit and Vegetable Snacks:

- Apple slices with peanut butter
- Fresh fruit such as grapes, oranges, pears or melons
- Plain fat-free or low-fat yogurt with berries or sliced fruit
- 1/4 cup of nuts with a piece of fruit
- Cut up vegetables dipped in hummus
- Dried fruit such as apricots, bananas, cranberries or raisins
- A fruit smoothie using fat-free or low-fat yogurt with fresh or frozen fruit (Try with bananas, peaches or strawberries)
- Low-fat salad dressing with broccoli, cucumbers, red and green peppers or celery and carrot sticks
- Use the microwave to quickly cook frozen vegetables and sweet potatoes

Health Benefits of Eating Fruits and Vegetables:

- Reduces risk for heart attack and stroke
- Reduces risk of obesity and type 2 diabetes
- Helps protect from certain types of cancers
- Helps promote an overall healthier lifestyle

MolinaHealthcare.com

MOLINA HEALTHCARE

Your Extended Family.

Do you have questions?

Call our 24-hour Nurse Advice Line.

We are here to help you.

English:
(888) 275-8750

Español:
(866) 648-3537

TTY/TDD:
711

Distributed by Molina Healthcare. All material in this brochure is for information only. It does not replace your provider's advice.

To get this information in other languages and accessible formats, please call Member Services. This number is on the back of your Member ID card.

Mammograms

Breast Cancer Screening

MolinaHealthcare.com

MOLINA HEALTHCARE
Your Extended Family.

MOLINA HEALTHCARE
Your Extended Family.

45418DM0914

What is a breast cancer screening?

Breast cancer screening means checking your breasts for cancer before there are signs or symptoms. Mammograms help your provider check your breasts for possible cancer.

What is a mammogram?

A mammogram is an X- ray of the breast.

Why should you get a mammogram?

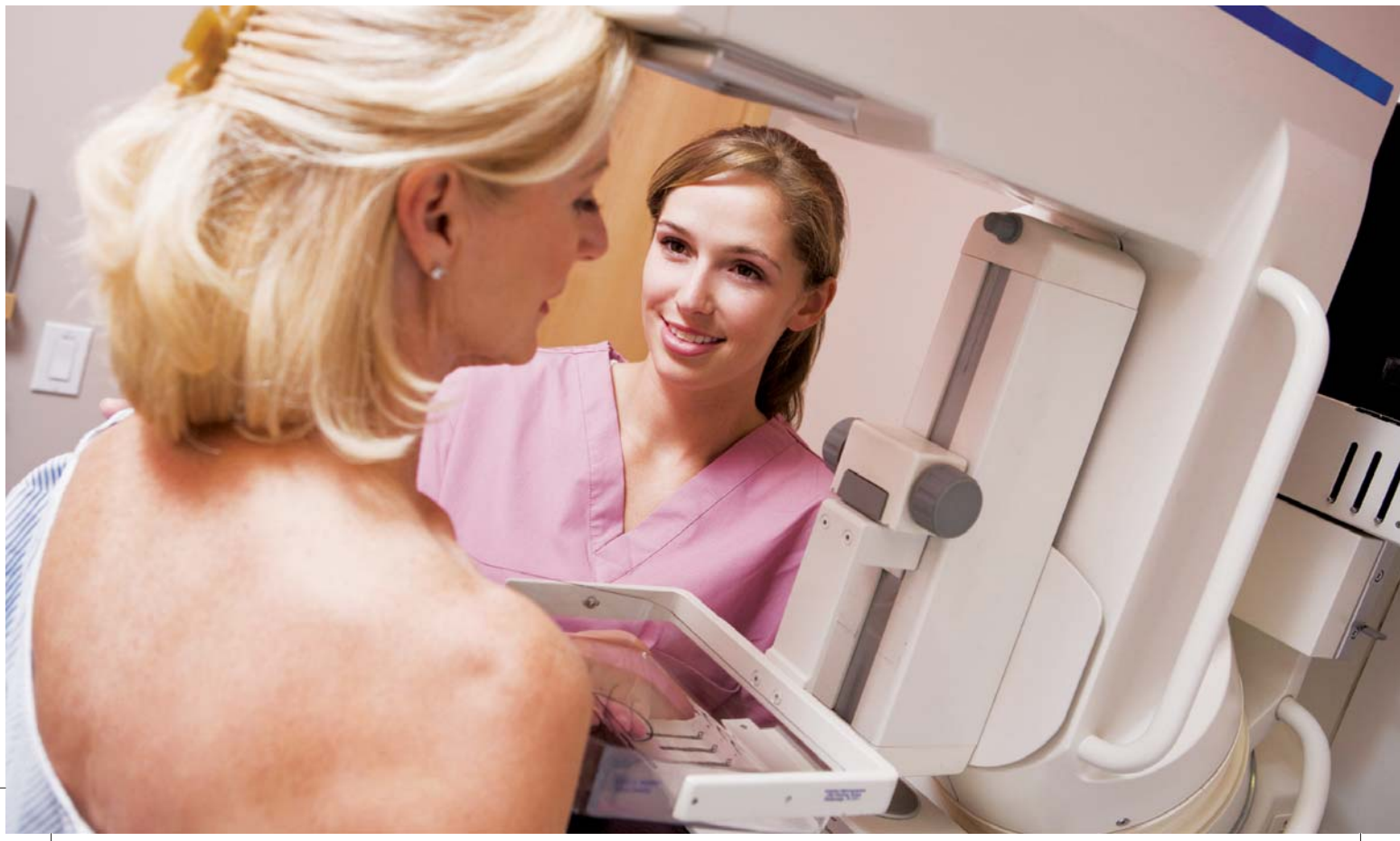
A mammogram can detect breast cancer early. Breast cancer is smaller and easier to treat if found early.

What does a mammogram show?

The x-ray will show any lump or mass in your breasts that does not look normal. A provider will compare your results to your previous mammogram to look for changes in each breast.

How often should you get a mammogram?

Women who are 50 to 74 years of age should get a mammogram every 2 years. If you have had breast cancer, other breast problems or have a family history of breast cancer, you might need to get mammograms before age 50. You might also need to get them more often. Talk to your provider about when to start and how often you should have a mammogram.



Medical Information

Pharmacy Name: _____

_____

Phone: _____

Allergies: _____

_____

_____

_____

_____

_____

_____

_____

Medical Conditions:

_____

_____

_____

_____

Current Medications:

_____

_____

_____

_____

Dosage Instructions:

_____

_____

_____

_____

Provider Information

Primary Care Provider (PCP):

_____

Phone: _____

Provider: _____

Phone: _____

Emergency Contact

Name: _____

_____

_____

Phone: _____

Diabetes Care Checklist

MolinaHealthcare.com

45715DM1014

Diabetes Screening Checklist

Use this checklist to help you manage your diabetes screenings. Schedule regular visits with your provider. Ask your provider if you need any of these screenings.

Diabetes Screenings:

HbA1c – This test shows the average blood sugar for the last 2-3 months. You should receive this at least two times a year. You may need this test more often if you have not met your goal or your provider changes your therapy.

LDL-C – This test tells the amount of fat in your blood. You should receive this test once a year.

Retinal Eye Exam – This exam checks for eye disease. You should receive this test once a year.

Microalbumin for Nephropathy – This test detects kidney disease. You should receive this test once a year.

Blood Pressure - Your provider will check your blood pressure at each provider visit.

Foot Exam - This test will check circulation and tell you if the nerves in your feet are working right. Your provider will perform this test at least once a year.

General Shots:

Flu - Get your flu shot once a year.

Pneumonia - This shot is for anyone 2 years of age and older. Get this shot once in your lifetime. Your provider may suggest getting a second shot.

Patient Name:

_____

Date of Birth:

_____

Member ID#:

_____

Provider Name:

_____

Screening							
HbA1c							
Date:							
Result:							
LDL-C							
Date:							
Result:							
Retinal Eye Exam							
Date:							
Result:							
Microalbumin for Nephropathy							
Date:							
Result:							
Blood Pressure							
Date:							
Result:							
Foot Exam							
Date:							
Result:							

When should I go to Urgent Care?

Urgent Care Centers treat health problems that can't wait until your next Primary Care Provider (PCP) visit. They treat health problems that are not a threat to your life. Most Urgent Care Centers see you on a walk-in basis. Many are open evenings and weekends. Waiting time is shorter than in the Emergency Room (ER).

Urgent Care

Use Urgent Care for conditions such as:

- Sore throat, cough or runny nose
- Muscle strains/sprains
- Minor cuts/ burns
- Earache
- Rashes
- Fever
- General wound care
- Animal bite
- Urinary tract infection
- Mild asthma
- Flu screening

Emergency Room

Use the Emergency Room (ER) for sudden injury or sickness such as:

- A lot of bleeding
- Poisoning (Poison Control Center (800) 222-1222)
- A bad burn
- Trouble breathing
- Drug overdose
- Miscarriage
- Chest pain
- Broken bones
- Stroke

- Call your PCP if you have any questions about whether or not the condition is an emergency. Your PCP will tell you if you need to be seen at his or her office, an Urgent Care Center or the ER.
- Call your Molina Healthcare Care Manager after you go to an Urgent Care Center or ER.
- You can find your nearest Molina Urgent Care Center at www.MolinaHealthcare.com. Click "Find a Doctor or Pharmacy". Click "Find a Hospital/Facility". Select Urgent Care Center in the "Hospital/ Facility Type" drop down-box.
- You can also receive care from any non-Molina Urgent Care Center by showing your Molina ID Card.
- If you think you have a severe injury or illness, call 911.

For Questions About Your Health, Please Call Our 24-Hour Nurse Advice Line.

English: (888) 275-8750
Spanish: (866) 648-3537
TTY: 711

MolinaHealthcare.com

MOLINA® HEALTHCARE

Your Extended Family.

Distributed by Molina Healthcare. All material in this flyer is for information only. It does not replace your provider's advice. To get this information in other languages and accessible formats, please call Member Services. This number is on the back of your Member ID card.

MY ASTHMA ACTION PLAN

MY NAME: _____

MY PROVIDER'S NAME: _____
PHONE: _____

MY PHARMACY: _____
PHONE: _____

WHAT IS A CONTROLLER MEDICINE?

Controller medicines help prevent asthma symptoms. Use them each day as prescribed by your provider. Talk to your provider about how long your medicine will last. Refill your medicine 5 to 7 days before it is gone.

WHAT IS RESCUE OR QUICK RELIEF MEDICINE?

Rescue or quick relief medicines act quickly to open the airways and make it easier to breathe. Use these medicines to treat an asthma attack. They relieve symptoms like shortness of breath, coughing, chest tightness or wheezing. This medicine will not help to control your asthma.

48013CORP0215

WHAT ARE COMMON ASTHMA TRIGGERS?

- Exercise
- Illness or colds
- Dust
- Pollen
- Emotions
- Mold or mildew
- Pet dander
- Certain foods
- Tobacco or wood smoke
- Strong odors

WHAT ARE MY ASTHMA TRIGGERS?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

MY ASTHMA ACTION PLAN

I FEEL WELL

- Breathing is good
- No cough, wheeze or shortness of breath
- Can work and play

My Peak Flow Number

_____ to _____

My Best Peak Flow is:

_____

I take these long-term controller medicines each day:

Medicine	How Much:	Take When:	Last Filled On:	Need a Refill On:
_____	_____	_____	___/___/___	___/___/___
_____	_____	_____	___/___/___	___/___/___
_____	_____	_____	___/___/___	___/___/___
_____	_____	_____	___/___/___	___/___/___

Before exercise, I take:

Medicine	How Much:	Take When:	Last Filled On:	Need a Refill On:
_____	_____	_____	___/___/___	___/___/___

I DO NOT FEEL WELL

- Cough, wheeze, shortness of breath or chest tightness
- Hard to breathe
- Wake up at night

My Peak Flow Number

_____ to _____

In addition to my long-term controller medicine each day, I take these relief medicines when my asthma gets worse:

Medicine	How Much:	Take When:	Last Filled On:	Need a Refill On:
_____	_____	_____	___/___/___	___/___/___
_____	_____	_____	___/___/___	___/___/___
_____	_____	_____	___/___/___	___/___/___
_____	_____	_____	___/___/___	___/___/___

Call your provider if you have these symptoms often, or if your relief medicine does not work.

I FEEL AWFUL

- Medicine not helping
- Breathing hard, fast
- Can't talk or walk well
- Very short breaths

My Peak Flow Number

_____ to _____

Medical Alert – Get Help Now!

In addition to my long-term and relief medicines, I take these medicines until I can talk to my provider:

Medicine	How Much:	Take When:	Last Filled On:	Need a Refill On:
_____	_____	_____	___/___/___	___/___/___
_____	_____	_____	___/___/___	___/___/___
_____	_____	_____	___/___/___	___/___/___
_____	_____	_____	___/___/___	___/___/___

Call 911 if your asthma attack is severe and does not improve.

Molina Healthcare of California
200 Oceangate, 6th Floor
Long Beach, CA 90802

Temporary Return Service Requested

DATE: 03/09/2015
NPI: 8351432568
TAX ID: 951643332
Check or EFT Trace # 03678777

000000-000000-000000-000001 2524 1060CK01
Test Hospital 7
12620 S FIGUEROA ST
LOS ANGELES, CA 925090833

EXPLANATION OF PAYMENT

SUMMARY OF PAYMENT

Billed Amount:	$3,585.00	Refunds:	$0.00
Contract/Allowed Amt:	$1,039.86	Interest:	$0.00
Disallow Amount::	$2,545.14	Coinsurance:	$0.00
Gross Plan Payable:	$1,039.86	Deductible:	$0.00
COB Amt:	$0.00	FFS Withhold:	$0.00
Co-Pay:	$0.00	Total Paid Amount:	$1,039.86

Payment Amount: $1,039.86

Confidential Protected Health Information

This document contains confidential Protected Health Information that is protected under HIPAA and other applicable federal and state laws. This information should be safeguarded at all times and should be securely destroyed when no longer needed. This information is intended only for use by the authorized recipient. Any unauthorized use or disclosure of this information should be reported to Molina Healthcare.

To file a provider claim reconsideration, please see the reconsideration procedure on the back of this page.

Exciting COB Enhancement: Molina can now accept COB claims through the standard 837 EDI file format.

IMAGE COPY

Molina Healthcare of California
200 Oceangate, 6th Floor
Long Beach, CA 90802

USBank
Havre, MT
usbank.com
93-455/929

03678777

03/09/2015

VOID AFTER 90 DAYS

PAY One Thousand Thirty-Nine and 86/100 **$1,039.86

VOID

TO THE ORDER OF

Test Hospital 7
12620 S FIGUEROA ST
LOS ANGELES, CA 925090833

VOID

Joseph M Molina MD

Authorized Signature 1060CK01

⑈03678777⑈ ⑆092904554⑆ 1500806593 89⑈

Molina's Process

Provider was paid according to the provider's contract rates effective on the date of service. Or, for non-contracted providers, at the plan's reasonable and customary rates on file with the Department of Managed Health Care and based on the applicable Medi-Cal fee schedule or Medi-cal payment rate on the date of service.

Corrected or Contested Claims Process

Attention: Claims Department

If a corrected or contested claim is submitted through the Provider Dispute Resolution process, please be advised that the claim will be forwarded to the Claims Department for processing. Please resubmit a hard copy of the claim and include a copy of the Remittance Advice with the information requested.

Mail to:
Claims Department
P.O. Box 22702
Long Beach, CA 90801

Unbundling Process

If at any given time a procedure code is denied as incidental or unbundled service to another procedure code, please resubmit a hard copy of the claim with medical records in order to reconsider claim for processing.

Mail to:
Claims Department
P.O. Box 22702
Long Beach, CA 90801

Provider Dispute Resolution Process

Attention: Provider Dispute Resolution Unit

All Provider Disputes or Appeals request must be received within 365 days from the last claim action by Molina Healthcare of California. The dispute request should include a clear explanation or a description; including the original claim number, provider name, contact information and supporting documentation.

Contested Dispute

If additional information is not received, or not received in timely manner (30 working days), the Provider Dispute request will be closed.

If you wish to file a provider dispute, please submit a written request to the following address:

Provider Dispute Resolution
P.O. Box 22722
Long Beach, CA 90801

For any questions, please call our Claims Customer Service at 877-665-4626

EXPLANATION OF PAYMENT

Molina Healthcare of California

Explanation of Payment for:
Test Hospital 7
12620 S FIGUEROA ST, LOS ANGELES, CA 925090833
NPI: 8351432568
TAX ID: 951643332

Paid Date: 03/09/2015 **Check or EFT Trace # 03678777**

Patient Name: GOMEZ, MARIO **Member ID#: 13302015254107** **Payer Claim Ctrl#: 15063609396** **Patient Control #: 1546643**
Rendering Provider Name: Test Rendering Hospital 7 **NPI#: 7777777** **Program: Imperial - MHC**

Claim Line	Date Service From / Service Thru	Rev Code / cpt/hpc	Units	Mod 1 / 3	Mod 2 / 4	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amount	Co-Pay Applied	Refund Amount / Interest	Co-insurance	Deductible	FFS Withhold	Net Plan Payable	FSS CAP	Line Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd	Msg
1	01/28/2015		1.00			$474.00	$117.02	$356.98	$117.02	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$117.02	FFS	PAID	CO	45		
	01/28/2015	X0030										$0.00										
2	01/28/2015		12.00			$120.00	$42.12	$77.88	$42.12	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42.12	FFS	PAID	CO	45		
	01/28/2015	X0034										$0.00										
3	01/28/2015		1.00			$35.00	$9.78	$25.22	$9.78	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$9.78	FFS	PAID	CO	45		
	01/28/2015	X0036										$0.00										
TOTAL AMOUNT:						**$629.00**	**$168.92**	**$460.08**	**$168.92**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$168.92**						
												$0.00										

IMAGE COPY

Patient Name: GOMEZ, MARIO **Member ID#: 13M12006847101** **Payer Claim Ctrl#: 15063609397** **Patient Control #: 1546577**
Rendering Provider Name: Test Rendering Hospital 7 **NPI#: 7777777** **Program: Imperial - MHC**

Claim Line	Date Service From / Service Thru	Rev Code / cpt/hpc	Units	Mod 1 / 3	Mod 2 / 4	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amount	Co-Pay Applied	Refund Amount / Interest	Co-insurance	Deductible	FFS Withhold	Net Plan Payable	FSS CAP	Line Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd	Msg
1	02/07/2015		1.00	UJ		$395.00	$126.80	$268.20	$126.80	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$126.80	FFS	PAID	CO	45		
	02/07/2015	X0030										$0.00										
2	02/07/2015		13.00			$130.00	$45.63	$84.37	$45.63	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$45.63	FFS	PAID	CO	45		
	02/07/2015	X0034										$0.00										
TOTAL AMOUNT:						**$525.00**	**$172.43**	**$352.57**	**$172.43**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$172.43**						
												$0.00										

EXPLANATION OF PAYMENT

Molina Healthcare of California

Explanation of Payment for:
Test Hospital 7
12620 S FIGUEROA ST, LOS ANGELES, CA 925090833
NPI: 8351432568
TAX ID: 951643332

Paid Date: 03/09/2015 **Check or EFT Trace # 03678777**

Patient Name: GOMEZ, MARIO **Member ID#: 13M10238017106** **Payer Claim Ctrl#: 15063609398** **Patient Control #: 1546619**
Rendering Provider Name: Test Rendering Hospital 7 **NPI#: 7777777** **Program: Imperial - MHC**

Claim Line	Date ServiceFrom / ServiceThru	Rev Code / cpt/hpc	Units	Mod 1 / 3	Mod 2 / 4	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amount	Co-Pay Applied	Refund Amount / Interest	Co-insurance	Deductible	FFS Withhold	Net Plan Payable	FSS CAP	Line Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd	Msg
1	02/09/2015		1.00			$387.00	$117.02	$269.98	$117.02	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$117.02	FFS	PAID	CO	45		
	02/09/2015	X0030										$0.00										
2	02/09/2015		12.00			$120.00	$42.12	$77.88	$42.12	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42.12	FFS	PAID	CO	45		
	02/09/2015	X0034										$0.00										
TOTAL AMOUNT:						**$507.00**	**$159.14**	**$347.86**	**$159.14**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$159.14**						
												$0.00										

IMAGE COPY

Patient Name: GOMEZ, MARIO **Member ID#: 13382042537103** **Payer Claim Ctrl#: 15063610343** **Patient Control #: 14372418**
Rendering Provider Name: Test Rendering Hospital 7 **NPI#: 7777777** **Program: Imperial - MHC**

Claim Line	Date ServiceFrom / ServiceThru	Rev Code / cpt/hpc	Units	Mod 1 / 3	Mod 2 / 4	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amount	Co-Pay Applied	Refund Amount / Interest	Co-insurance	Deductible	FFS Withhold	Net Plan Payable	FSS CAP	Line Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd	Msg
1	11/19/2014		1.00	UJ		$484.00	$126.80	$357.20	$126.80	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$126.80	FFS	PAID	CO	45		
	11/19/2014	X0030										$0.00										
2	11/19/2014		13.00			$130.00	$45.63	$84.37	$45.63	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$45.63	FFS	PAID	CO	45		
	11/19/2014	X0034										$0.00										
3	11/19/2014		1.00			$70.00	$7.36	$62.64	$7.36	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$7.36	FFS	PAID	CO	45		
	11/19/2014	93005										$0.00										
TOTAL AMOUNT:						**$684.00**	**$179.79**	**$504.21**	**$179.79**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$179.79**						
												$0.00										

EXPLANATION OF PAYMENT

Molina Healthcare of California

Explanation of Payment for:
Test Hospital 7
12620 S FIGUEROA ST, LOS ANGELES, CA 925090833
NPI: 8351432568
TAX ID: 951643332

Paid Date: 03/09/2015 **Check or EFT Trace # 03678777**

Patient Name: GOMEZ, MARIO **Member ID#: 13M12002715101** **Payer Claim Ctrl#: 15063614167** **Patient Control #: 1546715**
Rendering Provider Name: Test Rendering Hospital 7 **NPI#: 7777777** **Program: Imperial - MHC**

Claim Line	Date Service From / Service Thru	Rev Code / cpt/hpc	Units	Mod 1 / 3	Mod 2 / 4	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amount	Co-Pay Applied	Refund Amount / Interest	Co-insurance	Deductible	FFS Withhold	Net Plan Payable	FSS CAP	Line Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd	Msg
1	01/31/2015 01/31/2015	X0030	1.00			$385.00	$117.02	$267.98	$117.02	$0.00	$0.00	$0.00 $0.00	$0.00	$0.00	$0.00	$117.02	FFS	PAID	CO	45		
2	01/31/2015 01/31/2015	X0034	13.00			$130.00	$45.63	$84.37	$45.63	$0.00	$0.00	$0.00 $0.00	$0.00	$0.00	$0.00	$45.63	FFS	PAID	CO	45		
3	01/31/2015 01/31/2015	X0036	1.00			$35.00	$9.78	$25.22	$9.78	$0.00	$0.00	$0.00 $0.00	$0.00	$0.00	$0.00	$9.78	FFS	PAID	CO	45		
4	01/31/2015 01/31/2015	93005	1.00			$70.00	$7.36	$62.64	$7.36	$0.00	$0.00	$0.00 $0.00	$0.00	$0.00	$0.00	$7.36	FFS	PAID	CO	45		
TOTAL AMOUNT:						**$620.00**	**$179.79**	**$440.21**	**$179.79**	**$0.00**	**$0.00**	**$0.00 $0.00**	**$0.00**	**$0.00**	**$0.00**	**$179.79**						

IMAGE COPY

Patient Name: GOMEZ, MARIO **Member ID#: 13M12024845101** **Payer Claim Ctrl#: 15063614170** **Patient Control #: 1546709**
Rendering Provider Name: Test Rendering Hospital 7 **NPI#: 7777777** **Program: Imperial - MHC**

Claim Line	Date Service From / Service Thru	Rev Code / cpt/hpc	Units	Mod 1 / 3	Mod 2 / 4	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amount	Co-Pay Applied	Refund Amount / Interest	Co-insurance	Deductible	FFS Withhold	Net Plan Payable	FSS CAP	Line Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd	Msg
1	01/31/2015 01/31/2015	X0030	1.00			$385.00	$117.02	$267.98	$117.02	$0.00	$0.00	$0.00 $0.00	$0.00	$0.00	$0.00	$117.02	FFS	PAID	CO	45		
2	01/31/2015 01/31/2015	X0034	13.00			$130.00	$45.63	$84.37	$45.63	$0.00	$0.00	$0.00 $0.00	$0.00	$0.00	$0.00	$45.63	FFS	PAID	CO	45		
3	01/31/2015 01/31/2015	X0036	1.00			$35.00	$9.78	$25.22	$9.78	$0.00	$0.00	$0.00 $0.00	$0.00	$0.00	$0.00	$9.78	FFS	PAID	CO	45		
4	01/31/2015 01/31/2015	93005	1.00			$70.00	$7.36	$62.64	$7.36	$0.00	$0.00	$0.00 $0.00	$0.00	$0.00	$0.00	$7.36	FFS	PAID	CO	45		
TOTAL AMOUNT:						**$620.00**	**$179.79**	**$440.21**	**$179.79**	**$0.00**	**$0.00**	**$0.00 $0.00**	**$0.00**	**$0.00**	**$0.00**	**$179.79**						

EXPLANATION OF PAYMENT

Molina Healthcare of California

Explanation of Payment for:
Test Hospital 7
12620 S FIGUEROA ST, LOS ANGELES, CA 925090833
NPI: 8351432568
TAX ID: 951643332

Paid Date: 03/09/2015 **Check or EFT Trace # 03678777**

Claim Line	Date ServiceFrom ServiceThru	Rev Code cpt/hpc	Units	Mod 1 3	Mod 2 4	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amount	Co-Pay Applied	Refund Amount Interest	Co-insurance	Deductible	FFS Withhold	Net Plan Payable	FSS CAP	Line Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd	Msg

DESCRIPTION OF HIPAA ADJUSTMENT & REMARK

ADJ GRP CODE	DESCRIPTION
CO	Contractual Obligation

ADJ RSN CODE	DESCRIPTION
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)

IMAGE COPY

Molina's integrated health care management model supports its diverse physical, behavioral and social services using evidence-based clinical practices to influence member behavior, improve health outcomes, and contain cost.

SECTION 9 – CARE COORDINATION

Please explain how you propose to execute Section 9 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Molina understands, agrees and will comply with all Care Coordination requirements set forth in accordance with Section 9 of Attachment 1—Scope of Work its entirety, and comply with 42 C.F.R. § 438.208.

Molina will implement its Integrated Care Management Program for all members of Iowa Health and Wellness, and Healthy and Well Kids in Iowa (*hawk-i*) programs. The Molina Integrated Care Management model of Case Management and Interdisciplinary Care Teams adhere to comprehensive person-centered, member directed Individual Care Plans to ensure members receive the right services, in the right setting, at the right time. Molina's person-centered approach to care engages and empowers members at every opportunity; utilizing resources based on specific member needs; promoting self-care; and supporting physicians and other providers that member identifies to participate in the Interdisciplinary Care Team in maximizing member health outcomes while serving member individualized needs and goals of care.

The goals of the Interdisciplinary Care Team are designed to improve care delivery and health and functional outcomes; reduce health disparities across all populations; reduce costs by preventing unnecessary utilization; promote member autonomy; keep members living in the community with increased independence, and improve transitions across all settings. Care Teams are established based on the member's stated preferences; specific physical, behavioral, social, and environmental needs; existing relationships; and staff capacity and expertise.

Molina's Integrated Care Management model incorporates and addresses the unique needs of its members and provides a strategy to stratify members into different levels of care based on either historical data provided by the state prior to enrollment or results of the member's initial health risk assessment. While every member will have individual physical, behavioral, social, and environmental needs, Molina has designed its risk levels around the resources needed to serve each of these distinct needs. The participants, the frequency, and the level of interaction will vary based on member need and risk level.

Molina's Care Coordination expertise is derived from deep experience in implementing and operating programs that feature person-centered care coordination across health care services and community support systems and throughout transitions between healthcare delivery settings. These programs include medical home initiatives; highly regarded disease management programs; demonstrated success in blending and braiding funding streams across a wide variety sources; the ability to cover the spectrum of physical and behavioral diagnoses with provider networks that are contoured specifically to member needs; and the technologies requisite for managing all of the above with demonstrated proof of cost effectiveness and quality enhancements for both Medicaid and Medicare contracts.

9.1 General

1. Describe proposed strategies to ensure the integration of LTSS care coordination and Contractor-developed care coordination strategies as described in Section 9.

Molina members will be screened for unmet needs in physical, social, behavioral health and functional areas that may require a variety of medical, behavioral health and Long Term Services and Supports (LTSS) as possible interventions. All members will be screened to identify risk and prioritization of contact utilizing historical data when provided by the state and by the use of the initial health risk assessment.

A face-to-face comprehensive assessment will be conducted in the member's home or the setting of their choice. Molina Case Managers will utilize a comprehensive assessment tool that includes assessment of the member's medical and functional status, IADL's/ADL's, safety concerns and physical and behavioral health needs. Members will be assessed for waiver program eligibility using the appropriate nursing facility level of care determination tool approved by Iowa and long term service and supports will be incorporated in member's service plan within their integrated care plan to reflect their individualized needs and preferences.

Whenever a change in health status is reported to Molina by a member, family or legal representative, designee, regulatory agency, Home and Community Based Service (HCBS) providers and any other providers, a Molina Case Manager will conduct a comprehensive reassessment of the member and make referrals for LTSS and long-term care assessment based on assessment findings. All referrals received will be processed without regard to a waiting list so that services can be initiated as soon as the eligibility determination is completed.

Molina's Case Managers will work with members to develop an Individualized Care Plan (ICP) and authorize waiver services for integration into the overall ICP. Case Managers will integrate in the ICP opportunities for disease management education and medication review to support member goals for self-management and adoption of healthy behaviors. Long Term Care assessment for level of care determination results will be shared in the Molina Interdisciplinary Care Team meetings based on the member's needs and preferences and documented in Molina's Electronic Health Management Platform.

Members who transition into a long-term nursing facility after implementation will be monitored by Molina staff to evaluate any change to their condition or member desire and appropriateness to transition back into the community with LTSS services. Members desiring to return to the community will be assessed utilizing the required Long Term Care Assessment to determine appropriate level of services and eligibility for Money Follows the Person (MFP).

Molina will contract with LTSS providers within the established counties to ensure that members receive the necessary services and interventions for self-determination and care in the least restrictive environment. Molina will develop relationships with existing HCBS providers in order to establish an adequate provider network. The following are some of the types of providers that will be included in Molina's LTSS program:

- **Adult Day Health Care (ADHC)** – Medically supervised care and services provided at a licensed day care center.
- **Adult Day Health Care (ADHC) Transportation –** Transportation to and from the Adult Day Health Care program is provided within 15 miles of the center.
- **Companion Care (In-home Respite for Caregiver Relief) –** As part of the services offered in the Community Choices waiver, this service is defined as short-term caregiver relief. This may be provided by an agency or as member-directed care.

- **Environmental Modification** – Pest control services and physical adaptations to the home that may include ramps or repair/minor home modifications to allow wheelchair access, bathroom safety supplies, and other safety and access related modifications.
- **Home Delivered Meals** – Regular or special diet meals delivered to the member's home.
- **Incontinence Supplies** – Limited supply of protective undergarments, hygiene supplies and underpads to maintain skin integrity.
- **Nursing Facility (Long Term Custodial Care)** – Once admitted to a nursing facility, Molina's case management team will continue to provide care coordination, review of Minimum Data Set and PASRR assessments, and will conduct comprehensive needs assessments to support members individualized care plan needs and to avoid unnecessary medical costs such as hospitalizations and prescription drugs (utilizing clinical pharmacy consults as necessary). Ongoing care coordination will also be used to determine if the nursing facility resident has the desire and feasibility to transition back to the community and need for Money Follows the Person and Long Term Service and Supports referrals.
- **Palliative Care Program** – This program and its interventions focus on pain management and comfort care. Palliative care providers help optimize quality of life for Molina members who have a serious, chronic or life-limiting illness who may not meet the hospice criteria of a terminal illness with a six month or less life expectancy. This program may assist members with their transition to a formal hospice program when appropriate along the care continuum.
- **Personal Care I (Light Homemaking Services)** – A service that provides assistance with general household activities.
- **Personal Care II (Personal Care and Light Homemaking Services)** – A service that helps with activities of daily living such as bathing, dressing, preparing meals, housekeeping, and observing health signs.
- **Personal Emergency Response System (PERS)** – This service provides an electronic device which enables high-risk individuals to secure help in the event of an emergency.
- **Respite Care (Facility-Setting)** – Temporary relief for the member's caregiver by member's admission to an in-patient facility (nursing home or hospital) or community residential care facility (CRCF).

Community-based LTSS are based on the member's physical functional, behavioral health, intellectual/developmental needs and will be subject to specific eligibility requirements, limitations and exclusions.

9.1.1 Initial Screening

1. Describe your plan for conducting initial health risk screenings.

Molina will perform an initial health risk screening for all new members of the Iowa Health and Wellness, and Healthy and Well Kids in Iowa (*hawk-i*) programs no later than ninety (90) days of effective enrollment to assess members for any health care or service needs based on physical health or pregnancy, behavioral health, LTSS, social, functional and psychological status and any identified gaps in care. The initial health risk screenings constitute the beginning of Molina's Case Management activities for care coordination services.

Molina Health Care Services teams will complete the Initial Telephonic Health Risk Assessment (THRA) in collaboration with members, parent/guardians/healthcare proxies as appropriate and other individuals identified by the member to participate in order to identify special needs, services and supports that may

assist in optimizing the member's health status. When necessary, the initial assessment is used in alternative formats to identify and accommodate the specific cultural, linguistic and physical needs of members including the most vulnerable, frail, disabled, or near end-of-life individuals. Upon request, Molina Health Care Services staff can provide the assessment in the member's preferred written or spoken language and/or alternate formats, which will effectively communicate the information.

When the Health Care Services assessment team identifies a member as Waiver-eligible, Moderate Risk, High Risk or in Long Term Care, they refer that member to the Case Management team who will conduct a Face-to-Face Comprehensive Needs Assessment (FCNA) within 30 days of being referred to Case Management. If Molina receives claims data from DHS on members prior to the enrollment date, the initial health risk screening process begins with risk stratification through predictive modeling software to assess members for care coordination services and special health care needs. Members are then stratified from low to high risk. This stratification process assists Molina staff in prioritizing outreach to identify any gaps in member care needs and ensuring a smooth transition.

When identified through claims data or predictive modeling, a member identified as Moderate Risk, High Risk, or in Long Term Care will receive a FCNA within 30 calendar days of effective enrollment. Findings from assessment(s) are utilized to create an Individualized Care Plan (ICP). Results of assessments and ICPs are shared with members, Interdisciplinary Care Team (ICT) participants, Primary Care Provider (PCP), and other stakeholders based on member's preference. All outreach efforts, as well as member consent to complete the initial screening is documented in Molina's electronic health management platform.

2. Submit a proposed initial health risk screening tool. Exhibits and attachments may be included.

See Attachment 9.1.1.2-1 Initial Health Risk Screening Tool for DHS review and approval. Molina's health risk screening tool collects information to assess members' physical, behavioral, social, functional and psychological status and needs to determine the need for care coordination, behavioral health services, or any other health or community services need. Molina's health risk assessment screening tool complies with NCQA standard for health risk screenings and contains questions that can tie to social determinants of health. Molina will submit initial and comprehensive assessments for DHS approval per contractual guidelines.

3. Describe the methods that you will use to determine whether changes in member health status warrant subsequent screening.

All Molina members receive at minimum an annual comprehensive assessment conducted by Molina's Healthcare Services Team. At that time, members receive an explanation about Care Management services and are encouraged to contact Molina for any concern, especially if there is a change in their health status or needs, to assist the member across healthcare and social support delivery systems. After a comprehensive assessment, Case Managers works members on a new or updated Individualized Care Plan (ICP) and HCBS service plan if appropriate. Members who might benefit from ongoing Case Management support and intervention are identified and encouraged to participate.

When members request or agree to participate in the Case Management program, Case Management contact is scheduled according to acuity and member needs. During times of care transition or health stabilization, Case Managers may make contacts weekly or biweekly or more often as necessary. The goal of Case Management intervention is to assist members towards stability where medical and behavioral health care and support services are in place. As member's health and service needs are met and stable, Case Management contacts can be further apart. Members are encouraged to contact their Case Manager at any time for any concern.

When Case Managers receive notification of emergency room use and/or hospitalization from claims data, providers and members, member outreach is attempted during the inpatient stay or within two (2) days of emergency room. Molina Case Managers deploy Transitions of Care protocol that will follow the member from admission, discharge planning and follow up, through 30 days after discharge home. Case Managers will ensure that the member understands the discharge recommendation regarding healthcare follow up appointments and testing, home health visits, physical therapy, dietary restrictions, medications changes and assist with removing any barriers members may face to achieving health goals after an acute event or change of health status. Case Managers will assess members for HCBS, caregiver and/or social needs that may have changed as a result of a change medical or behavioral health or functional status, and assist members in the process of obtaining needed services within a timeframe that maintains member health and safety.

4. Describe methods that you will use to maximize contacts with members in order to complete the initial screening requirements.

To maximize contacts with members in order to complete the initial screening requirements, Molina will make at least three outreach attempts to reach the member. The attempts are made at different times of the day and different days of the week and may include after-hours attempts, if necessary. For members with higher acuity or as appropriate, the contact attempt is an in-person visit deploying Molina Case Managers or Community Connector program staff. A letter providing Case Management program overview information, as well as details for member to contact Molina to conduct the Health Risk Assessment (HRA), along with a paper copy of the mailed HRA is sent to members when they are not able to be contacted via telephonic method and is considered part of the robust outreach efforts.

If the phone number is incorrect or disconnected, a staff member will check for additional entries of change of phone number or addresses in Molina's electronic health management platforms; contact the pharmacy utilized for updated information; contact the PCP or any other provider of care for updated phone number and/or address, and check any authorizations in place for new or updated information. We will also check with assigned caregivers for any member receiving services from Long Term Care Supports and Services (LTSS) or any agency worker or social worker whose contact information has been included among the member's Interdisciplinary Care Team. People Finder or any other Molina contracted external database programs that are available to Molina are utilized to research member's location and contact information.

Members that Molina has been unable to contact continue to be monitored for changes in health or functional status through quarterly review of utilization data that may assist in locating them for assessment and connection to their Molina single point of contact for ongoing needs.

9.1.2 Comprehensive Health Risk Assessment

1. Submit a proposed validated comprehensive health risk assessment tool. Exhibits and attachments may be included.

See Attachment 9.1.2.1-1 Comprehensive Health Risk Assessment Tool. The health risk assessment tool will be submitted to DHS for review and approval.

2. Propose the timeframe in which all comprehensive health risk assessments shall be completed after initial member enrollment.

The comprehensive health risk assessment for all new members will be completed within 90 days after member enrollment. Members, his/her family, caregivers or representative are immediately engaged in the

process through the initial telephonic comprehensive health assessment completed within the first 90 days of effective enrollment. This initial engagement includes education on the integrated care process that includes the Individualized Care Plan (ICP) and case management services that are available to the member. Member preferences for communication needs and provider participants are documented. Within the first 90 days, members will be stratified based on the use of a predictive modeling tool and surveillance data. The combination of the health risk assessment, behavioral health risk assessment and predictive modeling tool, along with feedback from the member, his/her family, caregivers or representative, and PCP, ensures that Molina has the appropriate information required to develop an ICP.

3. Describe how the assessment process will incorporate contact with the member and his/her family, caregivers or representative, healthcare providers and claims history.

When a member is identified as having special needs, Moderate to High Risk, multiple emergency room visits, or hospitalizations, or a need to follow-up on problem areas identified in the initial screening, the member is referred to Case Management. A face-to-face comprehensive healthcare needs assessment is conducted, as well as an assessment of the appropriateness of having the member evaluated for HCBS or Long Term Care. The assessment incorporates a review of the member's claims and diagnostic history, contact with the member and his/her family, caregivers or representative, contact with the member's health care providers and identification of the member's preferred Interdisciplinary Care Team (ICT). As an essential part of the assessment process, the Case Manager performs a lengthy onsite visit at the member's place of residence, if possible, to include an in-person evaluation of member's environment and mobility and to discuss options with the member. Case Managers assess the members' situation, discuss the member's goals, and promote services that allow the member to safely remain in the least restrictive setting. Case Managers, with input from ICT participants, gather knowledge of all of the service options available to members and, during the development of the Care Plan, will supply the member with a list of providers available for the chosen services.

Member preferences and decision-making participation are essential to Molina's Integrated Care Management model, as Molina is committed to assisting the member with achieving their individual goals of care. During the assessment process, Molina includes the member, his/her family, caregivers or representative, providers, and pertinent historical claims information in the Care Plan process, which supports both development and successful achievement of the member's Individualized Care Plan (ICP) goals. The member's needs and preferences, including cultural, literacy and religious components, are always considered when developing the ICP. The Case Manager also evaluates the member's readiness to change and to implement strategies to promote healthy lifestyle choices, including motivational interviewing techniques, self-management coaching and interventions and includes these interventions in the ICP.

Behavioral health and developmental/intellectual and related conditions and needs are also considered in the care plan development with member and member's parents/guardian and/or proxy. The Care Plan interventions and goals are stated in the member's own words. Case Managers are responsible for describing and offering choices to the member regarding least restrictive Home and Community Based Services. The comprehensive health risk assessment also includes an assessment of a member's need for assignment to a health home that meets all requirements of as described in Section 3.2.10 Chronic Condition Health Homes.

Members review the care plan choices and provide the Case Manager with input so that the member's decisions and choices are implemented and assist members in achieving their desired individual quality of life outcomes, such as, I decide where and with whom I live; I make decisions regarding my supports and services; I feel safe; I am free from abuse and neglect. Member's always have access to their Care Plan through Web Portal, which is accessible by members, providers, and caregivers with appropriate member consent. Members also have direct access to their Case Manager and may request a Care Team or Care

Plan review at any time. The Case Manager coordinates, facilitates, and monitors the plan; the PCP and other Care Team participants provide input, guidance, and adhere to the plan; but the member is the driver and primary decision maker of the plan.

9.1.3 Care Coordination

1. Describe in detail your proposed care coordination program including selection criteria and proposed strategies.

Molina's Care Coordination Program will coordinate and monitor care for all members of the Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa (*hawk-i*) programs identified as having a special health care needs. Case Managers and Interdisciplinary Care Teams will develop and adhere to evolving Individualized Care Plans to ensure members receive the right services in the right setting at the right time. Molina uses a person-centered approach to care, engaging and empowering members at every opportunity; assigning resources based on specific member needs; promoting self-care; and supporting physicians in developing and integrating care, and promoting medical home and health home models, as appropriate to maximize member health outcomes. Molina's Care Coordination Program will include catastrophic case management, disease management, programs to target members overusing and/or abusing services; discharge planning, and transition planning.

The goals of the Interdisciplinary Care Team are designed to keep members living in the community with increased independence; improve care delivery and health and functional outcomes; reduce health disparities across all populations; reduce costs by preventing unnecessary utilization; promote member autonomy; and improve transitions across all settings. Care Teams are established based on the member's stated preferences; specific physical, behavioral, social, and environmental needs; existing relationships; and staff capacity and expertise.

Molina's Care Management program activities start with its new member initial health risk screening assessment process to address physical health, behavioral health, LTSS needs and any gaps in care. If Molina receives claims data from DHS on members prior to the enrollment date, the new member assessment process begins with a risk stratification process through predictive modeling software. Members are then stratified from low to high risk. Members receiving waiver services and members residing in nursing facilities are also identified during this process. This stratification process assists Molina staff in prioritizing outreach to identify any gaps in member care needs and ensuring a smooth transition.

If appropriate, members are then assigned to a level of care according to their identified needs and complexity of care. A Case Manager is assigned to more complex members for further assessment, follow-up and Individualized Care Plan development, which addresses gaps in care and coordination of services (e.g., physical health, behavioral health, social and LTSS). Molina Case Managers work with the Interdisciplinary Care Team to ensure the Individualized Care Plan is a collaborative effort, addressing all identified member care needs and preferences.

Molina's Interdisciplinary Care Team consists of the member and/or their designated caregiver, the member's primary care physician (PCP), Molina Case Management staff including the Case Manager, additional Care Team participants, including Specialty Providers, Behavioral Health Providers and Community Connectors, based on each member's needs and preferences.

Catastrophic Case Management
Molina utilizes various proactive triggers for Care Management including Predictive Risk score information and health information technology resources, including predictive modeling, to help identify members for early intervention and participation in intensive case management.

Disease Management

The primary goal of Disease Management member intervention is to increase self-efficacy related to lifestyle changes for risk reduction and self-monitoring for the members' respective condition. In addition, each available service supports the provider by offering education and other resources to assist members in achieving optimal self-management knowledge and skills, including the importance of accessing regular primary care, creating a realistic treatment plan and adopting personal behavioral changes that contribute to optimizing healthy outcomes.

Molina's Disease Management interventions are supported at both the corporate and health plan level through its case management programs, which includes screening, education, data collection and reporting services. Disease Management is also incorporated throughout all levels of case management. This collaboration enables cost-effective centralized administrative functions while maximizing the availability of clinical staff to directly interact with members and their families and ensure access to and continuity of care. Molina will benefit from the experience and best practices of Molina's sister health plans, which collectively provide Disease Management services for Medicaid, Medicare and CHIP contracts in 11 states and the Commonwealth of Puerto Rico. The success of member engagement in Molina Disease Management programs is reflected in a consistently low opt-out rate of less than one percent.

Each Disease Management intervention is comprised of patient education delivered by experienced Case Managers; ongoing communication and collaboration with state-specific resources; and clinical case management and provider education using a collaborative team approach. Evidence-based, nationally recognized clinical practice guidelines form the foundation of all of Molina's Disease Management programs.

Determining Eligibility for Disease Management Programs

Members are identified for inclusion in Molina's Disease Management programs by reviewing internal sources of data each month, such as claims, encounter, pharmacy and 24-hour Nurse Advice Line data. Members may also be referred by Utilization Management staff, providers or themselves for evaluation. All members identified as eligible for participation are automatically enrolled and mailed an introductory welcome letter and program materials. Members are provided with the appropriate telephone numbers in the event they need additional information or have questions about the program. The Member Handbook and member newsletters also provide information about Molina's Disease Management programs. The member participates in the respective program for the duration of his or her eligibility with the plan's coverage or until the member opts out by requesting to be removed from the program registry.

Once a member is identified as a potential Disease Management program participant, he/she is risk-stratified based on internal sources of data and the member's response to a health risk assessment questionnaire included in the initial program mailing. Risk stratification results in assigning the member to one of four levels of care (low, moderate, high and intensive). Intensity of outreach and education increases for each subsequent stratification level. If at any time a member requires a higher level of care, a referral is made to Case Management.

Disease Management Programs

Molina offers several culturally appropriate Disease Management programs, including the following:

- **Cardiovascular Disease (Hypertension, Coronary Artery Disease, and Congestive Heart Failure)**. The *Heart Healthy Living* program is designed for adults who are active Molina members 18 years of age or older upon enrollment in the program.
- **Chronic Obstructive Pulmonary Disease**. The *Healthy Living with COPD* program is designed for adults who are active Molina members 35 years of age or older upon enrollment in the program.
- **Depression Care Management**. The *Depression Care Management* program is designed for adults 18 years of age or older participating in one or more of Molina's chronic disease management programs.

- **Schizophrenia Care Management**. Members identified with schizophrenia or other Severe and Persistent Mental Illness (SPMI) receive care coordination that is designed to be predominately individualized with contact made by a Case Manager they can come to trust.
- **Dementia Care Management**. Molina's *Dementia Care Management* program is designed for members with an identified diagnosis of dementia.
- **Diabetes**. The *Healthy Living with Diabetes* program is designed for children and adults who are Molina members with a confirmed diagnosis of diabetes (non-gestational and/or non-steroid-induced).
- **Asthma**. *Breathe with Ease* asthma program is designed for children and adults who are Molina members and at least two years of age upon enrollment in the program.

Molina will ensure that these programs meet the state and regulatory requirements specified by DHS to meet its goals and objectives.

Programs to Target Members Overusing and/or Abusing Services

Community Connectors are trained by Molina to serve as extenders for Case Managers and member navigators to provide education, advocacy and social support, and coordinate with the member's Interdisciplinary Care Team to deliver whole-person care with special emphasis on members who have a history of two or more inpatient hospital admission in the last six months and are struggling to manage chronic health conditions that place them at risk for utilization, such as CHF, diabetes, COPD/asthma and CAD.

Molina targets members who may be overusing and/or abusing services by recognizing the importance of reaching out to members with positive messaging that reinforces the benefits of utilizing primary care services. From the Welcome Call to contact with the Case Manager and Community Connectors, Molina makes every effort to ensure members understand how to contact their PCP and navigate the health care system. Molina's Case Managers and Community Connectors often work with members to help them prepare for their appointments by ensuring they have confidence to discuss their physical and behavioral health needs with their PCP. Molina also recognizes that a member's lack of knowledge about disease progression and prevention can contribute to Emergency Room use and avoidable hospitalizations; therefore, Molina administers wellness and prevention programs that are aimed at coaching members to have conversations with their PCPs about prevention and condition management to include topics such as immunizations (e.g., pneumovax, flu shot) and lifestyle changes (e.g., quitting smoking and weight loss, including special diets that are unique to the member's individualized needs and preferences).

Molina has implemented community-based intervention programs in its sister health plans that are aimed at decreasing inappropriate utilization of Emergency Rooms that have included collaborating with primary care centers to extend office hours, and supporting Community Health Workers programs that, in conjunction with Molina's Interdisciplinary Care Teams, can deliver whole-person care. Molina has successfully implemented these programs in New Mexico, a state where exceptionally high Emergency Room utilization is a challenge, and proposes to implement a similar program in its Iowa health plan.

Discharge Planning

During Concurrent Review, Molina implements appropriate discharge planning for members and facilitates a seamless transition to an appropriate setting. Molina's Utilization Management Care Review Clinicians collaborate with hospital staff and the member and his/her family/caregivers to create an appropriate discharge plan. They review the medical necessity and appropriateness for selected post-discharge services that may include home health care services, infusion therapy, durable medical equipment, skilled nursing facility placement, rehabilitative services, behavioral health intensive community-based case management, or substance abuse treatment.

2. Provide data on outcomes achieved in your care coordination programs operated in other states, if applicable.

Molina Healthcare of New Mexico

Integrated Care Management Approach for Members with Co-morbid Diabetes/SMI

Molina Healthcare of New Mexico recognized that a focus on population-specific, as well as regional needs is critical in the identification of locations or groups with the potential for improved outcomes, cost containment or cost reduction resulting from designations of Health Homes. For example, Molina Healthcare of New Mexico identified a population in North Central New Mexico with a high concentration of co-morbid diabetes and severe mental illness. Molina partnered with a community-based, culturally competent provider to develop an integrated approach to comprehensive care management and health education for this specific population. This partnership is an example of an approach to the designation of potential Health Home entities that targets areas of highest needs with the potential for greatest improvement.

Molina Healthcare of Michigan

Community Connectors Program

Molina Healthcare of Michigan implemented its Community Connectors Program as part of an objective analysis beginning in September 2013 using five Community Connectors to serve the greater Detroit region. The objective of the analysis was to compare the difference in member inpatient and Emergency Room utilization and Per Member Per Month (PMPM) cost of care before the member's first visit with a Community Connector and after the first visit. Molina Healthcare of Michigan's Community Connectors Program was designed to address needs that often impede members' ability to access appropriate and timely health care. Members are assigned a Community Connector for a variety of reasons, including the need for help with finding a PCP; assistance with housing needs; or help with connecting to community resources.

The intervention time period for this analysis was eight total months from September 2013 through April 2014. Molina collected data on pre-utilization up to six months prior to the first visit by the Community Connector and up to six months after the first visit. Members had, on average, five months of pre-intervention and five-months of post-intervention data available for the analysis. Michigan Community Connectors focused on members who had at least one pre-intervention inpatient or Emergency Room visit. Molina created a pre- and post-analysis, using members as their own control. The member's first visit date with a Community Connector was the member's indicator variable for the start of the Community Connector intervention. All visits and costs before the first visit were considered pre-intervention, and all visits and costs after the first visit were considered post-intervention. Molina computed the Wilcoxon signed rank for dependent populations to test for significant differences between pre-intervention and post-intervention PMPM Emergency Room cost of care; PMPM inpatient cost of care; and PMPM total cost of care. Finally, Molina estimated the total year cost avoidance, cost savings and return on investment for the program's first year of operation using estimations from the analysis.

Utilizing the sample of 144 members who had at least one inpatient or Emergency Room visit in the pre-intervention period, Molina calculated the one-sample paired signed-rank test and found that there was a significant difference for all of the cost of care values comparing the post-intervention to pre-intervention time period. The Community Connector Program resulted in a decrease of inpatient admissions and Emergency Room utilization and a significant and cost savings difference in per member cost of care for members who had received the intervention in its first year of operation. The total cost savings of the program for the first year was $194,816 or a 1.82 return on investment. This assessment, however, does not account for the potential increases in HEDIS scores or member satisfaction leading to sustained enrollment that also may have occurred due to the success of Community Connector member engagement. The success of the Community Connectors Program in the Detroit area has enabled Molina

Healthcare of Michigan to expand to other areas in the state of Michigan, and will allow for implementation of the program for dual eligible members once the demonstration has begun.

Molina Healthcare of Washington
The Washington Medicaid Integration Partnership Program (WMIP) was a Molina managed care pilot program, ending in June 2014, that provided coverage for Supplemental Security Income (SSI) or SSI-related Medicaid clients in Snohomish County who were 21 years of age or older. Members enrolled into WMIP received medical, mental health and chemical dependency services, and if they qualified, long-term care benefits. Molina Healthcare of Washington has deep understanding of the needs of the local population, and recognizing that Hispanics are the fastest-growing racial group in the county, increasing 124.7% between 2000 and 2010 and accounting for one-third of the county's population increase during this period, recruited multilingual staff; developed educational and informational resources in non-English languages; and developed appropriate tools for assisting and serving the growing Hispanic population, including facilitating culturally and linguistically appropriate screenings and assessments, referrals to culturally appropriate community providers, and working with partner agencies to ensure service providers (i.e., home care providers) were appropriate.

9.1.4 Risk Stratification

1. Describe your proposed risk stratification methodology.

Placing Members in Care Coordination Based on Assessed Level of Risk
Molina's methodology for risk stratification utilizes its Integrated Care Management model for care coordination, incorporating and addressing the unique needs of its members. Molina's risk stratification methodology provides a strategy to stratify members into one of four levels of care from highest to lowest risk, based on either historical data provided by the state prior to enrollment, and/or results of the member's initial health risk assessment. While members have different individual physical, behavioral, social, and environmental needs, Molina has designed its risk levels around the resources needed to serve each of these distinct needs. The participants, the frequency, follow-up, and the level of interaction will vary based on member needs and risk level, and may be adjusted with a change in member status.

2. Describe your proposed risk stratification levels.

Risk Stratification Levels – Case Management Levels

The intensity of interventions provided to members increases for each subsequent level of the Interdisciplinary Case Management program, which consists of four levels of care:

- Level 1 – Low Risk Health Management;
- Level 2 – Moderate Risk Case Management;
- Level 3 – High Risk Complex Case Management, and
- Level 4 – Intensive Risk Case Management.

If at any time, a member requires a different level of care, a reassessment of risk is conducted and a new plan is made for the administration of the appropriate level of interventions. The Case Management Program interventions ensure that the member and/or family/caregiver understand key self-management concepts, which include accessing primary care, medication reviews by providers and identification of lifestyle changes the member is willing and able to make, and have the resources to implement the concepts. All Case Management education is consistent with nationally accepted guidelines for the respective chronic condition or high-risk pregnancy, which has an intensive, nurse-led program that members are referred to upon identification as having a high risk pregnancy. Behavioral health, substance

abuse and long-term care case management approaches are integrated throughout all aspects of the program.

3. Describe how care would be managed for members in each risk stratification level.

Case Management for Members in each Risk Stratification Level

The four levels of Molina's Interdisciplinary Case Management program, and how care is managed for members in each risk stratification level is described below, including how Molina determines member eligibility for each level of care.

Level 1 – Low Risk Health Management

Level 1 – Health Management is focused on disease prevention and health promotion. It is provided for members whose lower acuity chronic conditions, behavior (e.g., smoking or missing preventive services) or unmet needs (e.g., transportation assistance or home services) put them at increased risk for future health problems. The goal of Health Management is to increase member knowledge, thereby empowering them to improve their health and access needed services. At this level, members receive educational materials via mail about how to improve lifestyle factors that increase the risk of disease onset or exacerbation. Topics covered include smoking cessation, weight loss, nutrition, exercise, hypertension, hyperlipidemia, and cancer screenings, among others. Members are given the option, if they so choose, to engage in telephone-based health coaching with Health Management staff, which includes nurses, social workers, dieticians, and health educators. Coaching may be delivered in conjunction with PCP goals that may include additional interventions and updates to the care plan, which the Case Manager will continually monitor and communicate to all involved entities.

The list below outlines the key triggers that result in a members' placement into Level 1 – Health Management. The triggers listed are not all inclusive. A member may be placed in this level based on other clinical needs or provider recommendation.

<u>Triggers for Level 1</u>

Member has one inpatient admission within the previous six consecutive months with specific conditions. Targeted diagnoses include:

- Asthma;
- Cancer;
- Cardiovascular;
- Chronic obstructive pulmonary disease (COPD);
- Congestive heart failure (CHF);
- Diabetes;
- Hepatitis C;
- Human Immunodeficiency Virus (HIV);
- Hypertension (HTN);
- Progressive Neuromuscular Disease; and
- Psychiatric Disorders (Anxiety Disorder, Major Depressive Disorder).

Level 2 – Moderate Risk Case Management

Level 2 Case Management is provided for members who have moderate-risk chronic illness requiring ongoing intervention. These services are designed to improve the member's health status and reduce the burden of disease through education and assistance with the coordination of care. The goal of Case Management is to collaboratively assess the member's unique health needs, create Individualized Care

Plans with prioritized goals, and facilitate services that minimize barriers to care for optimal health outcomes. Case Managers have direct telephonic access with members.

The list below outlines the key triggers that result in a members' placement into Level 2 – Case Management. The triggers listed are not all inclusive. A member may be placed in this level based on other clinical needs or provider recommendation.

Triggers for Level 2
Member has one or more diagnosis below with two hospital inpatient admission in the last six months.

Targeted diagnoses:
- Asthma;
- AIDS/HIV;
- Cancer;
- Cardiovascular Disease (CVD);
- Congestive heart failure (CHF);
- Chronic obstructive pulmonary disease (COPD);
- Diabetes;
- Hepatitis C;
- Human Immunodeficiency Virus (HIV);
- Hypertension (HTN);
- Progressive Neuromuscular Disease; and
- Psychiatric Disorders (Bipolar Disorder, Borderline Personality Disorder, Major Depressive Disorder, Substance Use Disorder, Schizophrenia/Schizoaffective Disorder, Posttraumatic Stress Disorder).

Level 3 – High Risk Complex Case Management
Level 3 – High Risk Complex Case Management is provided for members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the health care system to facilitate the appropriate delivery of care and services. This level of care includes intensive case management for members with special health care needs. The goal of Complex Case Management is to help members improve functional capacity and regain optimum health in an efficient and cost-effective manner. Comprehensive assessments of member conditions include the development of a case management plan with performance goals and identification of available benefits and resources. Case Managers monitor, follow-up and evaluate the effectiveness of the services provided on an ongoing basis. Complex Case Management employs both telephonic and face-to-face interventions. This level includes the use of Community Connectors to support Molina's most vulnerable members within their home and community to assist with social services access and coordination. Level 3 also include members who are receiving HCBS services and those residing in nursing facilities.

The list below outlines the key triggers that result in a members' placement into Level 3 – Complex Case Management. The triggers listed are not all inclusive. Other indicators will be considered as appropriate, including examination of durable medical equipment, pharmacy, inpatient and emergency department utilization. A member may be placed in this level based on other clinical needs or provider recommendation.

Triggers for Level 3
Member has one or more diagnosis below with three hospital inpatient admissions in the last six months and exhibits any of the following:

- Predictive modeling risk score and/or PRISM score indicating high risk;
- Pharmacy data indicating high risk;
- Five or more co-morbidities; and
- High-risk chronic illness with clinical instability as demonstrated by three or more admissions or six or more Emergency Department visits within a six month period;
- Targeted diagnoses:
  - Asthma;
  - Human Immunodeficiency Virus (HIV);
  - Cancer;
  - Cardiovascular Disease (CVD);
  - Congestive heart failure (CHF);
  - Chronic Obstructive Pulmonary Disease (COPD);
  - Hepatitis C;
  - Human Immunodeficiency Virus (HIV);
  - Hypertension (HTN);
  - Progressive Neuromuscular Disease;
  - Diabetes; and
  - Psychiatric Disorders (Bipolar Disorder, Borderline Personality Disorder, Major Depressive Disorder, Substance Use Disorder, Schizophrenia/Schizoaffective Disorder, Posttraumatic Stress Disorder).

Level 4 – Intensive Risk Case Management

Level 4 – Intensive Risk Case Management is provided for members at imminent risk for emergency department visit, an impatient admission or institutionalization. Level 4 also include members who are currently institutionalized but qualified to transfer to a home or a community setting. Level 4 is designed to focus high touch, high intensity resources aimed at keeping people in or moving people back to the community. Members who may be considered at high-risk for institutionalization include those facing imminent loss of their living situation; members with insufficient caregiver arrangements; members with deteriorating mental or physical conditions; or members with terminal illness. The Case Manager is the primary coordinator of HCBS services for Level 4 members, with support from the HCBS provider and Community Connector.

Triggers for Level 4

Member exhibits one or more diagnosis below; four or more hospital inpatient admissions in the last six months related to:

- Asthma;
- Cancer;
- Cardiovascular Disease (CVD);
- Chronic obstructive pulmonary disease (COPD);
- Congestive heart failure (CHF);
- Diabetes;
- Hepatitis C;
- Human Immunodeficiency Virus (HIV);

- Hypertension;
- Progressive Neuromuscular Disease; and
- Psychiatric Disorders (Bipolar Disorder, Borderline Personality Disorder, Major Depressive Disorder, Substance Use Disorder, Schizophrenia/Schizoaffective Disorder, Posttraumatic Stress Disorder).

9.1.5 Member Identification

1. Describe how you will identify members eligible for care coordination programs, including how the following strategies will be utilized:

a. Predictive modeling;

Molina utilizes evidenced-based, industry-standard predictive modeling tools that support consistently accurate risk assessment and stratification and supplement information gathered by Molina's Case Management staff through the initial risk screening and comprehensive health risk assessment process to allow Molina to identify members eligible for care coordination programs, and to place members according to risk category into one of four levels from highest to lowest risk. Members receiving waiver services, members residing in nursing facilities, and members with high risk pregnancy are also identified during this process. This stratification process assists Molina staff in prioritizing outreach to identify any gaps in member care needs and ensuring a smooth transition.

Predictive Modeling for Existing Members Using MEDai
As six months' worth of data becomes available, existing members' risk is re-evaluated on a monthly basis using MEDai, Molina's web-based predictive modeling software solution. MEDai helps to identify high-risk members and flag members for monitoring and enrollment in Case Management programs. Using claims, encounter, referral and authorization, pharmacy, assessments and other available data, MEDai analyzes information to provide clear direction for assigning resources and making decisions. All members identified as high-risk can then receive a Health Risk Assessment and be appropriately referred for Case Management, Disease Management, care coordination or other clinical programs. The MEDai predictive modeling application uses over 150 evidence-based guidelines measuring 26 clinical conditions to group members into appropriate risk levels. Risk score outputs include:

- **Forecasted Risk and Cost** – MEDai identifies members who are of highest risk, displays individual factors driving the risk, and prioritizes opportunities, including potential future cost and the likelihood of avoiding additional high-cost expenditures for recipients with chronic conditions. Also identified are members who appear to be low risk given their utilization or other data, but whose clinical history indicates a high probability of movement toward a higher risk level;
- **Acute and Chronic Impact Predictions** – Once Molina identifies high-risk, manageable members, MEDai's impact models assist in prioritizing and focusing intervention initiatives. Members at greatest risk for inpatient admissions or Emergency Department visits will have a different Case Management focus than those members with multiple chronic illnesses requiring assistance in improving or maintaining their compliance with prescribed care guidelines; and
- **Motivational Predictions** – These predictions can be used to further target the intervention initiative. Members with low motivation may have social, economic or behavioral problems that require a very different type of case management approach than members who are motivated to be active participants in their care, but may not know what to do.

b. Claims review;

Molina employs a highly coordinated and comprehensive system that identifies at-risk members who may

benefit from an integrated Case Management program that begins upon enrollment, or even prior to enrollment if key claims information is received on identified program beneficiaries. This identification occurs through an analysis of all available data, which may include claims data.

The methodology used by Molina's data analytics staff to analyze claims data to identify members who are in need of Case Management services and the level of Case Management needed, includes analyzing:

- Claims data to identify frequent Emergency Department use for services that could be more appropriately provided through outpatient facilities or community behavioral health resources;
- Claims data of high-risk pharmacy utilization such as failure to fill psychiatric medications, narcotic misuse, poly-pharmacy and off-label prescribing patterns; and
- Claims data of potentially misaligned treatments with diagnoses, such as in the prescription of an antidepressant without a mood disorder diagnosis. This may indicate that the PCP, or other non-psychiatric prescriber, may be focused on other physical treatment needs and prescribed the antidepressant as a secondary treatment. Such a case would require further investigation, assessment and follow-up.

c. Member and caregiver requests; and

Molina's Case Managers will work with members and family/caregivers, PCP, Community Connector, long-term care provider, behavioral health provider to coordinate services and ensure requests and member prefrences for physical and behavioral health needs are being met. This coordination will occur through the Interdisciplinary Care Team (ICT), meetings with the member and family/caregiver, and monthly direct follow-up by the Case Manager. Case Managers will update the Individualized Care Plan and continue to work with the member's family/caregivers, the assigned PCP to promote coordination with physical health care services. Coordination shall include communication of the Individualized Care Plan updates, medication management, LTSS services and needs, and progress among behavioral health providers, medical specialists, and long-term care providers; and assistance in making appointments, arranging transportation, and following up to ensure services are rendered as appropriate.

d. Physician referrals.

Post initial enrollment, referrals may be generated at any time from a PCP, specialist, facility staff, Community Connector, home health aide, member self-referral, or staff managing Molina's Nurse Advice Line, when needs are identified in the course of case management or other care coordination activities, or when a Case Manager sees a change in behavior and suspects a physical or behavioral health issue. Upon any such event, the Case Manager will conduct a re-assessment and initiate a referral as appropriate.

9.1.6 Care Plan Development

1. Describe in detail how person-centered care plans will be developed for each member.

Molina recognizes that the care of each member of Iowa Health and Wellness, and Healthy and Well Kids in Iowa (*hawk-i*) programs requires coordination of many services and providers across multiple disciplines to serve a member's unique physical, behavioral, social, and environmental needs. To ensure member's needs and services are well communicated and well-coordinated, person-centered Individualized Care Plans are developed to reflect the expressed needs and desires of members and their families/caregiver.

Development of Person-Centered Individualized Care Plans

Molina develops detailed person-centered Individualized Care Plans that include:

- Establishment of priorities of member's goals and necessary actions for members, Case Managers and other Interdisciplinary Care Team (ICT) members;
- Identification of barriers in communication and care coordination;
- Facilitation of seamless transitions between care settings;
- Creation of a communication plan with providers and members; and
- Monitoring of whether the member is receiving the recommended care, in the necessary time frame, in the less restrictive setting.

Individualized Care Plans are based on the findings of the initial health risk screening, comprehensive health risk assessment, and available medical records to ensure that care for a member is adequately coordinated and appropriately managed and member is engaged in their own care. The Individualized Care Plan also incorporates input from ICT participants; aligns care planning and interventions with program goals around wellness, prevention, evidence-based management of chronic conditions and care coordination with the goals of empowering member to maintain their treatment goals, address any functional and social/caregiver deficits, retain the highest level of independence possible in their home and community setting, and reflect member expectations and member's understanding of provider expectations.

The Case Manager schedules a Care Team conference, which includes the member/caregiver, and presents the draft Care Plan for review, improvement, and approval. The team discusses steps toward success: clear assignment of roles and responsibilities; milestones; timelines; commitment by all parties; and goals, interventions, and outcomes that are aligned with the individual member's needs, valued as important, fully understood, achievable, and measurable. The Case Manager finalizes the Care Plan based on this input and enters the plan into Molina's electronic health management platform Clinical Care Advance for easy monitoring and tracking.

2. Describe how the care plan development process will be individualized and person-centered.

Individualized person-centered Care Plan development and modification starts with the member's input. The Case Manager will discuss the member's goals and preferences, as well as physical, behavioral, social, environmental, and cultural needs during the comprehensive assessment, when identifying and arranging appropriate services, and throughout the ongoing Care Plan process. The Care Plan contains these member approved goals and objectives and specific interventions tailored to the members' stated needs and preferences. Care Team staff are specifically selected around the member's needs to ensure the appropriate expertise and resources are represented. Community Connectors may be included to help articulate the member's needs, in particular, their social, environmental, and cultural needs, and to help design appropriate interventions. The Case Manager is ultimately responsible for ensuring that member's needs are accurately identified and ultimately met to ensure positive health outcomes, enhanced access, enhanced quality and safety, improved care delivery, and improved member satisfaction.

3. Describe how the care plan development process will incorporate findings of the initial health risk screening, comprehensive health risk assessment, medical records and other sources.

Development of the person-centered Individualized Care Plan begins with incorporating findings of the initial health risk screening, comprehensive health risk assessment, medical records and other available sources to develop Care Plans for all members eligible for the care coordination program.

Molina's assessment strategy accomplishes two goals: (1) rapidly identify high-risk members, and (2) assign all members into the appropriate level of care management to ensure that they receive services in an efficient and effective manner. Molina screens all new members upon enrollment followed by a more

comprehensive assessment based on individual needs. Using monthly state eligibility data, Molina's Integrated Care Management staff initiates the assessment process with an initial telephonic screening. Molina's screening assessment evaluates a member's functional status and immediate service needs, and identifies those at risk for institutionalization. An evidenced-based predictive modeling tool is used to supplement this information and group members into one of four levels from highest to lowest risk.

When identified as moderate or high risk or with urgent needs or gaps in care, members are referred for a comprehensive health assessment to be completed by the Case Manager within ninety (90) days of enrollment. Molina's comprehensive health assessment tool exceeds NCQA requirements and was approved by CMS as part of a Dual Eligibles/Special Needs Program (SNP) filing. The predictive modeling and assessment tools draw on multiple sources of data (medical and pharmacy claims, encounters and services information, electronic health records, member demographics and enrollment history, provider history, prior member assessments, electronic visit verification for HCBS, case management notes, disease registries, lab results, referral data) and input from members, family/caregivers, Interdisciplinary Care Team participants and the community.

A critical component of the assessment is the member's functional status including activities of daily living (ADLs) and instrumental ADLs (IADLs). Environmental assessments identify home modifications needed to improve safety or access for all Level 3 and 4 members and other members as needed. Molina uses Tablet technology to gather information that can readily be shared with everyone involved in the member's care. The Tablet provides easy remote access to data about the member such as claims, pharmacy, lab results, past assessments, visit logs and current Care Plan information. The Case Manager reviews all information to determine if additional assessment is needed, following stratification protocols and engaging the member and caregiver to help in the development and successful implementation of the Care Plan. To promote home and community-based care and foster independence, members who will benefit receive in-home assessments of their mobility, home safety, history of falls, ADLs, IADLs, diet, skin condition, medication compliance and/or screenings for dementia, mental health, and substance use.

4. Submit a sample care plan for each proposed risk stratification level.

Molina has submitted a sample care plan for each risk stratification level. For a sample care plan for each risk stratification level refer to Attachment 9.1.6.4-1 Sample Level 1 Care Plan; Attachment 9.1.6.4-2 Sample Level 2 Care Plan; Attachment 9.1.6.4-3 Sample Level 3 Care Plan; and Attachment 9.1.6.4-4 Sample Level 4 Care Plan.

5. Describe how you will ensure that there is a mechanism for members, their families and/or advocates and caregivers, or others chosen by the member, to be actively involved in the care plan development process.

Development of the Individualized Care Plan includes the involvement of the member, their families and/or advocates and caregivers, or others chosen by the member to establish the members' personal health care goals and living situation, the medical, behavioral health and service provider care necessary to achieve the member's goals.

Case Managers applies the results of the comprehensive health assessment to the drafting of the member-specific Care Plan. The Case Manager schedules an Interdisciplinary Care Team conference, which includes a multidisciplinary team of qualified health care professionals including specialists caring for the member, the member/caregiver, and presents the Care Plan for review, improvement, and approval. The team discusses steps toward success: clear assignment of roles and responsibilities; milestones; timelines; commitment by all parties; and goals, interventions, and outcomes that are aligned with the individual member's needs, valued as important, fully understood, achievable, and measurable. The Case Manager

finalizes the Care Plan based on this input and enters the plan into Clinical Care Advance for easy monitoring and tracking.

6. Describe how you will identify other caseworkers to be included in the care plan process and how services will be coordinated to avoid duplication and/or fragmentation of services.

Molina Case Managers utilize the Interdisciplinary Care Team (ICT) comprised of other caseworkers to ensure the Individualized Care Plan is a collaborative effort, addressing all identified member care needs and preferences. The role of the ICT is to integrate all participants who provide care to the member including primary care, specialty care, behavioral health, and referrals to, and coordination of community-based resources, as appropriate to ensure there is no duplication and/or fragmentation of services for members. ICT meetings allow the Case Manager to present concerns to a wide range of peers and collaborators, including other Case Managers and Community Connectors whose experience and knowledge can be accessed for the member in focus.

7. Indicate how you will ensure that clinical information and the care plan is shared with the member's PCP (if applicable) or other significant providers.

After the development of the Care Plan and any Care Plan updates, the Case Manager uses Clinical CareAdvance system that stores all clinical information, to produce the Care Plan and share it with the PCP, or other significant providers, and the member based on their stated preference. Clinical Care Advance directly feeds the Web Portal, which permits a member or provider to generate their own copy of the Care Plan at any time and Care Plans can always be provided to members and providers by any Molina Care Management staff upon request.

8. Describe how cultural considerations of the member would be accounted for in the care planning process and how the process will be conducted in plain language and accessible to members with disabilities or limited English proficiency.

The cultural and linguistic considerations of a member are integrated into the Individualized Care Plan (ICP). As many of the populations Molina serves are culturally diverse, understanding that health education needs and utilization of preventive care and chronic care/self-management services is often impacted by cultural health beliefs and practices is central to the provision of person-centered care and critical to Molina's Integrated Care Management model. Molina has the experience and resources needed to address diverse populations and utilizes culturally competent and best practice approaches to accommodate the cultural and linguistic diversity of its members. Cultural competency is embedded in the training required of all Molina employees.

Using the language that the member uses to describe their conditions, concerns and goals of care is written into the member's ICP as a standard practice of Case Managers. Care Plans are developed in plain language that is easily understood by members, as are educational materials provided to members. Molina also provides and maintains 24-hour access to oral and interpreter services for members whose primary language is not English. This includes all medical and non-medical points of contact. Providers are informed about the language requirements and resources available. Care Plans are made accessible to members who have disabilities and/or have limited English proficiency.

The Case Manager will discuss the member's cultural needs during the comprehensive assessment, when identifying and arranging appropriate services, and throughout the ongoing Care Plan process. The Care Plan contains member -approved goals and objectives and specific interventions tailored to the member's stated needs and preferences. Interdisciplinary Care Team members are specifically selected around the member's needs and stated preferences to ensure the appropriate expertise and resources are represented.

Community Connectors may be included to help articulate the member's needs, in particular, their cultural needs, and to help design appropriate interventions.

9. Describe how the proposed care plan process will include a system to monitor whether the member is receiving the recommended care.

The Case Manager is ultimately responsible for ensuring that member's needs are accurately identified and ultimately met to ensure positive health outcomes, enhanced access, enhanced quality and safety, improved care delivery, and improved member satisfaction. The ICP is updated with the details of interventions and education to document successfully completed goals, as well as new and outstanding goals remaining the ICP. It is also important for the Case Manager to give feedback to the member and educate as much as possible to promote member empowerment in all aspects of care. Encouragement and holding the member accountable for follow-through are important interventions of the Case Manager and Community Connector.

Case Managers work closely with members in the development of the Care Plan and monitors progress to achieve the mutually agreed-upon goals. The member's preferences, including cultural and religious, are always considered when developing the Care Plan. The Case Manager evaluates the member's readiness to change and implements strategies to promote healthy lifestyle choices. Behavioral health needs are considered in implementing the Care Plan and behavioral health goals are stated in the member's own words. Case Managers are responsible for describing and offering choices to the member regarding least restrictive Home and Community Based Services.

The Case Manager collaborates with the member upfront to ascertain and implement a consistent, mutually beneficial mode of communication. This can include home visits, phone, fax, Web Portal or other social media. To ensure person-centered care, the primary conduit of information between the member and the health care system is the Case Manager. This is critical so that feedback can be received from the member in terms of any complications, service issues or unmet expectations with the Care Plan.

9.1.7 Tracking and Reporting

1. Describe how you propose to track and report on care coordination programs and share care coordination information with the member, authorized representative and treatment providers.

Molina tracks and produces reports on care coordination programs using its Clinical CareAdvance system, and through the Interdisciplinary Care Team and the Provider and Member Web Portals, shares care coordination information with the member, authorized representative and treatment providers. Clinical CareAdvance provides the ability to identify specific members who need preventive care or who may benefit from specialized programs such as Disease Management, Care Coordination, or Case Management, including Behavioral Health and Long Term Care Case Management.

Clinical CareAdvance mines the data on a schedule and identifies members based on programmed algorithms that include such clinical data as diagnoses and procedures. Data obtained from these methods can be shared with the member, family/caregiver, and all authorized representative and treatment providers, including behavioral health providers; primary care providers; specialists, and the Interdisciplinary Care Team. Based on this data, Molina designs and implement many tailored outreach programs to offer disease education and self-management programs to our members, as well as reminders for preventative care and referrals to LTSS evaluation.

Molina's Care Management Team is provided with a systematic and objective means to monitor, measure, and evaluate the care, services, to facilitate positive member outcomes at both the individual level and the systemic level in Clinical CareAdvance. Clinical CareAdvance integrates all systems

relating to Care Coordination, Case Management, Disease Management, Claims history, and Utilization Management functions, providing the integrated information sharing among appropriate staff.

Clinical CareAdvance provides the Care Management team with comprehensive health monitoring and reporting tools; Case Manager alerting; real-time member identification and stratification; customized real-time statistics and reports; and outbound communication methods tailored to the member.

This total integration benefits members and providers when discussing issues relating to appropriate care and services. Molina documents information obtained from providers, members, Care Coordination, Case Management, Disease Management, and Utilization Management data, in the Clinical CareAdvance system. Member adherence is documented in the appropriate secure health management data platform.

2. Describe the system that you will use to integrate and share information about members in order to facilitate effective care coordination.

Molina uses Clinical CareAdvance to integrate and share information about members in order to facilitate effective care coordination. The Clinical CareAdvance System is a web-based integrated platform for performing Case and Disease Management. It enables a member-centric view for clinical users by aggregating data from variety of sources such as predictive modeling risk scores, claims, pharmacy, lab, etc. Clinical users can leverage sophisticated criterion to identify and stratify 'at risk' members, generate guidelines-based Care Plans, perform health risk assessments, and track and document member interaction. Clinical CareAdvance is highly configurable and can be customized easily to add new assessments, forms, letters etc. using the content editor tool.

9.1.8 Monitoring

1. Describe your care coordination monitoring strategies.

Molina continuously monitors its Care Coordination program on an ongoing basis to enhance and improve its Care Coordination services. The foundation of Molina's success in helping members attain improved health outcomes is based on the efforts of its Case Management team. Case Management and support staff develop and coordinate individualized care through initial health risk screening and comprehensive assessments, and continuous monitoring of member's needs. To meet the distinct social and medical needs of its culturally diverse members, Molina's highly skilled and experienced staff of RN's, LPN's and Social Workers focus on the cultural and language obstacles of its populations and offers programs proven to increase access and utilization of services that promote preventive care and healthy life styles. In order to support members in incremental changes toward managing their disease, Case Management staff uses motivation interviewing techniques to collaborate with enrollees in setting self-management goals.

2. Describe how case specific findings will be remediated.

Health Care Services staff perform continuous monitoring of service delivery, and members' adherence to the Individualized Care Plan and treatment plan goals. Any findings that occur during the course of this monitoring will be addressed as expeditiously as the members' needs warrant, either through the Interdisciplinary Care Team, or through direct contact with the member, caregiver, Primary Care Physician, specialists or other medical providers involved with the members care.

9.1.9 Reassessments

1. Describe in detail your process for reviewing and updating care plans.

Molina reviews and updates Individualized Care Plans with all members at a minimum of annually and based on an automatic annual comprehensive healthcare needs assessment. Members who participate in Case Management or are followed by a Case Manager due to LTSS need or NSF placement are followed on a schedule based on level of care or as needed. And, for members who experience a hospitalization, a Transition of Care protocol is started with the member receiving support and assistance from admission to 30 days post-discharge.

As an example of how a Case Manager prioritizes needs and schedules member contact; for members who are assessed as requiring Complex Case Management due to three or more inpatient admissions in the last six months, and one or more diagnoses of chronic conditions, such as COPD/asthma, CHF, AIDS or schizophrenia, they are contacted weekly or biweekly as necessary. This allows the Case Manager to provide support to the member and to assist with provider appointments, treatment and medication changes, Interdisciplinary Care Team meetings and provision of home health and/or HCBS with the goal of stabilization of members' health status and care. With stabilization, the member can be moved to a lower level of care and case management contact and support continuing, but on a monthly, quarterly or as appropriate basis.

Care Teams, including members and providers, are actively involved any time there is a Care Plan review or change. Care Plans are evaluated periodically by the Care Team based on a routine schedule and upon a transition in care or change in member health status as identified by the Case Manager to determine if their present care levels are adequate as members may move between stratified levels of care groups over time as their needs change. The Case Manager leads the review and revision of the Care Plan based on these evaluations and provides an updated copy to all parties based on stated preferences. All members of the Care Team have access to the Care Plan at any time through the Web Portal. Molina ensures members or providers can request a reassessment at any time.

2. Describe the protocol that you will use for re-evaluating members to determine if their present care levels are adequate.

To re-evaluate members to determine if their present care levels are adequate, the Care Management Team analyzes utilization data and Molina's predictive modeling software (MEDai). Levels of care are re-evaluated on a monthly basis as soon as six months' worth of data becomes available. If member utilization data indicate the onset of a serious condition, or worsening of an existing condition the assigned Case Manager will consult with Molina's Interdisciplinary Care Team to evaluate and establish greater levels of care.

This risk score indicates the appropriate healthcare services staff assignment for further outreach and follow up for the individual member. Members may also be assessed for appropriate risk stratification by referrals from providers, community agencies and other Molina staff.

If, at any time a member requires a different level of care, a reassessment of risk is conducted and a new plan is made for the administration of the appropriate level of interventions. Reassessments are performed upon any change in status or care setting, or routinely as defined by the member's risk level, as well as the automatic annual reassessment. Care Plans and risk scores are updated as required, and at a minimum annually.

The intensity of interventions provided to members increases for each subsequent level of the Interdisciplinary Case Management program, which consists of four levels of care: Level 1 – Low Risk; Level 2 – Moderate Risk; Level 3– High Risk/Complex Case Management, and Level 4–Intensive Risk.

3. Indicate the triggers which would immediately move the member to a more assistive level of service.

Molina utilizes various proactive triggers which would immediately move the member to a more assistive level of service for Care Management including Predictive Risk score information and health information technology resources, including predictive modeling, to help identify members for early intervention who may become catastrophic cases. All significant change events are addressed as timely as possible to ensure facilitating the resolution of the member's concerns.

Level of Care criteria includes review of a member's utilization data and number of chronic disease diagnoses from a list of conditions identified as having a high risk potential for utilization. For example, if a member has had two or more inpatient admission in the last six months and has a diagnosis of one or more conditions, such as CHF, COPD/asthma, diabetes, HTN, this member is identified as someone who may benefit from Case Management participation and Interdisciplinary Care Team collaboration at a moderate. If a member has had four or more inpatient admissions in six months and has a diagnoses of one or more of the chronic conditions that continue to put this member at high risk for utilization, this member will be referred for Intensive Case Management with immediate Case Manager and Interdisciplinary Care Team involvement and in-person assessment.

MOLINA HEALTHCARE

Telephonic Health Risk Assessment (THRA)

Member Name: **Responder's Name:** **Relationship to Member:** **Member Healthcare ID:** **DOB:** **State:**	**Home Phone: ( )** **Cell Phone: ( )** **Other: ( )** **DATE: / /**

	QUESTION	RESPONSE
COMMUNICATION/ CULTURAL NEEDS/ GENERAL		
1	Do you or a covered family member have a language need other than English?	☐Yes ☐No
1A	If yes, choose language:	☐Arabic ☐Mandarin ☐Russian ☐Somali ☐Spanish ☐Vietnamese ☐Other Other:
2	Do you have a healthcare power of attorney or legal guardian? If yes, specify name and phone number:	☐Yes ☐No
3	Do you have any hearing, vision, cultural, religious, spiritual or language needs that medical community providers need to be aware of to provide appropriate care and information to you? If yes, describe:	☐Hearing ☐Language ☐Religion/Spiritual ☐Vision ☐None ☐Other
4	Which provider/physician(s) do you see most frequently? (indicate name and specialty and/or PCP)?	
5	When was the date of your last visit? (list provider name and date)	
6	Can you get a ride to the doctor's office or clinic if needed? If no describe:	☐Yes ☐No ☐Not Sure
7	Other than yourself, would you like your caregiver or any other individual involved in discussions about your care? If yes, who?	☐Yes ☐No
COGNITIVE SCREENING		
8	Do you have any trouble with your memory?	☐Yes ☐No
9	Now I'm going to ask you a few basic questions. What is the year? What is the month? What is the day of the week?	 Correct: ☐Yes ☐No Correct: ☐Yes ☐No Correct: ☐Yes ☐No
10	I am going to name 3 objects. Please wait until I say all 3 words, then you repeat them. Please remember what the 3 objects are because I am going to ask you to name them again later. Apple Table Car	 Recall: ☐Yes ☐No Recall: ☐Yes ☐No Recall: ☐Yes ☐No

MOLINA HEALTHCARE

Telephonic Health Risk Assessment (THRA)

HEALTH & WELLNESS		
11	Do you/your child have any of these conditions? If other, list/describe:	☐ Amputation ☐ Asthma ☐ Cancer ☐ Coronary Artery Disease ☐ Congestive Heart Failure ☐ COPD (Chronic Obstructive Pulmonary Disorder) ☐ Developmental Delay ☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ HIV/AIDS ☐ Kidney Disease ☐ Major Depression ☐ Major Organ Transplant ☐ Malnutrition ☐ Behavioral Health Issues Describe: (i.e., Schizophrenia, Bipolar, PTSD, ADHD, autism) ☐ Paralysis ☐ Pregnancy ☐ Seizure Disorder ☐ Sickle Cell ☐ Stroke ☐ Substance Use ☐ None
11A	If other, list/describe:	
12	What is your most recent weight?	☐ Pounds ☐ Kilograms DATE
13	What is your height?	☐ Inches ☐ Centimeters
14	BMI Calculation Results:	CALCULATION PRE POPULATES
15	Compared to others your (your child's) age, would you say your (your child's) health is…..	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
16	What is your main health concern right now?	
17	What were the 3 objects I asked you to remember? Apple Table Car	Recall: ☐ Yes ☐ No Recall: ☐ Yes ☐ No Recall: ☐ Yes ☐ No **Two "No" answers above? Add cognitive screening needed to individualized care plan at end of THRA.**
18	Have you (your child) had any of the following screenings?	☐ Adolescent/Child Immunization ☐ Breast Cancer Screening ☐ Colorectal Cancer Screening ☐ Diabetes Eye Exam ☐ Glaucoma ☐ Lead Screening in Children ☐ One provider visit in the last year ☐ Well Child Visit ☐ None ☐ Other
18A	If other, list/describe:	
19	How many times have you (your child) visited the ER in the last 6 months?	☐ Less than 2 visits ☐ 3-5 visits ☐ 6 visits or more ☐ None

MOLINA HEALTHCARE

Telephonic Health Risk Assessment (THRA)

	Reason for Visit:	
20	How many times have you (your child) been admitted to the hospital in the last 6 months? Reason for visit:	☐ 1 admission ☐ 2 admissions ☐ 3 – 4 admissions ☐ 5 admissions or more ☐ None
21	Do you have pain?	☐Yes ☐No
21A	If yes, rate your pain on a 1-10 scale (10 worst).	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
21B	If yes, do you have a pain management plan?	☐Yes ☐No
MEDICATION INFORMATION		
22	Do you take 6 or more prescribed medications per day?	☐Yes ☐No ✔ **(Yes- plus 3 chronic diagnosis in red above qualifies mbr for MTMP scheduling at the end of the THRA)**
23	Do you have any allergies to medications?	☐Yes ☐No
23A	If yes, describe reactions:	
24	Do you take your medications as prescribed?	☐Yes ☐No
24A	Do you understand what your medications are for and why you are taking them?	☐Yes ☐No
24B	Plan to address adherence issues:	☐ Provider member with education ☐ Sent member education materials ☐ Scheduled MTMP appointment
25	Do you use tobacco?	☐Yes ☐No
25A	If Yes, would you like help quitting?	☐Yes ☐No ✔ **If Yes, refer to Molina Smoking Cessation program.**
SOCIAL		
26	What is your current living situation?	☐Homeless ☐Lives alone ☐Lives in a group home ☐Lives in a shelter ☐Lives with other family ☐Lives with others unrelated ☐Lives with spouse ☐Lives in assisted living fac. ☐In a Nursing Facility ☐ None of the above
27	Are you **receiving** assistance with any of the following activities: **includes eating, toileting, transferring*	☐**Bathing** ☐Dressing ☐Housekeeping ☐**Personal Care/Hygiene** ☐**Preparing Meals** ☐Setting up medications ☐Shopping ☐None ☐**Adult Day Services** ☐Other **Response 1,4,5, or 9 will qualify mbr for LTSS referral at end of THRA.**
28	Do you **need** assistance with any of the following? (same options) **includes eating, toileting, transferring* If other, please list/describe	☐Bathing ☐Dressing/Putting on clothes ☐Toileting ☐Hygiene/Grooming ☐Maintaining Continence ☐Eating/Feeding yourself ☐Walking and transferring (such as moving from bed to wheelchair ☐Other ☐None
29	Do you **need** assistance with any of the following?	☐Managing finances ☐Transportation ☐Shopping

MOLINA HEALTHCARE

Telephonic Health Risk Assessment (THRA)

	If other, please list/describe	☐ Preparing Meals ☐ Using the telephone or help with other communication devices ☐ Managing your medications ☐ Housing/home maintenance/housekeeping ☐ Other ☐ None
30	Are you using the following equipment or assistive devices? If other, list/describe:	☐ Cane ☐ C-pap or Bi-pap ☐ Elevated toilet seat ☐ Glucometer ☐ Home vent ☐ Hospital bed ☐ Nebulizer ☐ Oxygen ☐ Scooter ☐ Suctioning ☐ Shower chair ☐ Walker ☐ Wheelchair ☐ None ☐ Other
31	Do you have a living will or an advanced directive in place? **(If no, provide explanation on what an advanced directive is and how to obtain.)**	Living will ☐ Yes ☐ No Advanced directive ☐ Yes ☐ No If no, enter the date when you provided explanation on what an advanced directive is and how to obtain: DATE ☐ Request further information ☐ Declined discussion
32	Over the last 2 weeks, how often have you had little interest or pleasure in doing things?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
33	Over the last 2 weeks, how often have you been feeling down, depressed or hopeless?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
34	Have you ever been worried about how you are thinking, feeling or acting?	☐ Yes ☐ No
35	Has anyone ever expressed concerns about how you were thinking, feeling, or acting?	☐ Yes ☐ No
36	Have you ever harmed yourself or thought about harming yourself?	☐ Yes ☐ No
PARTICIPATION		
37	We have programs that can help you feel more confident in your ability to manage your (your child's) health. Are you interested in receiving any of our care coordination services? Would you like to work with a member of our team? Please rate your desired level of involvement in the care planning process:	 ☐ Yes ☐ No ☐ Actively Managed ☐ Mail only ☐ Monitoring

Telephonic Health Risk Assessment (THRA)

Schedule MTM appt now via Outlook Calendar

LTSS referral to health plan Case Management team.

Complete Individual Care Plan

Remember to add cognitive screening in care plan for applicable members.

MOLINA HEALTHCARE

Telephonic Comprehensive Needs Assessment (TCNA)

Member Name: **Responder's Name:** **Relationship to Member:** **Member Healthcare ID:** **DOB:** **State:**	**Home Phone: ( )** **Cell Phone: ( )** **Other: ( )** **Date: / /**

QUESTION		RESPONSE
Hello this is _____ with Molina. I am hoping to talk with you today about your health and see how you are doing. Do you have a few minutes that we could talk?		
COMMUNICATION/ CULTURAL NEEDS/ GENERAL		
1.	Do you or a covered family member have a language need other than English?	☐Yes ☐No
1a.	If yes, choose language:	☐Arabic ☐Russian ☐Mandarin ☐Somali ☐Spanish ☐Vietnamese ☐Other Other:
2.	Do you have a healthcare power of attorney or legal guardian? If yes, specify name and phone number:	☐Yes ☐No
3.	Do you have any hearing, vision, cultural, religious or language needs that medical community providers need to be aware of to provide appropriate care and information to you? If other, describe:	☐ Hearing ☐ Language ☐ Religion/spiritual ☐ Vision ☐ None ☐ Other

PLEASE LIST PROVIDERS:

Provider Name	Specialty	Phone Number	Date of Last Appointment	Date of Upcoming Appointment

4.	Which physician(s) do you see most frequently? (indicate name and specialty and/or PCP)?	
5.	When was the date of your last visit? (list provider name and date)	Click here to enter a date.
6.	Can you get a ride to the doctor's office or clinic if needed? If no describe:	☐Yes ☐No ☐Not sure
7.	Are you able to understand instructions from and communicate needs to your provider or caregiver?	☐Yes ☐No ☐Does not have a caregiver
8.	Do you have a living will or an advanced directive in place? **(If no, provide explanation on what an advanced directive is and how to obtain.)**	Living will ☐Yes ☐No Advanced directive ☐Yes ☐No ☐Request further information

MOLINA HEALTHCARE

Telephonic Comprehensive Needs Assessment (TCNA)

		☐Declined discussion If no, enter the date when you provided explanation on what an advanced directive is and how to obtain: DATE
9.	Other than yourself, would you like your caregiver or any other individual involved in discussions about your care? If yes, who?	☐Yes ☐No
COGNITIVE SCREENING		
10.	Do you have any trouble with your memory?	☐Yes ☐No
11.	Now I'm going to ask you a few basic questions about your memory. What is the year? What is the month? What is the day of the week?	 Correct: ☐Yes ☐No Correct: ☐Yes ☐No Correct: ☐Yes ☐No
12.	I am going to name 3 objects. Please wait until I say all 3 words, then you repeat them back to me. Please remember what the 3 objects are because I am going to ask you to name them again later. Apple Table Car	 Recall: ☐Yes ☐No Recall: ☐Yes ☐No Recall: ☐Yes ☐No
HEALTH & WELLNESS - GENERAL		
13.	Compared to others your (your child's) age, would you say your (your child's) health is…..	☐Excellent ☐Very Good ☐ Good ☐Fair ☐Poor
14.	What is your main health concern right now?	
15.	What were the 3 objects I asked you to remember? Apple Table Car	 Recall: ☐Yes ☐ No Recall: ☐ Yes ☐ No Recall: ☐Yes ☐No **Two "No" answers above? Add cognitive screening needed to individualized care plan at end of THRA.**
16.	Do you/your child currently have or have a history of any of these conditions? **What is your surgical history?**	☐ Amputation **Include diagnosis year for CCM** ☐ Asthma ☐ Breast Cancer ☐ Cancer ☐ Coronary Artery Disease ☐ Congestive Heart Failure ☐ COPD (Chronic Obstructive Pulmonary Disorder) ☐ Developmental Delay ☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ HIV/AIDS ☐ Kidney Disease ☐ Major Depression ☐ Major Organ Transplant ☐ Malnutrition

MOLINA HEALTHCARE

Telephonic Comprehensive Needs Assessment (TCNA)

		☐ Behavioral Health Issues (Schizophrenia, Bipolar, PTSD, ADHD, Autism) ☐ Paralysis ☐ Pregnancy ☐ Seizure Disorder ☐ Sickle Cell ☐ Stroke ☐ Substance Use ☐ None ☐ Other
16a.	If other, list/describe:	
HEALTH & WELLNESS – MEDICATION & SCREENING		
17.	Do you take 6 or more prescribed medications per day?	☐Yes **Do you take any past relevant medications? (CCM Only)** ☐No
18.	Do you have any allergies to medications?	☐Yes ☐No

PLEASE LIST MEDICATIONS:

Prescribed Medication	Dose	Route	Frequency	Start Date	Stop Date	Reason for Medication

Over the Counter Medication	Dose	Route	Frequency	Start Date	Stop Date	Reason for Medication

Vitamins/ Supplements Herbals	Dose	Route	Frequency	Start Date	Stop Date	Reason for Medication

19.	Are you taking your medications as prescribed?	☐Yes ☐No
19a.	If no, which ones?	
19b.	If no, what is preventing you from taking your medication as prescribed by your physician?	☐Cost, ☐Scheduling, ☐Side Effect, ☐Transportation, ☐Understanding, ☐Visual Problems, ☐None, ☐Other If Other, list/describe:
19c.	If No, plan to address adherence issues:	☐Provided member with education ☐Sent educational materials ☐Scheduled MTMP appointment
	Do you understand what your medications	☐Yes

MOLINA HEALTHCARE

Telephonic Comprehensive Needs Assessment (TCNA)

	are for and why you are taking them?	☐No
20.	Do you use tobacco?	☐Yes ☐No
20a.	If Yes, would you like help quitting?	☐Yes ☐No ✔ **If Yes, refer to Molina Smoking Cessation program.**
20.	Have you (your child) had any of the following screenings?	☐ Adolescent/Child Immunization ☐ Breast Cancer Screening ☐ Colorectal Cancer Screening ☐ Diabetes Eye Exam ☐ Glaucoma ☐ Lead Screening in Children ☐ One provider visit in the last year ☐ Well Child Visit ☐Influenza ☐Pneumonia ☐ None (Support member with scheduling appt as needed) ☐ Other
20a.	If other, list/describe:	
HEALTH & WELLNESS – UTILIZATION & PAIN MANAGEMENT		
21.	How many times have you (your child) visited the ER in the last 6 months? Reason for Visit:	☐ Less than 2 visits ☐ 3-5 visits ☐ 6 visits or more ☐ None
22.	How many times have you (your child) been admitted to the hospital in the last 6 months? Reason for visit:	☐ 1 admission ☐ 2 admissions ☐ 3 – 4 admissions ☐ 5 admissions or more ☐ None
23.	Do you have pain?	☐Yes ☐No
23a.	If yes, where is your pain located?	
23b.	If yes, rate your worst pain on a 1-10 scale (10 worst).	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
23c.	If yes, do you have a pain management plan?	☐Yes ☐No
23d.	How much of the time have you experienced pain or hurting over the last 5 days?	☐Almost constantly ☐Frequently ☐Occasionally ☐Rarely ☐Unable to answer
24e.	Over the past 5 days, has pain made it hard for you to sleep at night?	☐No ☐Yes ☐Unable to answer
24f.	Over the past 5 days, have you limited your day-to day activities because of pain?	☐No ☐Yes ☐Unable to answer
25.	Have you fallen any time in the last 2-6 months?	☐No ☐Yes ☐Unable to remember
25a.	If yes, did you have any fractures or injuries related to a fall in the last 6 months?	☐No ☐Yes ☐Unable to remember
HEALTH & WELLNESS – WEIGHT & DIET		
26.	What is your weight?	☐pounds ☐kilograms Date:
27.	What is your height?	☐inches ☐centimeters

MOLINA HEALTHCARE

Telephonic Comprehensive Needs Assessment (TCNA)

28.	BMI Calculation	CALCUALTION AUTO POPULATES
29.	Do you have any problems with the following?	☐Loss of liquids/solids from mouth when eating or drinking ☐Holding food in mouth/cheeks or residual food in mouth after meals ☐Coughing or choking during meals or when swallowing medications ☐Complaints of difficulty or pain with swallowing ☐None of the above
30.	Have you lost weight in the last few months?	☐Yes ☐No ☐Unsure
30a.	If Yes, how much?	☐Less than five pounds ☐Five to ten pounds ☐Ten pounds or more
30b.	If yes, was the weight loss on purpose?	☐Yes ☐No
31.	Have you gained weight in the past few months?	☐Yes ☐No
31a.	If yes, how much?	☐Less than five pounds ☐Five to ten pounds ☐Ten pounds or more
31b.	Was the weight gain on purpose?	☐Yes ☐No
32.	Are you on a special diet for medical reason?	☐Yes ☐No
32a.	If Yes, check any or all:	☐Calorie supplement ☐Low fat/cholesterol ☐Low salt/sodium ☐Low sugar/carb ☐Other
32b.	If Other, please describe:	
32c.	How long have you been on this diet?	
32d.	Why are you on this diet?	
33.	Do you have any problems that make it hard for you to chew or swallow?	☐Yes ☐No
33a.	If yes, check any or all:	☐Mouth/tooth/dentures ☐Pain or difficulty swallowing ☐Taste ☐Nausea ☐Saliva production ☐Other
33b.	If other, please describe:	
HEALTH & WELLNESS – OTHER CONDITIONS		
34.	Do you have any problems with vision?	☐Blindness ☐Cataracts ☐Glaucoma ☐Macular degeneration ☐Required glasses or assistive devices to read ☐Retinal disease ☐Unable to read medications and/or large font ☐Uses Braille ☐None ☐Other
34a.	If other, list/describe:	
35.	Do you have any problems with hearing?	☐Deafness ☐Hearing aid

MOLINA HEALTHCARE

Telephonic Comprehensive Needs Assessment (TCNA)

		☐Hearing loss ☐Inactive hearing aid ☐Other amplification device ☐Requires TTY ☐Uses American Sign Language ☐None ☐Other
35a.	If other, list/describe:	
36.	Do you have any problems with your bladder such as urinary leakage or getting to the bathroom quickly enough?	☐Always continent ☐Occasionally continent (less than 7 episodes of incontinence) ☐Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) ☐Always incontinent (no episodes of continent voiding) ☐N/A (member has catheter, urinary ostomy, or no urine output for the last 7 days)
36a.	If so, have you talked your doctor about treatment options?	☐ Yes ☐ No Please describe:
37.	Do you have any problems with your bowels such as getting to the bathroom quickly enough for bowel movements?	☐Always continent ☐Occasionally continent (One episode of bowel incontinence) ☐Frequently incontinent (Two or more episodes of bowel incontinence, but at least one continent bowel movement) ☐Always incontinent (no episodes of continent bowel movements) ☐N/A (member had ostomy, or no bowel movement for the last 7 days)
37a.	If so, have you talked your doctor about treatment options?	☐ Yes ☐ No Please describe:
38.	Do you have problems with constipation?	☐Yes ☐No
39.	Do you have any skin problems (e.g. rashes, wounds, burns or skin tears) that are slow to heal?	☐Yes ☐No
40.	Are you experiencing any problems with balance when doing the following:	
	a. Moving from seated to standing position?	☐Steady at all times ☐Not steady, but able to stabilize without human assistance ☐Not steady, only able to stabilize with human assistance
	b. Walking (with assistive device if used)?	☐Steady at all times ☐Not steady, but able to stabilize without human assistance ☐Not steady, only able to stabilize with human assistance
	c. Turning around and facing the Opposite direction when walking?	☐Steady at all times ☐Not steady, but able to stabilize without human assistance ☐Not steady, only able to stabilize with human assistance
	d. Moving on and off the toilet?	☐Steady at all times ☐Not steady, but able to stabilize without human assistance ☐Not steady, only able to stabilize with human assistance
	e. Surface to surface transfer (transfer between bed and chair or wheelchair)	☐Steady at all times ☐Not steady, but able to stabilize without human assistance ☐Not steady, only able to stabilize with human assistance
SOCIAL		
41.	What is your current living situation?	☐Homeless ☐Lives alone

MOLINA HEALTHCARE

Telephonic Comprehensive Needs Assessment (TCNA)

		☐Lives in a group home ☐Lives with other family ☐Lives with spouse ☐In a Nursing Facility ☐Lives in a shelter ☐Lives with others unrelated ☐Lives in assisted living fac. ☐Other
41A.	If other, please describe:	
42.	Is your living situation at risk (loss of housing, domestic violence, dangerous neighborhood):	☐Yes ☐No If yes, please explain:
43.	Over the last 2 weeks, how often have you been feeling down, depressed or hopeless?	☐Not at all ☐Several days ☐More than half the days ☐Nearly every day
44.	Over the last 2 weeks, how often have you had little interest or pleasure in doing things?	☐Not at all ☐Several days ☐More than half the days ☐Nearly every day
ADLs/IADLs		
43.	Are you **receiving** assistance with any of the following activities: **includes eating, toileting, transferring*	☐**Bathing** ☐Housekeeping ☐**Preparing Meals** ☐Shopping ☐**Adult Day Services** ☐Other ☐Dressing ☐**Personal Care** ☐Setting up medications ☐None ☐Finances **Response 1,4,5, or 9 will qualify mbr for LTSS referral at end of THRA**
44.	Do you **need** assistance with any of the following? (same options) **includes eating, toileting, transferring* *If other, please list/describe:*	☐Bathing ☐Toileting ☐Maintaining Continence ☐Walking and transferring (such as moving from bed to wheelchair ☐Other ☐None ☐Dressing/Putting on clothes ☐Hygiene/Grooming ☐Eating/Feeding yourself
45.	Do you **need** assistance with any of the following? If other, please list/describe	☐Managing finances ☐Shopping ☐Preparing Meals ☐Using the telephone or help with other communication devices ☐Managing your medications ☐Housing/home maintenance/housekeeping ☐Other ☐None
46.	Are you using the following equipment or assistive devices?	☐Cane ☐Glucometer ☐ebulizer ☐Suctioning ☐C-pap or Bi-pap ☐Home vent ☐Oxygen ☐Shower chair ☐Elevated toilet seat ☐Hospital bed ☐Scooter ☐Walker

MOLINA HEALTHCARE

Telephonic Comprehensive Needs Assessment (TCNA)

	If other, list/describe:	☐Wheelchair ☐None ☐Other
PARTICIAPTION		
47.	We have programs that can help you feel more confident in your ability to manage your (your child's) health. Are you interested in receiving any of our care coordination services? Would you like to work with a member of our team? Please rate your desired level of involvement in the care planning process:	 ☐Yes ☐No ☐Actively Managed ☐Mail only ☐Monitoring

What goals would you like to set and work on to improve your overall health? How would you prioritize these goals? (High, Med, Low)

We will hold an ICT meeting to review your case and make sure that all of your needs are being met, would you like to attend this or would you like me to discuss the outcome with you after the meeting?

Molina Healthcare Inc

Individualized Care Plan Report
Level 1

Assigned Case Manager:

Kelly G.	[888-562-5442 x 000]
Michelle H.	[8885625442 x 311762]
William B.	[8885625442 x 316018]

Member Details:

Member Last Name:	DOO	Member First Name:	SCOOBY
Member Middle Initial:	E	Date Of Birth:	01/01/1212
Medicaid ID:	1780610335	Medicare ID:	
Medicaid Effective Date:	01/01/2078	Medicare Effective Date:	
Current Acuity Level:	Low		
Gender:	M	Primary Language:	ENGLISH
Primary Phone:		Home Phone:	8642254262 ext Unkn
Mobile Phone:			
Current Mailing Address:	111 East Rocky Road Lane APT 1R SLC, UT 84111		
E-Mail Address:			
Caregiver / Representative:	Not Applicable	Contact Phone:	
Relationship To Member:			

Associated Providers (past 6 months):

Doctor, Fun E.

Reason for Recent Health Visits/ Tests and/or Diagnosis History:

DX Date	DX Code	Description
01/13/2014	250.0	Diabetes mellitus without mention of complication

Recent Authorizations (past 6 months):

No authorization.

No lab data.

Assessments (past 6 months):

No assessment.

Molina Healthcare Inc

Individualized Care Plan Report
Level 1

Enrollment in Inpatient / Outpatient Facilities (past 6 months):

No enrollment in Inpatient/Outpatient facility.

Allergies:

No allergy

Medications / Rx (past 6 months):

Date	Physician	Medication	Refill Status
5/29/2014	Doktor, Fuhn E.	Metformin HCL 500mg BID	Filled: 5/30/2014; 2-refill remaining

Individual Care Plan (ICP) Goals, Barriers, Interventions & Outcomes:

Type	Description	Priority	Due Date
Problem: Newly enrolled D-SNP member			
Goal [Short-term]	Member will have telephonic health risk assessment completed to determine special needs, missing preventive services, need for disease specific educational materials and for stratification to case management if needed.		11/19/2014
Intervention	CM to contact member on 11/25/14 as requested by member on initial phone contact.		11/25/2014
Outcome	Mr. Doo will demonstrate compliance in completing Health risk assessment and will be assigned to case manager as appropriate for education and coordination.		11/25/2014
Barriers	Member has a cell phone with limited minutes.		11/25/2014

Molina Healthcare Inc

Individualized Care Plan Report
Level 1

Member Consent:

No Member Consent.

Telephone Assistance:

If you have any questions or concerns about your membership or current coverage, please call 1-888-562-5442, Monday-Sunday from 7:00 AM to 6 PM PST. If you are hearing impaired, please call TTY/TDD at 1-877-688-9891 to assist you with your call.

If you have trouble accessing the member portal, please call 1-866-449-6848.

If you have any questions or concerns about recent medical/health issues, please call 1-888-275-8750 or TTY/TDD at 1-866-735-2929. (Español: 1-866-648-3537; TTY/TDD 1-866-833-4703.)

If you have any questions or concerns about the information on this plan of care or the services you're receiving, please call your case manager.

----- END OF REPORT -----

Molina Healthcare Inc

Individualized Care Plan Report
Level 1

SIGNED ACKNOWLEDGEMENT AND RECEIPT OF INDIVIDUALIZED CARE PLAN

On behalf of member SCOOBY DOO, the Individualized Care Plan (dated 10/20/2014) has been fully reviewed between the following case manager and the member (or their authorized representative or designated caregiver). A copy of this Individualized Care Plan will be made available to the member and/or their authorized representative or designated caregiver.

Signature of Member or Authorized Representative

Member/Representative Signature Date

Print Name of Member or Authorized Representative

If Authorized Representative, declare Relationship to Member

Signature of Case Manager

Case Manager Signature Date

Print Name of Case Manager

[Optional to use unless required by contract provisions and/or state regulations]

Molina Healthcare Inc

Individualized Care Plan Report

Reminders for Doctor Appointments:

A visit with your doctor is a chance for you to let him/her know:

1. How you feel.
2. Share your family's health history.
3. Your list of medications (current and past).
4. Discuss any health concerns you may have.

Things you can do ahead of time in order to have a successful visit:

1. Call ahead and get an appointment.
2. Let them know if you need an interpreter. We need at least three days' notice to get an interpreter for you.
3. Make a list of all your questions and needs.
4. Bring a list of your medications.
5. If you cannot keep your appointment, please call your doctor's office to re-schedule.

At your appointment:

1. Try to get to your doctor's office about 15 minutes early. You may need to fill out paperwork.
2. Tell your doctor your concerns and symptoms as best as you can.
3. If you did not understand something your doctor said, be sure to ask questions.
4. Please try to be patient if your doctor is running late. He/she may have a very sick patient that needs extra time.
5. Sometimes your doctor may have an emergency. They may have to go to the hospital to take care of another patient. This can happen with doctors that deliver babies. You may be given the option of seeing another doctor at the office.
6. Your doctor may refer you to a specialist or other health care provider. Be sure to ask if you will need to make the appointment. Sometimes your doctor's office will make it for you. Ask for the phone number of the other doctor's office before you leave.

Confidential Protected Health Information:
This document contains confidential protected Health Information that is protected under HIPAA and other applicable federal and state laws. This information is intended only for use by the Authorized User or entity to which it has been disclosed. Any unauthorized use or disclosure of this information should be reported to Molina Healthcare's privacy Hotline.

Molina Healthcare Inc

Individualized Care Plan Report
Level 2

Assigned Case Manager:

Kelly G.	[888-562-5442 x 000]
Michelle H.	[8885625442 x 311762]
William B.	[8885625442 x 316018]

Member Details:

Member Last Name:	DOO	Member First Name:	SCOOBY
Member Middle Initial:	E	Date Of Birth:	01/01/1212
Medicaid ID:	1780610335	Medicare ID:	
Medicaid Effective Date:	01/01/2078	Medicare Effective Date:	
Current Acuity Level:	High		
Gender:	M	Primary Language:	ENGLISH
Primary Phone:		Home Phone:	8642254262 ext Unkn
Mobile Phone:			
Current Mailing Address:	111 E ROCKY ROAD LANE APT 1R SLC, UT 84111		
E-Mail Address:			
Caregiver / Representative:	Not Applicable	Contact Phone:	
Relationship To Member:			

Associated Providers (past 6 months):

No associated provider.

Reason for Recent Health Visits/ Tests and/or Diagnosis History:

DX Date	DX Code	Description
01/13/2014	250.0	Diabetes Mellitus without complications

Recent Authorizations (past 6 months):

No authorization.

No lab data.

Assessments (past 6 months):

No assessment.

Molina Healthcare Inc

Individualized Care Plan Report
Level 2

Enrollment in Inpatient / Outpatient Facilities (past 6 months):

No enrollment in Inpatient/Outpatient facility.

Allergies:

No allergy

Medications / Rx (past 6 months):

Date	Physician	Medication	Refill Status
8/28/2014	Doktor, Fhun E.	Metformin HCL 500mg BID	Filled: 8/28/2014;
8/28/2014	Doktor, Fhun E.	Humulin R 0.5 to 0.8 unit/kg/day	Filled 8/28/14

Individual Care Plan (ICP) Goals, Barriers, Interventions & Outcomes:

Type	Description	Priority	Due Date
Problem: Knowledge of Insulin management			
Goal [ShortTerm]	Member understands the administration of insulin		11/19/2014
Intervention	Care manager will reinforce education on insulin types, prescribed dosage and administration		11/19/2014
Outcome	Member will demonstrate compliance of medication regimen as evidenced by improved blood glucose levels as seen on his daily blood sugar log		11/19/2014
Barrier	Has not accepted the need diagnosis/ condition		11/19/2014

Molina Healthcare Inc

Individualized Care Plan Report
Level 2

Type	Description	Priority	Due Date
Self-management goal	Member will follow recommended diet		10/20/2015
Intervention	Care manager will refer/coordinate care to dietitian as needed		01/18/2015
Intervention	Care manager will reinforce education regarding diet		10/20/2015
Outcome	Member will follow ADA diet as evidenced by improved HgbA1C, 6 or below and also maintaining a BMI of 24.0		02/17/2015
Barrier	Has not accepted the need for change		02/17/2015
Problem: Coordination			
Goal [LongTerm]	Member's care will be coordinated between all disciplines		01/18/2015
Intervention	Care manager will coordinate all aspects of members care		01/18/2015
Outcome	Members care plan reflects care coordination		01/18/2015

Member Consent:

No Member Consent.

Telephone Assistance:

If you have any questions or concerns about your membership or current coverage, please call 1-888-562-5442, Monday-Sunday from 7:00 AM to 6 PM PST. If you are hearing impaired, please call TTY/TDD at 1-877-688-9891 to assist you with your call.

If you have trouble accessing the member portal, please call 1-866-449-6848.

If you have any questions or concerns about recent medical/health issues, please call 1-888-275-8750 or TTY/TDD at 1-866-735-2929. (Español: 1-866-648-3537; TTY/TDD 1-866-833-4703.)

If you have any questions or concerns about the information on this plan of care or the services you're receiving, please call your case manager.

----- END OF REPORT -----

Molina Healthcare Inc

Individualized Care Plan Report
Level 2

SIGNED ACKNOWLEDGEMENT AND RECEIPT OF INDIVIDUALIZED CARE PLAN

On behalf of member SCOOBY DOO, the Individualized Care Plan (dated 10/20/2014) has been fully reviewed between the following case manager and the member (or their authorized representative or designated caregiver). A copy of this Individualized Care Plan will be made available to the member and/or their authorized representative or designated caregiver.

Signature of Member or Authorized Representative

Member/Representative Signature Date

Print Name of Member or Authorized Representative

If Authorized Representative, declare Relationship to Member

Signature of Case Manager

Case Manager Signature Date

Print Name of Case Manager

[Optional to use unless required by contract provisions and/or state regulations]

Molina Healthcare Inc

Individualized Care Plan Report

Reminders for Doctor Appointments:

A visit with your doctor is a chance for you to let him/her know:

1. How you feel.
2. Share your family's health history.
3. Your list of medications (current and past).
4. Discuss any health concerns you may have.

Things you can do ahead of time in order to have a successful visit:

1. Call ahead and get an appointment.
2. Let them know if you need an interpreter. We need at least three days' notice to get an interpreter for you.
3. Make a list of all your questions and needs.
4. Bring a list of your medications.
5. If you cannot keep your appointment, please call your doctor's office to re-schedule.

At your appointment:

1. Try to get to your doctor's office about 15 minutes early. You may need to fill out paperwork.
2. Tell your doctor your concerns and symptoms as best as you can.
3. If you did not understand something your doctor said, be sure to ask questions.
4. Please try to be patient if your doctor is running late. He/she may have a very sick patient that needs extra time.
5. Sometimes your doctor may have an emergency. They may have to go to the hospital to take care of another patient. This can happen with doctors that deliver babies. You may be given the option of seeing another doctor at the office.
6. Your doctor may refer you to a specialist or other health care provider. Be sure to ask if you will need to make the appointment. Sometimes your doctor's office will make it for you. Ask for the phone number of the other doctor's office before you leave.

Confidential Protected Health Information:
This document contains confidential protected Health Information that is protected under HIPAA and other applicable federal and state laws. This information is intended only for use by the Authorized User or entity to which it has been disclosed. Any unauthorized use or disclosure of this information should be reported to Molina Healthcare's privacy Hotline.

Molina Healthcare Inc

Individualized Care Plan Report
Level 3

Assigned Case Manager:

Kelly G. [888-562-5442 x 000]

Michelle H. [8885625442 x 311762]

William B. [8885625442 x 316018]

Member Details:

Member Last Name:	SCOOBY	Member First Name:	DOO
Member Middle Initial:	E	Date Of Birth:	01/01/1212
Medicaid ID:	1780610335	Medicare ID:	
Medicaid Effective Date:	01/01/2078	Medicare Effective Date:	
Current Acuity Level:	High		
Gender:	M	Primary Language:	ENGLISH
Primary Phone:		Home Phone:	8642254262 ext Unkn
Mobile Phone:			
Current Mailing Address:	111 East Rocky Road Lane APT 1R SLC, UT 84111		
E-Mail Address:			
Caregiver / Representative:	Not Applicable	Contact Phone:	
Relationship To Member:			

Associated Providers (past 6 months):

No associated provider.

Reason for Recent Health Visits/ Tests and/or Diagnosis History:

DX Date	DX Code	Description
01/13/2014	196.0	NEOP, MLIG, LYMPH HEAD/NECK/FACE
01/24/2014	196.0	NEOP, MLIG, LYMPH HEAD/NECK/FACE
01/24/2014	199.1	NEOP, MLIG, NOS
02/25/2014	285.9	ANEMIA NOS
01/24/2014	311	DISORDER, DEPRESSIVE NEC

Recent Authorizations (past 6 months):

No authorization.

No lab data.

Assessments (past 6 months):

No assessment.

Molina Healthcare Inc

Individualized Care Plan Report
Level 3

Enrollment in Inpatient / Outpatient Facilities (past 6 months):

No enrollment in Inpatient/Outpatient facility.

Allergies:

No allergy

Medications / Rx (past 6 months):

Date	Physician	Medication	Refill Status
8/28/2014	DOKTOR, FUHN E.	CEPHALEXIN CAP 500 MG (30)	Filled: 8/28/2014;
8/28/2014	DOKTOR, FUHN E.	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG (20)	Filled: 8/28/2014;
7/25/2014	DOKTOR, FUHN E.	LEVETIRACETAM TAB 1000 MG (60)	Filled: 7/28/2014;
7/25/2014	DOKTOR, FUHN E.	VENLAFAXINE HCL CAP SR 24HR 75 MG (BASE EQUIVALENT) (30)	Filled: 7/25/2014;
5/29/2014	DOKTOR, FUHN E.	ZOLPIDEM TARTRATE TAB 10 MG (30)	Filled: 5/29/2014; 5-refill remaining
5/29/2014	DOKTOR, FUHN E.	ZOLPIDEM TARTRATE TAB 10 MG (30)	Filled: 7/9/2014; 4-refill remaining
5/29/2014	DOKTOR, FUHN E.	ZOLPIDEM TARTRATE TAB 10 MG (30)	Filled: 8/13/2014; 3-refill remaining
5/29/2014	DOKTOR, FUHN E.	ZOLPIDEM TARTRATE TAB 10 MG (30)	Filled: 9/23/2014; 2-refill remaining

Individual Care Plan (ICP) Goals, Barriers, Interventions & Outcomes:

Type	Description	Priority	Due Date
Problem: Waiver Service Plan			
Goal [Short-term]	Mr. Doo has a back-up plan in the event the personal care attendant does not arrive to help him with his shower		11/19/2014
Intervention	If personal care attendant does not arrive to assist with bi-weekly shower, Mr. Doo will notify Daughter Velma Dinkley at 800-123-1234 to assist		11/19/2014
Outcome	Mr. Doo has a copy of the back-up plan on the fridge and can tell daughter and CM what it is		11/19/2014
Goal [Short-term]	Mr. Doo has an emergency response plan in the event there is an environmental emergency that puts him at risk for harm		11/19/2014
Intervention	Care Manager assists member in developing an emergency response plan		11/19/2014
Intervention	Care Manager reviews the emergency response plan with the member every 6 months		04/18/2015
Outcome	Mr. Doo has a copy of the emergency response/disaster preparedness form		11/19/2014
Goal [Short-term]	Level of Care criteria is reviewed and Mr. Doo is financially eligible for waiver		12/19/2014

Molina Healthcare Inc

Individualized Care Plan Report
Level 3

Type	Description	Priority	Due Date
Intervention	The care manager ensures the Level of Care determination is received from the LOC Assessment completed by waiver service coordinator (Area Agency on Agency)		11/19/2014
Outcome	The member meets the state's Level of Care criteria to receive services		12/19/2014
Goal [Long-term]	The member will receive ongoing monitoring for additional interventions for safety or unmet needs and satisfaction with service plan and providers		10/20/2015
Intervention	Care manager will update the service plan as needed		01/18/2015
Intervention	Member will receive ongoing monitoring for potential abuse, neglect, exploitation and other incidents		10/20/2015
Intervention	Care manager completes face-to-face visits with member every 90 days and as needed for any significant changes in health/functional status		11/19/2014
Outcome	The member is safe and maintaining their current level of health and functional status		02/17/2015
Outcome	Member's service plan is meeting the member's needs and he expresses satisfaction with services and providers		02/17/2015
Problem: TOC			
Goal [Long-term]	Mr. Doo will be made aware of and follow his doctor's instructions when he leaves the hospital		01/18/2015
Intervention	Care Manager will review all instructions with Mr. Doo		01/18/2015
Outcome	Mr. Doo will repeat back the instructions		01/18/2015
Problem: Substance Use with other conditions			
Goal [Short-term]	Mr. Doo will stay Sober "to see his grand-kids"		12/19/2014
Intervention	Care Manager will give Mr. Doo resources to help him stay on path (these providers specialize in substance use)		12/19/2014
Intervention	Care Manager will educate member/family on effect of alcohol on disease process in the elderly population		12/19/2014
Outcome	Mr. Doo attended alcohol counseling class or AA meeting		12/19/2014
Outcome	Member recited one (1) complication related to alcohol consumption		12/19/2014
Problem: Knowledge of Diabetes Management			
Goal [Short-term]	Mr. Doo understands his diabetes		12/19/2014
Intervention	Care Manager will refer to Diabetic Education class		12/19/2014
Intervention	Care Manager will educate member on correlation between (Diabetes Blood Test) HgbA1C and blood sugar levels		12/19/2014
Intervention	Care Manager will facilitate notification to treating practitioner of potential health care or safety issues		12/19/2014
Outcome	Member able to teach back the ABC's of diabetes		12/19/2014
Outcome	Member able to teach back risk factors that contribute to diabetes		12/19/2014
Outcome	Member able to teach back the consequences of uncontrolled diabetes		12/19/2014
Outcome	Member able to teach back correlation between HgbA1C & blood sugar and interventions to improve		12/19/2014

Molina Healthcare Inc

Individualized Care Plan Report
Level 3

Type	Description	Priority	Due Date
Outcome	Member has completed educational classes		12/19/2014
Problem: Bathroom Safety			
Goal [Short-term]	Member will make immediate simple changes in bathroom to improve safety (bath bench/ Shower Hose)		11/19/2014
Intervention	Care Manager will order Home Safety Equipment		11/19/2014
Outcome	Member is able to teach back reasons for us safety modifications in bathroom		11/19/2014

Service Plan:

Date	Expense Type	Units/Visits	Cost per Unit/Visit	Total
10/20/2014	Personal Care services	10	$64.00	$640.00
10/20/2014	Home Medical Equipment	1	$110.00	$110.00
10/20/2014	Home Medical Equipment	1	$28.00	$28.00
			SUM	$778.00

Member Consent:

No Member Consent.

Telephone Assistance:

If you have any questions or concerns about your membership or current coverage, please call 1-888-562-5442, Monday-Sunday from 7:00 AM to 6 PM PST. If you are hearing impaired, please call TTY/TDD at 1-877-688-9891 to assist you with your call.

If you have trouble accessing the member portal, please call 1-866-449-6848.

If you have any questions or concerns about recent medical/health issues, please call 1-888-275-8750 or TTY/TDD at 1-866-735-2929. (Español: 1-866-648-3537; TTY/TDD 1-866-833-4703.)

If you have any questions or concerns about the information on this plan of care or the services you're receiving, please call your case manager.

----- END OF REPORT -----

Molina Healthcare Inc

Individualized Care Plan Report
Level 3

SIGNED ACKNOWLEDGEMENT AND RECEIPT OF INDIVIDUALIZED CARE PLAN

On behalf of member SCOOBY DOO, the Individualized Care Plan (dated 10/20/2014) has been fully reviewed between the following case manager and the member (or their authorized representative or designated caregiver). A copy of this Individualized Care Plan will be made available to the member and/or their authorized representative or designated caregiver.

Signature of Member or Authorized Representative

Member/Representative Signature Date

Print Name of Member or Authorized Representative

If Authorized Representative, declare Relationship to Member

Signature of Case Manager

Case Manager Signature Date

Print Name of Case Manager

[Optional to use unless required by contract provisions and/or state regulations]

Molina Healthcare Inc

Individualized Care Plan Report

Reminders for Doctor Appointments:

A visit with your doctor is a chance for you to let him/her know:

1. How you feel.
2. Share your family's health history.
3. Your list of medications (current and past).
4. Discuss any health concerns you may have.

Things you can do ahead of time in order to have a successful visit:

1. Call ahead and get an appointment.
2. Let them know if you need an interpreter. We need at least three days' notice to get an interpreter for you.
3. Make a list of all your questions and needs.
4. Bring a list of your medications.
5. If you cannot keep your appointment, please call your doctor's office to re-schedule.

At your appointment:

1. Try to get to your doctor's office about 15 minutes early. You may need to fill out paperwork.
2. Tell your doctor your concerns and symptoms as best as you can.
3. If you did not understand something your doctor said, be sure to ask questions.
4. Please try to be patient if your doctor is running late. He/she may have a very sick patient that needs extra time.
5. Sometimes your doctor may have an emergency. They may have to go to the hospital to take care of another patient. This can happen with doctors that deliver babies. You may be given the option of seeing another doctor at the office.
6. Your doctor may refer you to a specialist or other health care provider. Be sure to ask if you will need to make the appointment. Sometimes your doctor's office will make it for you. Ask for the phone number of the other doctor's office before you leave.

Confidential Protected Health Information:
This document contains confidential protected Health Information that is protected under HIPAA and other applicable federal and state laws. This information is intended only for use by the Authorized User or entity to which it has been disclosed. Any unauthorized use or disclosure of this information should be reported to Molina Healthcare's privacy Hotline.

Molina Healthcare Inc

Individualized Care Plan Report
Level 4

Assigned Case Manager:

Kelly G. [888-562-5442 x 000]

Michelle H. [8885625442 x 311762]

William B. [8885625442 x 316018]

Member Details:

Member Last Name:	DOO	Member First Name:	SCOOBY
Member Middle Initial:	E	Date Of Birth:	01/01/1212
Medicaid ID:	1780610335	Medicare ID:	
Medicaid Effective Date:	01/01/2078	Medicare Effective Date:	
Current Acuity Level:	High		
Gender:	M	Primary Language:	ENGLISH
Primary Phone:		Home Phone:	8642254262 ext Unkn
Mobile Phone:			
Current Mailing Address:	111 E Rocky Road Lane APT 1R SLC, UT 84111		
E-Mail Address:			
Caregiver / Representative:	Not Applicable	Contact Phone:	
Relationship To Member:			

Associated Providers (past 6 months):

Fuhn E. Docktor

Reason for Recent Health Visits/ Tests and/or Diagnosis History:

DX Date	DX Code	Description
07/13/2013	585.6	End Stage Renal Disease
08/10/2014	V42.0	Kidney Replaced by transplant
01/24/2012	401.9	Unspecified Essential Hypertension
07/13/2013	276.9	Electrolyte and fluid disorders not elsewhere classified
05/22/2002	295.70	Schizoaffective Disorder

Recent Authorizations (past 6 months):

Kidney transplantation

No lab data.

Assessments (past 6 months):

No assessment.

Molina Healthcare Inc

Individualized Care Plan Report
Level 4

Enrollment in Inpatient / Outpatient Facilities (past 6 months):

5 in-patient stays related to ESRD, subsequent Kidney transplant, early onset rejection and ICU stay
2 inpatient psychiatric stays related to poor med compliance with BH management and subsequent increase in delusions and paranoia

Allergies:

No allergy

Medications / Rx (past 6 months):

Date	Physician	Medication	Refill Status
8/15/2014	DOKTOR, FUHN E.	CellCept 1.5gm BID	Filled: 8/15/2014;
8/15/2014	DOKTOR, FUHN E.	Prograf 0.1 mg/kg/day	Filled: 8/15/2014;
7/25/2014	DOKTOR, FUHN E.	Vasotec 5mg QD	Filled: 7/28/2014;
7/25/2014	DOKTOR, FUHN E.	Fluphenazine 5mg QD	Filled: 7/25/2014;
7/25/2014	DOKTOR, FUHN E.	Lasix 40 mg QD in AM	Filled: 7/25/2014; 5-refill remaining
7/25/2014	DOKTOR, FUHN E.	Xanax 0.5MG tid	Filled: 7/25/2014; 4- refill remaining

Individual Care Plan (ICP) Goals, Barriers, Interventions & Outcomes:

Type	Description	Priority	Due Date
Problem: Medication Adherence			
Goal [Short-term]	Mr. Doo will demonstrate medication compliance as evidenced by B/P WNL, weight at baseline +/- 1lb, no s/s rejection post transplant, stabilization of BH s/s		11/19/2014
Intervention	Care manager will educate member on medication administration, importance of adherence, potential side effects and when to call their PCP.		11/19/2014
Outcome	Mr. Doo will verbalize importance of strict adherence to medication regimen and will repeat teaching to care manager to demonstrate understanding		11/19/2014
Barriers	Difficulty learning		11/19/2014

Molina Healthcare Inc

Individualized Care Plan Report
Level 4

Type	Description	Priority	Due Date
Problem: SNF transition of care			
Goal [Long-term]	Members who reside in contracted nursing facilities and/or assisted living facilities are monitored by a Care Manager.		01/18/2015
Intervention	Care Manager to contact facility to obtain information regarding member.		01/18/2015
Outcome	Member care reflects interdisciplinary collaboration between member/caregiver/family, Care Manager, facility healthcare provider, facility care manager and other identified disciplines		01/18/2015
Goal (Long Term)	Provide member with resources to allow him to return to his home in the least restrictive setting, with supports in place to ensure safety and assist member with ADLs		01/18/15
Intervention	Case Manager to assist member to apply for the Habilitation waiver program through HCBS. Care manager will coordinate this effort with the case manager for the waiver program and will update the care plan and involve the PCP as needed.		01/18/15
Outcome	Member with be transitioned from SNF to his primary residence with the assistance of waiver supports and ongoing case management for continued coordination and supports		01/18/15
Problem: Home Health coordination			
Goal [Short term)]	Member will receive HH services to care for post -transplant wound, medication set up, and Physical therapy		01/18/2015
Intervention	Care Manager will provide list of HH agencies to member and allow him to choose the agency, care manager will coordinate this effort		01/18/2015
Intervention	Care Manager will ensure the HH agency meets with the member prior to discharge and attend the ICT in order to collaborate with the plan of care		01/15/2015
Outcome	Mr. Doo will have the needed medical supports in his home in order to identify early complications and ensure successful discharge to home and prevent readmission		01/15/2015
Problem: Transportation			
Goal [Short-term]	Ensure transportation to and from all follow up appointments		01/25/2015
Intervention	Care Manager will schedule all needed transportation in advance with Transportation vendor		01/25/2015
Intervention	Care Manager will ensure that Member has needed assistive devices to get to and from the car to the clinic		01/25/2015
Outcome	Member will attend all follow appointments as scheduled		01/25/2015
Barrier	Member requires W/C or power scooter for ambulation		01/25/2015

Molina Healthcare Inc

Individualized Care Plan Report
Level 4

Type	Description	Priority	Due Date
Problem: Community resources			
Goal [Short-term]	Member will receive assistance with food and utilities		01/25/2015
Intervention	Care Manager will assign community connector to identify all community based needs, including assistance with paying for utilities, and food bank resources.		01/25/2015
Outcome	Member will not have a disruption in utility services and Member will have adequate food		01/25/2015

Member Consent:

Member Consent.

Telephone Assistance:

If you have any questions or concerns about your membership or current coverage, please call 1-888-562-5442, Monday-Sunday from 7:00 AM to 6 PM PST. If you are hearing impaired, please call TTY/TDD at 1-877-688-9891 to assist you with your call.

If you have trouble accessing the member portal, please call 1-866-449-6848.

If you have any questions or concerns about recent medical/health issues, please call 1-888-275-8750 or TTY/TDD at 1-866-735-2929. (Español: 1-866-648-3537; TTY/TDD 1-866-833-4703.)

If you have any questions or concerns about the information on this plan of care or the services you're receiving, please call your case manager.

----- END OF REPORT -----

Molina Healthcare Inc

Individualized Care Plan Report
Level 4

SIGNED ACKNOWLEDGEMENT AND RECEIPT OF INDIVIDUALIZED CARE PLAN

On behalf of member SCOOBY DOO, the Individualized Care Plan (dated 10/20/2014) has been fully reviewed between the following case manager and the member (or their authorized representative or designated caregiver). A copy of this Individualized Care Plan will be made available to the member and/or their authorized representative or designated caregiver.

Signature of Member or Authorized Representative

Member/Representative Signature Date

Print Name of Member or Authorized Representative

If Authorized Representative, declare Relationship to Member

Signature of Case Manager

Case Manager Signature Date

Print Name of Case Manager

[Optional to use unless required by contract provisions and/or state regulations]

Molina Healthcare Inc

Individualized Care Plan Report

Reminders for Doctor Appointments:

A visit with your doctor is a chance for you to let him/her know:

1. How you feel.
2. Share your family's health history.
3. Your list of medications (current and past).
4. Discuss any health concerns you may have.

Things you can do ahead of time in order to have a successful visit:

1. Call ahead and get an appointment.
2. Let them know if you need an interpreter. We need at least three days' notice to get an interpreter for you.
3. Make a list of all your questions and needs.
4. Bring a list of your medications.
5. If you cannot keep your appointment, please call your doctor's office to re-schedule.

At your appointment:

1. Try to get to your doctor's office about 15 minutes early. You may need to fill out paperwork.
2. Tell your doctor your concerns and symptoms as best as you can.
3. If you did not understand something your doctor said, be sure to ask questions.
4. Please try to be patient if your doctor is running late. He/she may have a very sick patient that needs extra time.
5. Sometimes your doctor may have an emergency. They may have to go to the hospital to take care of another patient. This can happen with doctors that deliver babies. You may be given the option of seeing another doctor at the office.
6. Your doctor may refer you to a specialist or other health care provider. Be sure to ask if you will need to make the appointment. Sometimes your doctor's office will make it for you. Ask for the phone number of the other doctor's office before you leave.

Confidential Protected Health Information:
This document contains confidential protected Health Information that is protected under HIPAA and other applicable federal and state laws. This information is intended only for use by the Authorized User or entity to which it has been disclosed. Any unauthorized use or disclosure of this information should be reported to Molina Healthcare's privacy Hotline.

Molina's successful quality improvement programs are the result of its cutting edge technology, local and national resources, and its commitment to continuously perform utilization review with our providers in a collegial, collaborative environment.

SECTION 10 – QUALITY MANAGEMENT AND IMPROVEMENT STRATEGIES

Please explain how you propose to execute Section 10 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Molina understands, agrees and will comply with all Quality Management and Improvement Strategies requirements set forth in accordance with Section 10 of Attachment 1—Scope of Work.

Commitment to Quality

Molina's NCQA-accredited health plans nationwide employ innovative integrated quality improvement approaches targeting the highest priority health needs of its members, ensuring consistent health plan performance improvement. Molina has achieved National Committee for Quality Assurance (NCQA) accreditation for nine of its 12 health plans (California, Florida, Michigan, New Mexico, Texas, Ohio, Utah, Washington and Wisconsin). These NCQA accredited health plans are ranked in the top 100 nationwide by the NCQA.

The health plans most recently added to the Molina family located in Illinois, South Carolina and the Commonwealth of Puerto Rico are not yet accredited, however, accreditation will be pursued as soon as possible.

Molina is dedicated to the delivery of quality care with the primary goal of improving the health status of our members. Our Quality Assessment and Performance Improvement (QAPI) program is committed to the provision of accessible, appropriate, cost-effective, high quality, integrated health care services for its members throughout the entire range of care with the primary goal of improving health outcomes and quality of life. Molina assists members as they move through the managed care system, coordinating care across different health care settings, reducing barriers to care, and supporting members in maintaining independence and reaching optimal health. The QAPI Program provides the organizational structure and supporting processes that enable Molina to fulfill its commitment to achieving clinical and operational excellence.

The scope of the QAPI Program is broad and encompasses the quality and appropriateness of care, including service availability and accessibility, quality of services and supports, network quality, care planning and implementation, coordination and continuity of care, and enrollee safety. It includes, but is not limited to: clinical quality performance measurement and improvement; disease management; medication management; Provider Services; Member Services; removing barriers and improving access; and getting the right level of service, to the right person, at the right time.

Molina has defined the following goals for the QAPI Program:

- Define, demonstrate and communicate the organization-wide commitment to and involvement in achieving improvement in quality of care, member safety, access and quality of service;
- Design and maintain programs that improve care and service outcomes within identified member populations;

- Ensure program relevance through understanding of the health plan's member demographics and provide services and interventions that address the diverse cultural, ethnic, racial and linguistic needs of its membership;
- Promote an enhanced quality of life for members, emphasizing quality patient outcomes and keeping members safely in the community;
- Develop processes to continually measure and improve member and provider satisfaction;
- Use a multidisciplinary committee structure to facilitate the achievement of Quality Improvement goals;
- Encourage and support a collaborative relationship among members/caregivers, providers, health plans and regulators to promote coordinated care, improve efficiency, and improve health outcomes;
- Protect the privacy and security of confidential member and provider information; and
- Maintain NCQA Accreditation.

10.1 Contractor Quality Management/Quality Improvement Program

1. Describe your Quality Management and Improvement Program, addressing all elements outlined in Section 10.1.2. Include how you will monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care delivered to members.

Molina understands, agrees and will develop a Quality Management and Improvement Program that will address all elements outlined in Section 10.1.2 QM/QI Program Requirements of Attachment 1 – Scope of Work.

Through annual program evaluation, ongoing measurement and analysis, Molina identifies priority areas and develops interventions. Molina applies its Outcomes Based Process model to analyze specific conditions, diagnoses, operational processes, services or populations for which measurable outcomes are desired. The process continues as a cycle of ongoing monitoring as outcomes are re-measured and the specific programs are enhanced with each cycle. Once approved for implementation, various departments and subcommittees continuously monitor the implemented activities and track the performance measures that have been defined.

Priority areas for improvement can be submitted by Molina staff, plan Medical Directors, or external providers and organizations, members and/or their caregivers. Target areas are prioritized for development based upon the following information:

- High volume, high cost utilization;
- Availability of scientific research to evaluate the technology;
- Service or care found to have a high potential for harm;
- Activity or service that are of great importance to the membership and providers;
- Impact to quality of life and health outcomes; and
- Known or suspected overutilization or inappropriate usage.

The Outcomes-based Process Model includes the following steps:

- Establish standards and benchmarks;
- Collect data;
- Analyze data and determine performance levels;
- Identify opportunities for improvement;
- Prioritize opportunities;

- Design and implement interventions, including corrective actions; and
- Measure effectiveness and adjust program design as necessary to achieve desired improvement.

Molina's improvement methodology is designed to address gaps in performance. Approaches to improve include, but are not limited to the following activities:

- Develop, modify or update organizational policy and procedures;
- Address gaps in staffing patterns or personnel, or training needs;
- Modification in network providers or scope of services provided;
- Tools, materials, processes and protocols to address member needs and services;
- Materials and systems to support providers in the delivery of care;
- Deploy new, or modification of existing systems, operations and tools; and
- Communication of results, changes, and updates internally and externally.

10.1.2.1 An annual and prospective five (5) year QM/QI work plan which sets measurable goals, establishes specific objectives, identifies the strategies and activities to be undertaken, monitors results and assesses progress toward the goals;

Molina understands, agrees and will comply with all requirements for developing an annual five year QM/QI work plan which will set measurable goals, establish specific objectives, identify the strategies and activities to be undertaken, monitor results and assess progress toward these goals in accordance with Section 10.1.2 QM/QI Program Requirements of Attachment 1 – Scope of Work.

10.1.2.2 Dedicated resources (staffing, data sources and analytical resources), including a QM/QI committee that oversees the QM/QI functions;

Molina has created an environment of accountability and collaboration and a process that fosters communication between departments to ensure compliance and quality. The Molina Healthcare of Iowa Board of Directors is responsible for the direction and oversight of the QAPI Program and has ultimate authority and accountability for the quality of care and services delivered to members. The Board delegates authority to Molina's version of the Quality Oversight Committee, the Quality Improvement Committee (QIC), a multidisciplinary team chaired by the Chief Medical Officer that includes senior management representation from all operational and administrative functions including clinical, business and administrative staff. Program activities are reported to the Board of Directors through quarterly Quality Assurance updates and annual Quality Assurance and program evaluations. The President of Molina Healthcare of Iowa will also serve as a member of the Board.

The QIC is responsible for the implementation and ongoing monitoring of the QAPI Program and sets the strategic direction for all quality activities. The QIC will maintain records that document the committee's activities, findings, recommendations, actions and results. Through the QIC, subcommittees recommend policy decisions, analyze and evaluate the progress and outcomes of all quality improvement activities, institute needed action and ensure follow-up.

Molina maintains dedicated QI Staff and Analytical Resources dedicated to collecting and integrating data, conducting analyses and implementing quality improvement activities. The staff includes, but is not limited to:

- Chief Medical Officer;
- QI Director*;
- Manager, QI Compliance*;
- Manager, Quality Interventions*;
- Quality Improvement Specialist/Coordinator*;

- Designated Behavioral Health Practitioner;
- Health Care Analyst;
- Credentialing Coordinator*; and

(*Denotes those positions 100% dedicated to QI).

Additional QI expertise in the following functional areas:
- Utilization Management (UM);
- Care and Case Management;
- Nurse Advice Line;
- Disease Management;
- Pharmacy;
- Member Services;
- Provider Services;
- Government Contracts; and
- Finance.

10.1.2.3 Address physical health, behavioral health and long-term care services;

Molina's QAPI Program fully integrates physical health, behavioral health and long-term care services quality monitoring and improvement. Molina encourages and includes network providers' participation on clinical committees that provide an avenue for contributing to the planning, design, implementation and review of the QAPI Program activities. Additionally, to ensure consistent quality care for its members, Molina's physical health, behavioral health and long-term care services policies and procedures include documentation requirements for the use, periodic review and appropriate application of written, evidence-based clinical decision-making criteria.

10.1.2.4 Mechanisms to detect and address both under- and over-utilization of services;

Molina will monitor over-utilization, under-utilization and appropriate utilization reviewed by interdisciplinary teams and the provider network through the following mechanisms:
- Electronic visit verification;
- Service authorization and care management reports addressing service delivery processes;
- Facility site reviews to ensure quality, ADA compliance and safety;
- Tracking quality of care issues, including adverse outcomes and sentinel events;
- Member complaint and appeal review;
- Practitioner medical, pharmacy and utilization profiles;
- Performance measures relative to implementation of preventive and clinical practice guidelines; and
- Oversight of delegated group member satisfaction and utilization.

10.1.2.5 A process to monitor variation in practice patterns and identify outliers;

Molina's Quality Improvement Committee (QIC) receives reports from all Quality subcommittees and advises and directs the subcommittees on the focus and implementation of the QAPI Program. The QIC reports to the Board any variance from quality performance goals and the plan to correct the variance. The QIC routinely monitors reports on clinical indicators and performance measures, including the results of External Quality Review Organization (EQRO) reviews, in order to identify trends that require action and opportunities to incorporate results into the QAPI Program. The program is structurally integrated through joint QIC and subcommittees.

10.1.2.6 Strategies designed to promote practice patterns that are consistent with evidence-based clinical practice guidelines through the use of education, technical support and provider incentives;

Molina will implement multi-faceted strategies that align with evidence-based clinical practice guidelines and promote healthcare coordination. Interventions will be designed to impact specific measures that are closely tied to DHS requirements. This will include financial rewards for performance, education for members and providers, and close coordination with all members of the care team who have the ability to impact the member's experience. To drive improvement in the performance of each profiled provider, the Quality Improvement department facilitates activities that ensure accountability and performance improvement. The nature and extent of provider follow-up will be based on the performance percentile ranking and the change in the prior period performance rates.

10.1.2.7 Analysis of the effectiveness of treatment services, employing both standard measures of symptom reduction/management, and measures of functional status;

Molina employs standard metrics and data analysis for continuously measuring effectiveness and demonstrated improvement in QAPI Program activities. These activities include, but are not limited to:

- Access/Availability, to include health risk assessments, appointment scheduling, network composition through assessment by volumes and type of providers and geographical analysis;
- Case and Disease Management Programs as measured by the use of and compliance with evidence-based guidelines and processes for structured assessment and follow-up as well as the use symptom management and functional status measures/tools (e.g., Activities of Daily Living/Instrumental Activities of Daily Living, asthma severity, pain assessment, PHQ-9);
- HEDIS® Measurement/Reporting and activities to address performance gaps;
- Demographic, health status, and utilization patterns of enrolled populations communities; and
- Co-morbid conditions and complexities associated with concurrent/on-going or unresolved medical and behavioral health issues.

Appropriate adjustments are made to account for seasonality, health risk or disease prevalence, geographic area and data completion.

Analyses may include various geographic groupings, such as eligibility, provider type, contract types, member cohorts based on disease, and health risk groupings. Such analyses are designed to answer questions related to appropriate utilization, performance improvement and optimal care delivery within the health care environment. Analysis of these various categories provides options for in-depth understanding of the drivers of care and service.

Overall effectiveness and demonstrated improvement are achieved through quantitative analysis of comparable data collected from internal and external normative and benchmark data and established thresholds and goals. If the comparative analysis indicates performance is under or over the baseline threshold, Molina will perform root cause analysis and investigate underlying barriers to achieving the desired performance level or behavioral change.

10.1.2.8 Monitor the prescribing patterns of network prescribers to improve the quality of care coordination services provided to members through strategies such as:

(i) identifying medication utilization that deviates from current clinical practice guidelines;

In our ongoing effort to improve the quality of care coordination services we provide our members, Molina monitors and evaluates provider and member utilization patterns of over- and under-utilization on an ongoing basis using data maintained in our QNXT medical management system and by Molina's Pharmacy Benefit Manager, CVS Caremark. QNXT data includes claims, membership, provider,

authorization and other encounter data. Molina staff analyzes data gathered from QNXT, medical record reviews, HEDIS statistics and other utilization management records to generate reports that identify opportunities for improvement. Our Utilization Management Committee reviews and analyzes the data, interprets any variances and develops interventions based on their findings.

(ii) identifying members whose utilization of controlled substances warrants intervention;

Molina's controlled substance reports that identify members whose prescription patterns may be indicative of drug-seeking behavior are reviewed on a regular basis. When appropriate and when approved by DHS, Molina will establish protocols for special "lock-in programs" where such members may be limited to individual prescribers/pharmacies in order to correct the behavior.

(iii) providing education, support and technical assistance to providers; and

The Utilization Management Committee and Pharmacy and Therapeutics Committee evaluate utilization trends, identify anomalies, investigate specific details, when necessary, and initiate actions, including provider education, support and technical assistance to address identified issues. Based upon situational circumstances, these two committees may recommend Provider Services staff conduct provider education to review contract requirements and resolve issues.

(iv) monitor the prescribing patterns of psychotropic medication to children, including children in foster care;

Molina's utilization reports are generated at a minimum annually and are designed to assist in monitoring quality and utilization trends. To meet DHS's requirements, Molina's psychotropic utilization report will include prescribing patterns of such medication to children, including children in foster care.

10.1.2.9 Written policies and procedures for quality improvement including methods, timelines and individuals responsible for completing each task;

Molina's QAPI staff works with the Quality Improvement Committee, subcommittees and other workgroups to plan, design, develop and implement policies and procedures and activities designed to improve quality outcomes. Molina uses the QI work plan to accomplish QAPI goals and objectives. The QI work plan is reviewed and updated at least quarterly and includes the methods, activities, timelines, proposed goals/targets and roles and responsibilities for accomplishing these objectives. Molina will evaluate the quality of care and services provided to Molina members through continuous oversight of performance, assessments and corrective action/improvement plans. Molina will develop and maintain delegation policies and procedures, and makes recommendations regarding delegation to the Quality Improvement Committee.

10.1.2.10 System for monitoring services, including data collection and management for clinical studies, internal quality improvement activities, assessment of special needs populations and other quality improvement activities found valuable by the Contractor or required by the Agency;

Molina collects and utilizes multiple data sources to monitor, analyze and evaluate the QI program and planned activities to address all target populations. Sound approaches and methods are used to develop indicators that are objective, clearly defined, accurate and complete. Molina uses systematic collection processes to assure valid, reliable and population appropriate data are reported for each line of business. Data that measures health outcomes and indices of quality are developed specific to Molina's targeted activities and Program goals.

Molina utilizes multiple data sources to monitor, analyze and evaluate the QI program and planned activities. These sources include, but are not limited to the following:

- Encounter data;
- Claims data;
- Pharmacy Benefit Manager data;
- Pertinent medical records (minimum necessary);
- Utilization reports and case review data;
- Provider and member feedback, complaints and grievances through standard intake process and from all internal departments such as utilization management, provider services and other internal and external sources;
- Provider and member satisfaction survey results;
- Appeal information (internal and external review);
- Statistical, epidemiological, and demographic member information including data to identify the cultural, ethnic, racial and linguistic needs of members;
- Authorization and denial reporting;
- Diagnostic information (laboratory, pathology, and radiography results);
- Enrollment and disenrollment data;
- HEDIS® data;
- Behavioral Health data;
- GeoAccess provider availability data and analysis;
- CAHPS® data;
- Case and disease management program data;
- Health Risk Assessment information; and
- Enrollment/Disenrollment data.

Data for all activities is collected and processed through a number of mechanisms such as electronic software and applications, manual collection processes, and available external resources.

Molina Healthcare utilizes QNXT, its core health information technology (HIT) system, and Clinical CareAdvance (CCA), a web-based member centric health management software application to assist in accomplishing the goals of the Quality Improvement Program objectives. Molina's health information technology systems manage and track the activities and progress of members throughout the course of care management.

Molina has detailed processes and procedures in place to review and monitor clinical data, including utilization, claims-based and HEDIS data, for many purposes and across many departments. The Quality Improvement Committee analyzes and evaluates the progress and outcomes of all quality improvement activities, institutes needed action and ensures follow-up. Through annual program evaluation, ongoing measurement and analysis, Molina identifies priority areas and develops interventions.

10.1.2.11 Participate in clinical studies and use Healthcare Effectiveness Data and Information Set® (HEDIS®) rate data, health care quality measures for Medicaid-eligible adults described in Section 1139B of the Social Security Act, Consumer Assessment of Health Plans (CAHPS) survey results and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members;

Molina uses the Healthcare Effectiveness Data Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) data to assess the quality and experience of care provided

to our members. Molina applies an outcomes-based process model to analyze HEDIS measures and the annual performance review of the CAHPS Member Satisfaction Survey. The process continues as a cycle of ongoing monitoring as outcomes are re-measured and the specific programs are enhanced with each cycle. Once approved for implementation, various departments and subcommittees continuously monitor the implemented activities and track the performance measures that have been defined. Additionally, other sources of member satisfaction data such as member complaints and other surveys are part of ongoing performance review. Member input provides a means to assess and improve member satisfaction, accessibility to services, as well as availability of the provider network. Performance measures provide a means to evaluate the care and services provided and implement interventions based on findings.

10.1.2.12Utilize and report on the Iowa Participant Experience Survey for members receiving HCBS services;

Molina will report on the Iowa Participant Experience Survey for members receiving home and community-based services (HCBS) to ensure DHS's requirements are met. Molina's process for monitoring and reporting on the appropriateness and effectiveness of HCBS provided to its members is encompassed in Molina's integrated care management process. The results of the Iowa Participant Experience Survey will be used to identify any problems in several areas including but not limited to: access to care, choice and control of types of services received, whether the member was treated with respect/dignity, and the degree of community integration. If performance needs to be improved in any of these areas, strategies and interventions will be developed to improve performance. Molina will measure the impact of the interventions and evaluate the effectiveness of our strategies, utilizing our QI improvement methods to ensure that our members receive quality care and services.

10.1.2.13Report any performance measures required by CMS;

All eligible Molina health plans collect, calculate and report HEDIS measures to NCQA. Molina will report all performance measures required by CMS and DHS. Molina applies an outcomes-based process model to analyze HEDIS measures and the annual performance review of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Member Satisfaction Survey. The process continues as a cycle of ongoing monitoring as outcomes are re-measured and the specific programs are enhanced with each cycle. Once approved for implementation, various departments and subcommittees continuously monitor the implemented activities and report on the performance measures that have been defined. Performance measures provide a means to evaluate the care and services provided and implement interventions based on findings.

10.1.2.14Utilize and report on all quality measures required by the Agency, as described in Section 14, including, but not limited to quarterly health outcomes and clinical reports, and the 3M Treo Solutions Value Index Score (VIS) measures;

Molina has the systems and resources in place to generate the required reports in Sections 14.1 through 14.11 of Attachment 1 – Scope of Work, as well as any additional ad hoc reports needed by DHS. Molina's Report Generation subsystem, integrated within the QNXT claims administration system is capable of supporting many reporting requirements for a wide range of areas, including but not limited to grievances and appeals, claims payment, utilization management, care coordination, member services, membership, encounters, provider, and premium data. Molina has an array of other tools, applications, and databases that supplement what is available from QNXT and enhance Molina's ability to extract data and produce reports for submission to DHS as well as for support of internal operations and improvement efforts.

Molina has experience in developing various reports of size and scope and is prepared to produce data and reports as required in subject areas of, but not limited to:

- Financial Reports (e.g., Medical Loss Ratio);
- Member Services Reports (e.g., Completion of Comprehensive Health Risk Assessment, Care Plan Development, CAHPS surveys, PCP Assignment);
- Provider Network Reports (e.g., GeoAccess and Credentialing);
- Quality Management Reports (e.g., HEDIS EPSDT);
- LTSS Reports (e.g., Nursing Facilities Admission Rates);
- Utilization Reporting (e.g., Prior Authorization Turn Around Time Compliance, Hospitalizations, and ER visits); and
- Claims Reports (e.g., Clean Claims Turnaround Time Compliance).

Molina will also be using the 3M Treo Solutions Value Index Score (VIS) measures to measure how well a provider can manage his or her patient population and to support quality improvement efforts. Molina will share performance on the VIS measures with providers to identify areas for improvement.

10.1.2.15 Procedures for collecting and assuring accuracy, validity and reliability of performance outcome rates that are consistent with best practice protocols developed in the public or private sector;

Accuracy in reporting is greatly enhanced by strong planning and design processes. Clear reporting specifications can also enhance the potential for automation to help reduce the impact of potential human error in report production. Internally, Molina establishes reporting specifications through the collaboration between subject matter experts who own the reports and the Healthcare Analytics team who will implement the specifications to produce the reports. In cases where the specifications are simple, the report owner and the Healthcare Analytics team can work together similar to an ad hoc request to document the specifications, translate the specifications into reporting logic, and test the results before putting the final output into production status. When the reporting specifications are more complex, a Business Requirement Document (BRD) process is used to ascertain the range of system and programming resources that will be needed to develop the report. The BRD process is most often used when subject matter experts from multiple departments will need to have input. This multi-disciplinary input helps to ensure that the report is designed from a full business oversight rather than only being designed from a singular viewpoint. The BRD is used throughout the process to maintain documentation of design, specification, testing, validation, and version control.

Collectively, Molina's corporate and local Iowa Healthcare and Analytics Team will offer data analytics expertise and experience, access to nationwide best practices, resources for developing tools and reports and capacity for larger scale projects. In other states, Molina's combined local and corporate reporting teams have provided invaluable leadership to states, working collaboratively with MCOs to improve the content and levels of comparative reporting across MCOs.

The Molina Analyst Forum is a mechanism for health plan and corporate analytic staff to share technical and business expertise, reports and analyses, and best practices enterprise wide. Similarly, the Finance and Analytics Management Committee, consisting of the plan Vice Presidents of Finance and Analytics and corporate analytics leadership, meets regularly to discuss emerging trends, solve problems, share best practices, and find support. Together these groups meet to identify problems, find solutions, and improve processes.

Additionally, Molina uses HEDIS data as one source to assess the quality of care provided to our members. HEDIS data are audited by an NCQA-approved auditing firm, which helps to ensure the data completeness and accuracy. Molina also continuously monitors HEDIS performance rates for any abnormalities or deviations from national benchmarks, investigates issues, and resolves data discrepancies if any are found.

10.1.2.16 Procedures for a provider pay-for-performance program;

Molina has Value Based Reimbursement (VBR) and Pay-for-Performance (P4P) models it has developed and proposed to providers that can include accountability and enhanced reimbursement. Molina's P4P Program will provide quarterly payments to its contracted providers based on the achievement of quality metrics as demonstrated through claims data. Payment will be made no sooner than 120 days after the close of the quarter in order to allow time for claims run-out. Molina's P4P program's overall success will be documented in the annual Quality Improvement evaluation and work plan. Molina will also assess HEDIS and CAHPS measurements annually for the overall outcome of each clinical measure relating to a P4P initiative and address whether the initiative is impacting quality of care, member and provider satisfaction, and cost of health care.

Subject to DHS approval, non-financial incentives could include additional educational offerings for provider staff, preferential member assignment to PCPs with superior quality scores, or imbedded case managers for high volume providers.

10.1.2.17 Member incentive programs aligned with the Healthiest State Initiative and other quality outcomes; and

Molina will develop a member incentive program that is aligned with the Healthiest State Initiative and will incentivize members with rewards for making healthy choices about their health and care. The program will utilize an innovative population health management technology and engagement system proven to improve health and lower costs. This closed-loop platform facilitates a multimedia engagement strategy that includes outbound calls, auto-calls, web portal engagement, text messages, and direct mail. The program utilizes the following successful strategies proven effective with low-income, diverse Medicaid populations:

- Incentives are tied to activities that align with HEDIS measures that can be easily tracked;
- Incentives are easy to understand and redeem by members;
- Incentive programs feature gamification that includes points assigned to all activities, virtual achievements, interactive quizzes and tools, and activity drawings;
- Incentives are clearly communicated in multiple mediums;
- Incentives are aligned with robust engagement and reinforced continuously via alerts & reminders;
- Incentives are personalized to a member's health status;
- Incentives are served through a closed-loop technology platform that tracks effectiveness; and
- The program includes robust health analytic reporting including quality metrics and ROI reporting.

10.1.2.18 Procedures to assess member satisfaction not already defined.

Molina reviews all sources of member satisfaction including but not limited to CAHPS surveys, disenrollment information, complaints and appeals. Member input provides a means to assess and improve member satisfaction, accessibility to services, as well as availability of the provider network. Molina's Quality Assessment and Performance Improvement Plan and Program Description and Work Plan outline activities based on CAHPS results and the process for identification of improvement opportunities. CAHPS performance survey measures provide a means to evaluate the care and services provided. These measures are at the core of Molina's Quality Improvement activities. Molina's staff, network providers' quality teams and committees review annual survey results to assess performance to benchmarks, performance thresholds, trended to previous performance and/or goals and to identify gaps and develop action plans.

2. Describe how you will utilize program data to support the development of the Quality Management and Improvement Work Plan.

Molina employs standard metrics and data analysis for measuring effectiveness and demonstrated improvement in QAPI Program activities. These include: utilization metrics; grievances, complaints and appeals; and access and availability standards. Appropriate adjustments are made to account for seasonality, health risk or disease prevalence, geographic area and data completion. Population analysis may identify specific adjustments needed to appropriately interpret results. Member continuity with the plan or provider, benefit design and special needs program participation are additional factors considered. Similarly, analysis and profiling of facilities and participating providers may assist in adjustments needed to interpret results or identify aberrant patterns.

Analyses may include various geographic groupings, such as eligibility, provider type, contract types, member cohorts based on disease, and health risk groupings. Such analyses are designed to answer questions related to appropriate utilization, performance improvement and optimal care delivery within the health care environment. Analysis of these various categories provides options for in-depth understanding of the drivers of care and service.

Overall effectiveness and demonstrated improvement are achieved through quantitative analysis of comparable data collected from internal and external normative and benchmark data and established thresholds and goals. If the comparative analysis indicates performance is under or over the baseline threshold, Molina will perform root cause analysis and investigate underlying barriers to achieving the desired performance level or behavioral change. Comparable data may include:

- Historical plan data that establishes utilization patterns, thresholds and performance goals, including plan data from other Molina plans, comparable products, regions and providers;
- Consumer Assessment of Healthcare Providers and Systems (CAHPS);
- HEDIS reporting data;
- NCQA Quality Compass and National Benchmarks;
- Accessing Care of Vulnerable Elders (ACOVE) quality measures;
- Regulatory standards and requirements;
- External Quality Review Organization (EQRO) requirements;
- Member complaint/grievance and appeals data;
- Nationally accepted industry standards and comparative data provided by associations;
- State Medicaid results and State and National Medicare results; and
- Evidenced-based standards from medical literature.

Reports are designed to identify opportunities for improvement to support comparisons of the target population. Analytic methods include measuring performance on a monthly basis, comparing results to year-to-date, prior period, same period prior years, rolling three, six, or 12 months, thresholds such as upper and lower control limits, goals, and benchmark data. Analysis of percent change and percent difference from thresholds and goals also supports identification of opportunities.

While quantitative reporting is critical, analysis is incomplete without qualitative analysis. Analysts and interdepartmental resources collaborate on qualitative analysis drawing conclusions regarding the causes, consequences, and opportunities for management and improvement. Molina considers it essential to distribute reports and analyses into the hands that can effect change. Molina's QAPI Program structure is designed to assess, plan, implement, and evaluate its activities based heavily on the gathering and analysis of utilization data. Data transformed into actionable information that is continuously measured and evaluated is at the core of the improvement activities of all Molina internal Quality committees.

3. Detail your experience in and strategies for improving quality indicators, including HEDIS measures, CAHPS measures and satisfaction surveys. Describe how you will apply that experience in Iowa.

Molina applies an outcomes-based process model to analyze HEDIS measures and the annual performance review of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Member Satisfaction Survey. The process continues as a cycle of ongoing monitoring as outcomes are re-measured and the specific programs are enhanced with each cycle. Once approved for implementation, various departments and subcommittees continuously monitor the implemented activities and track the performance measures that have been defined. Additionally, other sources of member satisfaction data such as member complaints and other surveys are part of ongoing performance review. Member input provides a means to assess and improve member satisfaction, accessibility to services, as well as availability of the provider network. Performance measures provide a means to evaluate the care and services provided and implement interventions based on findings.

For example, in 2010 the CAHPS Customer Service rating was below the 50th percentile; therefore an action plan was initiated. Molina administered targeted interventions throughout 2011, 2012, and 2013 to address this performance gap. In 2013, Molina met its Customer Service performance goal of 75th percentile for all plans. This level of performance was maintained in 2014 for the majority of plans. Significant activities were launched in the later part of 2012 and in 2013 which continue into 2014.

In 2012, Molina expanded the call center and re-designed the training program and required member service representatives receive targeted training in customer service "soft" skills. Molina also deployed the NICE recording application that allows supervisors to provide representatives immediate feedback while they handled their calls. Also, a system upgrade to QNXT enabled customer service associates quicker access to benefit information on specific members so they could respond to questions thoroughly. Starting in December 2012, Molina implemented the "Every Member Counts" program where all member and provider support staff were given training in customer service "soft" skills in addition to increasing staff awareness of the annual CAHPS survey and its importance. The process was established during 2013 to allow the transfer of inter-departmental member calls to avoid placing a member on-hold for extended periods while calls are transferred.

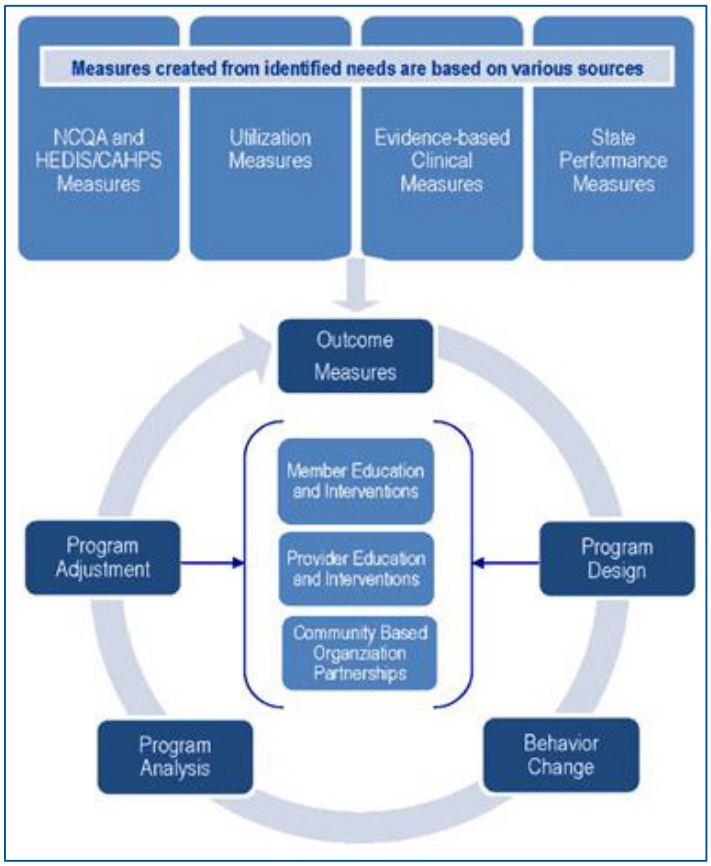
The following are examples of how Molina's Outcomes-based Process Model is used to analyze specific conditions, diagnoses, operational processes, services or populations for which measurable outcomes are desired to help guide its QAPI Program:

- Monitoring over-utilization, under-utilization, and appropriate utilization reviewed by interdisciplinary teams and the provider network through:
  - Electronic Visit Verification, service authorization and care management reports addressing service delivery processes;
  - Quantitative analysis of medical, behavioral health, pharmacy and utilization profiles requested and received from other health plans; and
  - Facility site reviews to ensure quality, ADA compliance, and safety.
- Continuity and Coordination of Care:
  - Transitions of Care processes and effectiveness of inter-provider communications.
  - Provider adherence to medical record keeping, confidentiality and documentation standards.
  - Tracking program referral and enrollment for timeliness and appropriateness.
  - Facilitation and arrangement with community and social service programs.

- Coordination with other health plans and providers of service.
- Evaluation of access and availability of care and service through:
  - Geographic access to community-based long-term care services and supports, and taking action to address gaps in the network; and
  - Evaluation of Customer Support Services telephone access, including access for the hearing impaired.
- Member satisfaction with and participation in improvement activities:
  - Review of all sources of member satisfaction including, but not limited to, CAHPS surveys, disenrollment information, grievances and appeals, and identify opportunities for improvement; and
  - Monitor observance of applicable antidiscrimination laws, including reasons for disenrollment.
- Evaluation of the effectiveness of Quality Improvement activities in producing measurable outcomes and improvements in member care and services:
  - Organization of ICTs to analyze service and process improvement opportunities, determine actions for improvement and evaluate results;
  - Track progress of quality activities;
  - Review/update the Quality Improvement work plan quarterly; and
  - Revise interventions as required based on analysis.

Molina's QAPI program applies the Outcomes-based Process model shown in Exhibit 10.1.3-1 below to analyze specific conditions, diagnoses, operational processes, services or populations for which measurable outcomes are desired.

Exhibit 10.1.3-1 Outcomes-based Process Model



The Outcomes-based Process Model includes the following steps:

- Establish standards and benchmarks;
- Collect data;
- Analyze data and determine performance levels;
- Identify opportunities for improvement;
- Prioritize opportunities;
- Design and implement interventions, including corrective actions; and
- Measure effectiveness and adjust program design as necessary to achieve desired improvement.

Molina's improvement methodology is designed to address gaps in performance. Approaches to improve quality and performance include the following activities:

- Develop, modify or update organizational policy and procedures;
- Address gaps in staffing patterns, personnel or training needs;
- Deploy new, or modify existing systems, operations and tools; and
- Communicate results, changes and updates internally and externally.

Any barriers detected with the intervention, or significant variation from performance standards, are reported to the Executive Quality Improvement Committee for further review and action. Performance thresholds are defined based on the professional literature, as well as practical experience, industry standards and available national benchmarks. Some specific sources used to identify performance standards and thresholds include:

- HEDIS®/CAHPS® Technical Specifications;
- NCQA Standards and Guidelines;
- NCQA Quality Compass and national benchmarks;
- Clinical standards of care (e.g., InterQual®);
- External Quality Review Organization (EQRO) requirements;
- Federal and state laws, regulatory standards and requirements;
- Molina's performance trends; and
- U.S. Preventive Services Task Force (USPSTF) recommendations.

QAPI Work Plans use data collected and processed through a number of mechanisms, such as electronic software and applications, manual collection processes, and external resources. The types of data/information monitored to identify opportunities for targeted performance and quality improvement interventions include, but are not limited to, the following:

- HEDIS reporting data;
- Utilization Management process data and internal monitoring reports;
- Claims review process/encounter data trends;
- Medication prescribing or usage trend data and reports;
- Feedback and requests from network providers; and
- Department or committee requests.

4. Describe your experience and strategies in working with network providers to improve outcomes.

Molina will introduce performance standards and quality outcomes into the provider agreements (e.g., early reports of changes in condition, reducing hospitalizations, reporting changes in medications, medication adherence, nursing home placement rates, member satisfaction, service delivery rates and compliance, improvement in member independence, compliance with primary care visit schedules, etc.) that will align the performance of the provider network to DHS goals. Each provider component will have incentives related to the provider's ability to deliver such objectives. Primary care physicians for example will have incentives related to improving standards of care related to medical home quality. PCPs will also receive bonus payments related to establishment of Medical Homes in the Molina model.

Molina encourages and includes network providers' participation on clinical committees that provide an avenue for contributing to the planning, design, implementation and review of the QAPI Program activities. Molina's QAPI Program fully integrates physical health and behavioral health quality monitoring and improvement. Molina's contracted Behavioral Health providers participate on the Quality Improvement Committees and its subcommittees. Through this committee participation, network providers:

- Review and provide feedback on proposed practice guidelines, preventive health standards, clinical protocols, health management programs, quality and HEDIS® results, new technology and other clinical issues regarding policies and procedures;
- Review proposed Quality Improvement study designs; and
- Participate in the development of performance improvement plans and interventions to improve levels of care and service.

In cases where specific specialty feedback or assistance is needed, community physicians/specialists are used to provide feedback on proposed interventions or programs. As needed, focus groups of providers

may be used for assisting with the design or evaluation of specific programs.

A designated Behavioral Health provider will participate in developing clinical and service activities for behavioral health. This ensures planning, design, implementation, review and follow-up of quality improvement activities encompass behavioral health. The designated Behavioral Health provider responsibilities include:

- Participating in the adoption of Behavioral Health best practice guidelines.
- Consulting and making recommendations on behavioral health projects/initiatives.
- Providing a Behavioral Health perspective on identified issues, assessment of potential and confirmed Behavioral Health quality of care concerns and member safety issues, provides recommendations for further action as it relates to behavioral health; and
- Screening member and Provider material for identification and communication of behavioral health needs.

Molina also actively works collaboratively with network providers to ensure members are receiving needed screenings such as hemoglobin A1c tests, nephropathy monitoring and retinal eye exams for diabetic members. For instance, Molina will share with providers a list of their members who have not had specific labs and screenings and provide education on the importance of these screenings and tips to improve performance on the measures. Improving performance on these measures will help to decrease admissions for diabetes short term complications and reduce the long-term effects of poor diabetes management. Molina has seen marked improvements in key diabetes measures such as retinal eye exams and HbA1c testing. With various strategies that included provider engagement on holding diabetes clinic days, distribution of gaps in care lists to providers, use of a mobile eye exam unit and member engagement through incentives, mailings and outreach calls, Molina was able to improve retinal eye exam rates from 39.21% in 2012 to 51% in 2014 and HbA1c testing from 81.36% in 2013 to 87.42% in 2014.

5. Outline the proposed composition of your Quality Management and Improvement Committee, and demonstrate how the composition is interdisciplinary and appropriately represented to support the goals and objectives of the Quality Management and Improvement Committee.

Molina has created an environment of accountability and collaboration and a process that fosters communication between departments to ensure compliance and quality. The Molina Healthcare of Iowa Board of Directors is responsible for the direction and oversight of the QAPI Program and has ultimate authority and accountability for the quality of care and services delivered to members. The Board delegates authority to Molina's version of the Quality Oversight Committee, the Quality Improvement Committee (QIC), a multidisciplinary team chaired by the Chief Medical Officer that includes senior management representation from all operational and administrative functions including clinical, business and administrative staff. Program activities are reported to the Board of Directors through quarterly Quality Improvement updates and annual Quality Improvement Program evaluations. The President of Molina Healthcare of Iowa will also serve as a member of the Board.

The QIC is responsible for the implementation and ongoing monitoring of the QAPI Program and sets the strategic direction for all quality activities. The QIC will maintain records that document the committee's activities, findings, recommendations, actions and results. Through the QIC, subcommittees recommend policy decisions, analyze and evaluate the progress and outcomes of all quality improvement activities, institute needed action and ensure follow-up. The QIC receives reports from all Quality subcommittees and advises and directs the subcommittees on the focus and implementation of the QAPI Program. The QIC reviews data from Quality Improvement activities to ensure that performance meets standard and makes recommendations for improvements to be carried out by subcommittees or by specific departments. The QIC reports to the Board any variance from quality performance goals and the plan to

correct the variance. The QIC routinely monitors reports on clinical indicators and performance measures, including the results of External Quality Review Organization (EQRO) reviews, in order to identify trends that require action and opportunities to incorporate results into the QAPI Program.

10.2 State Quality Initiatives

1. Describe how you propose to work with the Healthiest State Initiative.

Molina commends Iowa's goal to become the healthiest state based on the Gallup-Healthways Well-Being Index. To help improve Iowa's 2014 rank from #16 to #1, Molina intends to actively support opportunities that positively impact Iowa's ranking. Molina endorses the goals of the Healthiest State Initiative program because they are aligned with our company values and internal goals of improving health in communities.

Molina has been apprised of Iowa's Healthiest State Initiative, which includes three new programs for 2015: Assessment and Certification, T.E.A.M. (Teaching Employees Accountability Matters), and "Get Your Bib On." As an example of Molina's commitment to Iowa's Healthiest State Initiative, Molina will participate in the Assessment and Certification program and will seek to be certified as a Champion, Leader, or Advocate. Additionally, Molina leadership will review and assess how T.E.A.M can supplement our employee training and development program to ensure our staff is educated on program accountability and requirements. Furthermore, because "Get Your Bib On" is consistent with the HEDIS dental measure, Molina will highlight "Get Your Bib On" in communicating to providers and members the importance of members receiving at least one dental visit per year.

Molina will also encourage our employees, providers, and members to "Take the Healthiest State Initiative Pledge," which is an online registration that will allow electronic communication (e.g., news, information, etc.) to be disseminated to those who take the pledge. Lastly, to illustrate Molina's commitment to Iowa's Healthiest State Initiative, we are a proud sponsor at the "Healthiest in the Nation Sponsor Level" for the June 18 Healthiest State Conference "Taking Back Our Health."

Historically, Molina's key activities have been aligned with the Healthiest State Initiative's Focus 5 priority areas. For example, Molina offers smoking cessation programs, health educational materials about increasing the consumption of fruits and vegetables, and conducts outreach to members in various modalities to increase the percentage of preventive services completed, including an annual dental exam. For example, Molina's recent program in Utah taught children at Ellis Elementary School about the importance of a healthy diet and how to grow their own herb garden. Another example illustrating our alignment with the Healthiest State Initiative is our Diabetes Prevention program that was recently implemented in partnership with New Mexico State University. This program, offered in multiple languages, focused on diet, physical activity, and coping skills to maintain weight loss and healthy lifestyle changes.

Additionally, Molina will work with the Healthiest State Initiative by supporting SIM and ACO provider contracting. Molina will equip providers with data and information for health improvement strategies. Molina will also focus on communities to drive changes that improve population health, and improve health confidence in literacy and member experience.

Molina prides itself for being a company that supports not only healthy living for our members but also our staff. Improvements in health and quality of life are realized by addressing not only physical health but also the social and emotional factors that are crucial to overall well-being. Molina encourages all staff to complete an annual health risk assessment. In addition, gyms are available in most Molina locations.

Molina demonstrates all of the ten characteristics of a socially responsible employer as outlined in Iowa's Healthiest State Initiative. For example, Molina is committed to community service and has established a

vibrant corporate social responsibility initiative to support the communities we serve and to help those most in need. The Molina Helping Hands volunteer program provides volunteer opportunities to employees and facilitates this by offering time off for volunteer activities. Molina's Community Champions Awards recognize and affirm the contributions of everyday community heroes across the country. In addition, Molina trains for success by offering training programs and career growth. Molina also believes in employee recognition for contributions and encourages work/life balance. These combined efforts help to engage employees leading to employee satisfaction, and improvements in mental and emotional well-being.

Post-implementation, an important role of the Community Engagement Director will be evaluating additional opportunities to further integrate the elements of Iowa's Healthiest State Initiative in Molina's operations.

2. Describe how you propose to work with the Mental Health and Disability Services Redesign.

Molina supports Iowa's efforts to improve outcomes for its Mental Health and Disability Services that was launched in July 2014 with 15 regions as legislated through SF2315. Molina understands that the foundation of the Mental Health and Disability Services Redesign was based on the Iowa Olmstead plan and critical Iowa workgroups focusing on an integrated list of consumer-focused results. We will partner with the state to ensure services included in the Redesign will continue to provide Iowans with a regional base of services.

Molina values efficiency and collaboration in care models. In the Mental Health and Disabilities Redesign, service delivery systems coordinate funding and programming to ensure access to the spectrum of care. Molina will work with and support this redesign in several ways. Molina does not utilize a third party or subsidiary company to manage behavioral health outside of physical health. Molina's care management model, with a singular point of contact for providers and members, allows for coordinated and integrated planning and communication with less navigation burden, less administrative requirements, and less handoffs. Our Interdisciplinary Care Team Case Managers will work with the regional providers to ensure coordination of care amongst not only the behavioral health network but also the physical health network. Molina will support the crisis services requirement of this program through reimbursement of crisis services and by working with the regions to improve access and outcomes. Molina's senior behavioral health team has met and exchanged ideas and opportunities with Iowa Community Mental Health Centers through the Iowa Behavioral Health Association. These providers provide care in all regions of Iowa. Molina will work closely with these providers to meet the objectives of the Redesign. We will also partner with IPCA (FQHC's), who have provided a strong letter of support, to assist with coordinating physical and behavioral health. For more complex elderly and waiver-related care related to behavioral health and disability, Molina has a vision for Iowa Integrated Care Management, which will incorporate Molina Care Management with the preeminent providers in the community, including the University of Iowa and other critical providers.

Molina currently partners with the Illinois community regional providers in a similar effort. Crisis services are monitored and reimbursed not only by the service provided, but the outcome and follow up whether post discharge from the hospital or in a deflection to regional services. Molina encourages providers to enrich their scope of available ambulatory services in order to provide a more robust diversionary system. Molina will work with regions where there is a disparity of ambulatory services and through use of community connectors, case managers and community outreach programming, Molina will be able to identify gaps in services such as transportation, telephonic interdisciplinary care teams, and contracting for telemedicine services. Molina will obtain DHS approval of its proposed approach.

Molina's dedication to prevention also allows for additional collaboration with the regional systems of providers. Providing assessment, support and reimbursement for preventative services for at risk members

supports the redesign efforts as it allows for redirection of grant funds to better support more intense services supporting Severe and Persistent Mentally Ill (SPMI) members such as supportive housing and crisis diversion. Molina shares the Iowa Olmstead vision of a life in the community for everyone.

3. Propose strategies to incorporate the Value Index Score (VIS) as a tool to drive system transformation, and other strategies to support the State Innovation Model (SIM).

Molina has based health system transformation on the Institute for Health Improvement's emphasis on achieving the Triple Aim. The Triple Aim is aligned with the use of the Value Index Score and Iowa's State Innovation Model (SIM). Molina's experience in person-centered medical home, physical/behavioral health integration, and adherence to evidence-based medicine supported by health information technology are strategies supportive of these goals. Molina is committed to clinical improvement, performance measurement, transparency, and excellence in care coordination, care transitions and preventive care. Molina supports ACO models, like SIM, which are intended to deliver these objectives.

The Value Index Score (VIS) scores primary care providers across six dimensions of value, including primary and secondary prevention, chronic and follow up care, population health status, continuity of care, tertiary prevention, and member satisfaction; each of which is comprised of multiple measures. It is population-based, claims-based, risk adjusted, supported by research evidence, enables continuous evaluation and is correlated with the cost of care. Molina recognizes that a set of uniform metrics is a significant advantage in measuring results of population health. Incentive payments that have consistent methods also benefit value based purchasing by point of emphasis and scale and minimizing administrative burdens.

Molina understands that VIS facilitates important strategic goals in Iowa. As such, the VIS will be thoroughly analyzed to measure how well a provider can manage his or her patient population within the Molina system. Molina will share performance on VIS measures with providers and ACOs to identify areas for improvement. Because of its advantages in Iowa, Molina will strongly consider implementing an incentive model based on improvement in VIS scores, using results and implications of the program demonstrated in the baseline year. Molina has letters of intent or support, or verbal intent, with five of the six Iowa Health and Wellness Plan ACOs. Molina understands that 35% of all Iowa Health and Wellness Plan enrollees are in an ACO.

Other strategies include reporting and improving HEDIS results and CAHPS scores, as well as key utilization indicators including ER utilization, I/P Days, readmissions and pharmacy performance. Total cost results versus budgeted costs for populations in the SIM will also be measured. Molina will engage providers in the development of the ACO and promote transparency. Additionally, Molina will provide tools and reports for providers to provide actionable information for improving care and reducing costs.

4. Describe your experience in supporting a State authority in meeting the requirements of the Department of Health and Human Services Substance Abuse and Mental Health Services Administration Substance Abuse Prevention and Treatment Block Grant.

Molina is dedicated to developing a behavioral health program that will complement and assist the state and the community providers with meeting the requirements of the Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA) and Treatment Block Grant. The SAMHSA block grant has 17 goals that Iowa providers must comply with. Often Iowa providers are left bearing risk for most of the treatment requirements as the actual access and usage of services is typically much higher than expected. Molina has experience in meeting these goals and will work with the providers and communities of care to provide, coordinate and reimburse many of these services in Iowa to help meet and exceed these goals. Molina has partnered in several states with

our community partners to support services that are covered under the SAMHSA treatment block grant, including New Mexico, South Carolina, Illinois, California, as well as the Commonwealth of Puerto Rico.

Specific to substance abuse and mental health needs, Molina will partner with DHS and community providers to improve access to primary and other prevention services and treatment services. Molina Case Managers include disease management and education within the telephonic case management process. Molina also provides education, tools and support, as well as reimburses providers, on the use of prevention tools such as SBIRT. Molina's sister health plans also provide reimbursement for prevention services. For example, Molina of New Mexico contracts with community support workers and certified peer specialists to conduct outreach and support for members at risk. Additionally, Molina of South Carolina partners with the Department of Drug, Alcohol and Other Substances (DAODAS) to manage and reimburse for "Level 1" services as per the ASAM guidelines. Members who meet identified risk factors are provided access to community based individual, family and group settings with prevention and improved community access, stature and tenure as the goal. In Molina of Illinois, providers demonstrating best practices with community outreach and alternative opportunities for community tenure are being contracted to provide "living room" type services to the high risk population. Molina plans to partner with community providers and cover "Level 1" preventative services in Iowa.

Molina also has extensive experience in providing specialized services for members with special conditions. For example, Molina of South Carolina contracts with specialized outpatient providers that focus on pregnant women and women with dependents. These services include all levels of care including residential services that allow for medical care and cohabitation with their children. Transition of care to community based services that accommodate the member's family, medical and personal preferences are ensured. Molina will also contract with these service providers in the communities served in Iowa. Additionally, Molina has a high risk OB case management team who works closely with the behavioral health case managers to ensure that all pregnant members needs are met and services such as detox and medication management are provided by qualified providers in our network.

Additionally, Molina will work with providers in referral and coordination of services. Molina Case managers utilize an integrated multidisciplinary approach that includes Interdisciplinary Care Team meetings to help with coordination across all providers and supports. All Molina plans currently utilize Interdisciplinary Care Teams as a regular practice within case management programming. Molina Case Managers strive to ensure proper releases of information for all treating providers are documented in the member's electronic medical record so that all providers can access member information. Additionally, Molina has a provider portal that allows for visibility of encounter data and treatment plans as well as provide feedback to the treatment plans that is available to all providers a member permits access.

Molina will also partner with community providers to provide continuing education to members, community partners, and providers. Molina health plans have extensive community outreach and provider education opportunities. Molina of California provides regular in-services on coordination of care and behavioral health assessment and screening (e.g., SBIRT, PHQ-9) to primary care providers, clinics, County Behavioral Health collaborative and IPAs. Molina of Illinois provides quarterly technical assistant in-services to community behavioral health providers to review best practices, procedures and provide education on regional treads and important topics. Molina of New Mexico provides community outreach and education on behavioral health topics, procedures and services available through Molina in medical as well as behavioral health clinic settings, homeless shelters and outreach centers and clinics, and other community venues. Molina of Puerto Rico provides regular continuing education seminars to providers (both physical and behavioral health topics) as well as community educational opportunities on various health topics including behavioral health and substance abuse concerns specific to the community. Molina staff from all areas, including health care services, behavioral health, quality, provider outreach and community engagement will work with providers throughout Iowa to provide opportunities for education events whether Molina led or sponsored.

5. Submit a project plan describing your specific approach and timetable for addressing this section.

Refer to Attachment 10.2.5-1 Quality Improvement Draft Work Plan for addressing Section 10 Quality Management and Improvement Strategies. Additionally, Molina has provided the following sample timetable illustrating the key approaches addressing the state's quality initiatives.

Working with the Healthiest State Initiative (Key Approaches)	Approximate Target Date
Offer smoking cessation program to members.	January 2016
Hire Community Engagement Director.	January 2016
Organize health fairs that include wellness topics (e.g., healthy eating, preventive services).	June 2016
Measurement of key performance metrics.	June 2016
Implement member outreach strategies to encourage dental exam visit (e.g., telephone outreach, mailings).	August 2016
State Innovation Model (Key Approaches)	**Approximate Target Date**
Hire Community Outreach Director 90 day goal to evaluate feasibility of incorporating additional initiatives for Healthiest State Initiative Present plan by September 2016	January 2016
Begin performance measurement.	April 2016
Begin Transition of Care program.	June 2016
Use of Community Connectors.	June 2016
Promotion of patient-centered medical homes.	July 2016
CAHPS survey administration.	February 2017 - May 2017
[redacted]	March 2017

CONFIDENTIAL

10.3 Incentive Programs

1. Describe your proposed provider incentive programs.

Molina is committed to developing unique provider programs that are collaborative, foster innovation, and lead to improvements in quality and efficiency. To facilitate improvement in the performance of each provider, the Quality Improvement department facilitates activities that ensure accountability and performance improvement. Molina offers competitive payment as an incentive to join and participate in its network. Molina has Value Based Reimbursement (VBR) and Pay-for-Performance (P4P) models it has developed and proposed to providers that can include accountability and enhanced reimbursement.

Molina will offer both financial and non-financial incentive programs to reward providers who demonstrate continued excellence or significant improvement in quality metrics. The programs are designed to promote the enrollment and retention of the highest quality network providers; reward physicians and other providers for taking a broader, more active role in the management of members' health; and reward them for outcomes, quality and value instead of solely for visits or procedures. [redacted]

For the P4P Program, Molina will provide quarterly payments to its contracted providers based on the achievement of quality metrics as demonstrated through claims data. Payment will be made no sooner than 120 days after the close of the quarter in order to allow time for claims run-out. Molina's P4P program's overall success will be documented in the annual Quality Improvement evaluation and work plan. Molina will also assess HEDIS and CAHPS measurements annually for the overall outcome of each clinical measure relating to a P4P initiative and address whether the initiative is impacting quality of care, member and provider satisfaction, and cost of health care.

Subject to DHS approval, non-financial incentives could include additional educational offerings for provider staff, preferential member assignment to PCPs with superior quality scores, or imbedded case managers for high volume providers.

2. Describe your proposed member incentive programs.

Molina is committed to encouraging its members to improve their health outcomes. Molina will develop a member incentive and engagement program in Iowa that will reward members for making healthy choices about their health and care. This program will utilize an innovative population health management technology and engagement system proven to improve health and lower costs. This closed-loop platform facilitates a multimedia engagement strategy that includes outbound calls, auto-calls, web portal engagement, text messages and direct mail. The program utilizes the following successful strategies proven effective with low-income, diverse Medicaid populations:

- Incentives are tied to activities that align with HEDIS measures that can be easily tracked;
- Incentives are easy to understand and redeem by members;

CONFIDENTIAL

- Incentive programs feature gamification that includes points assigned to all activities, virtual achievements, interactive quizzes and tools, and activity raffles;
- Incentives are clearly communicated in multiple mediums;
- Incentives are aligned with robust engagement and reinforced continuously via alerts and reminders;
- Incentives are personalized to a member's health status;
- Incentives are served through a closed-loop technology platform that tracks effectiveness; and
- The program includes robust health analytic reporting including quality metrics and ROI reporting.

The program will feature member support through a Wellness Services call center to ensure members receive the proper assistance to earn and redeem their rewards. Dedicated call center staff will help members learn about the program; register for the program; redeem reward points; encourage program enrollment; and assist with technical issues.

To ensure members receive information on the rewards program, Molina will provide the following engagement communications:

- **Engagement Brochure.** Sent to all members.
- **Engagement Direct Mail.** Sent to targeted members based on reward eligibility.
- **First-Time Points Notification Booklet.** Sent with legal terms of use the first time a member earns points.
- **Early Engagement Member Cards.** New Member ID card that has a "rewards activation" sticker to verify contract information and link members to disease management resources before a claim.
- **High-risk Alert Engagement.** Sent to high-risk members based on more than 150 alerts generated from predictive health analytics.

Additionally, Molina will provide the following reward communications to encourage members to earn and redeem rewards:

- **Reward Achievement Alerts.** Sent each time a member earns reward points.
- **Reward Point Expiration Alerts**. Sent to members whose points are expiring.
- **Rewards Eligibility Termination Letter**. Sent when members are no longer Medicaid eligible.

All engagement and reward communications are sent in multiple mediums based on behavior. For example, if a member receives a direct mail and text message communication and completes a healthy activity as a result of the text message, text messaging is the medium prioritized for that member through the technology platform.

Under Molina's member rewards program, members will be automatically enrolled into the program and, upon registration, are eligible to earn and redeem rewards (Note: members can opt out of the program by contacting the Wellness Services call center). The following list illustrates the various types of rewards that Molina offers. Molina will work with the state to tailor these rewards to its performance measure requirements:

- **Healthy Smiles.** Members may earn reward for yearly dental visits.
- **Healthy Pregnancy.** Members earn reward points for completing a prenatal visit during their first trimester and completing a postpartum visit 21 – 56 days after delivery.
- **Asthma Management.** Members earn reward points for refilling their child's asthma controller as prescribed. Rewards points are awarded every first, third, sixth, ninth and twelfth refill to encourage ongoing medication adherence.
- **Diabetes Management.** Members earn reward points for completing an eye exam, HbA1c test and nephropathy test each year.

- **Health Assessment Completion.** Members who complete their Health Risk Assessment or their Comprehensive Needs Assessment are eligible to earn reward points once per year.
- **Antidepressant Medication.** Members earn reward points for refilling their antidepressant medication as prescribed. Reward points are awarded every 1st, 3rd, 6th, 9th, and 12th refill to encourage ongoing medication adherence.
- **Hypertension Medication.** Members earn reward points for refilling their hypertension medication as prescribed. Reward points are awarded every first, third, sixth, ninth, and twelfth refill to encourage ongoing medication adherence.
- **Well-Child and Well-Adolescent Visits.** Members earn reward points for completing annual physician visits.
- **Breast Cancer Screening.** Members earn reward points for completing an annual breast cancer screening.
- **Health Assessment Completion.** Members who complete their Health Risk Assessment earn reward points once per year.
- **Step-Up Challenge.** Members earn reward points by walking a specific number of steps within a 3- and 9-week period. Step goals can be modified based on health needs.

Upon earning reward points by participating in healthy activities, members can use their reward points to redeem items from the rewards catalog or order a rewards card that they can use to redeem healthy items from certain retailers. Rewards are tied to HEDIS criteria where applicable.

Members can redeem rewards online or by calling the Wellness Services call center. Members who have internet access can place orders through the online rewards catalog of healthy items. Examples of catalog items include basketballs, art sets, blood pressure monitors, medication lock boxes, baby bottles, and more. Members can also use the online interface to purchase a rewards card. Members who do not have internet access can place reward orders over the phone and receive a printed version of the rewards catalog. Members can also track their reward points online or over the phone.

See Attachment 10.3.2-1 Sample Member Rewards Program Booklet behind Tab 5.

HEDIS Measure Improvements

Molina's incentive program has a successful track record of achieving HEDIS measure improvements by focusing on improving members' compliance with key HEDIS services, which reward members for complying with recommended preventive and chronic care services. Molina strives to introduce more rewards that tie to HEDIS measures and align with cost savings.

Molina measures the success of its member incentive programs by analyzing the improvement of targeted HEDIS rates compared to previous results. The following HEDIS measures correspond to Molina's member incentive programs and represent key areas where data has indicated opportunities for improvement:

- Comprehensive Diabetes Care;
- Breast Cancer Screening;
- Prenatal Care;
- Postpartum Care;
- Adolescent Well Care;
- Well-Child Visits, First 15 Months of Life; and
- Well-Child Visits, Ages 3-6.

The success of Molina's member incentive program in achieving its goal of enhancing member

compliance with key preventive and chronic care services has resulted in improved HEDIS rates for many of the areas with active intervention programs, as shown in Exhibit 10.3.2-2.

Exhibit 10.3.2-2 Member Incentive Programs Impact

Plan	HEDIS Service	Percentage Point Improvement HEDIS 2013 to HEDIS 2014
Washington	Comprehensive Diabetes Care - HbA1c Testing	6.06%
Michigan	Comprehensive Diabetes Care – Eye Exam	8.61%
New Mexico	Breast Cancer Screening	11.83%
Michigan	Prenatal Care	3.25%
California	Postpartum Care	14.79%
Texas	Adolescent Well Care Visit	7.90%
Washington	Well-Child Visits: 0-15 Years of Age	5.43%

As a result of its incentive programs, Molina has made significant HEDIS rate improvements in those measures identified as opportunities for improvement. In particular, Molina has had success in motivating members on timeliness of prenatal care and postpartum care, breast cancer screening, diabetes care, and well-child visits.

10.4 Critical Incidents

1. Describe your critical incident reporting and management system.

Molina maintains a process for the identification, documentation, review and resolution of potential quality of care (PQOC) issues including Serious Reportable Adverse Events (SRAE) and Critical Incidents identified by members, internal and/or external sources. Molina monitors, manages and improves the quality of clinical care and services received by its members by investigating all PQOC issues.

The Quality Improvement (QI) Department uses a defined process for review of referred potential quality of care issues by:

- Investigating the issue;
- Reporting to appropriate agencies when appropriate;
- Documenting the results of the review and closure by the Medical Director;
- Initiating corrective action as indicated;
- Tracking data to determine case resolution time frames in the PQOC HIPAA-compliant database; and
- Reporting individual cases and systemic trends to the appropriate quality committee.

All PQOC cases referred to the QI Department are reviewed by appropriate clinical staff. First level review is performed by a QI registered nurse, it is then referred for second level review to a Medical Director and finally a third level review is performed by an internal peer review committee.

2. Describe strategies for training staff and network providers on critical incident policies and procedures.

Quality Improvement Department provides education of the potential quality of care (PQOC) policy and procedures, referral process, provider response time frame, corrective actions during Provider Office Management Meeting (POMM), Joint Operation Meeting (JOM), and HCBS centers and SNFs. The

Provider Manual contains information about the PQOC process and is shared with all providers at time of contracting and after every update. The PQOC annual report is distributed to providers via Just the Fax.

Molina also provides training to staff on critical incident policies and procedures. Health Care Services staff (including case managers and utilization management staff), as well as Nurse Advice Line staff, are trained to provide culturally competent, comprehensive and personalized clinical and non-clinical telephone services and possess significant competence in behavioral health and crisis intervention. Nurse Advice Line staff is trained to perform Member Services functions in addition to their usual function of providing immediate health care information and advice. Physicians are on-call to support staff for situations not covered by established clinical or administrative protocols.

3. Describe processes for implementing corrective action when a provider is out of compliance with critical incident reporting.

Potential quality of care issues (PQOC), including critical incidents, are identified through internal (e.g. Customer Support Center, Grievance and Appeals Unit, Provider Services, Claims Data, other Molina departments) and external sources (e.g. member, provider, community organizations, agencies, sub-contractors). Molina will perform ongoing review and assessments to track whether or not providers are compliant with critical incident reporting. If an issue is identified or Molina has reason to believe that a provider is not carrying out Critical Incident reporting activity in accordance with the terms of the requirements, Molina will work with the provider to develop a corrective action plan and will work with provider to ensure timely correction. If a resolution or correction is not attained after the implementation of the corrective plan, Molina will terminate the provider from the network.

Staff identifying a potential issue completes a referral form and forwards it to the QI department. If the PQOC is deemed a critical incident that involves a member receiving waiver services, the incident is reported to the appropriate agency and an Abuse, Neglect, and Exploitation form is completed and forwarded to the QI Department.

All PQOC cases referred to the QI department are reviewed by appropriate clinical staff. First level review is performed by a QI registered nurse; it is then referred for second level review to a Medical Director and finally a third level review is performed by an internal peer review committee.

Once the investigation occurs, the Medical Director assigns a responsible party for cases with confirmed quality of care issues. The responsible party may be a provider, health delivery organization, delegated group, non-physician staff member, contracted ancillary provider, or a department. The Medical Director determines the corrective action. Options for corrective actions include but are not limited to:

- Off-cycle review by Professional Review Committee;
- Counseling or education by the Medical Director or designee via written or verbal communication;
- Staff education by the Provider Services Department or another department;
- Policy or procedure improvement or protocol submission; or
- Practitioner response in writing to the issues identified.

All corrective action plans must be received from responsible party within a specified turn-around time.

4. Describe how critical incidents will be identified, tracked and reviewed and how data gathered will be used to reduce the occurrence of critical incidents and improve the quality of care delivered to members.

Molina monitors, manages and improves the quality of clinical care and services that members receive by investigating all potential quality of care (PQOC) issues including Serious Reportable Adverse Events

(SRAE) and critical incidents. PQOC issues are identified through internal departments (e.g., Member Services, Provider Services, Grievance and Appeals Department) as well as external sources (e.g., member, provider, community organizations, agencies, and subcontractors).

The Quality Improvement (QI) department uses the following steps for reviewing referred PQOC issues:

1. Investigating the issue.
2. Reporting to appropriate agencies when indicated.
3. Documenting the results of the review and closure by the Medical Director.
4. Initiating corrective action plans.
5. Tracking data to determine case resolution time frames in the PQOC database.
6. Reporting individual cases and systemic trends to the appropriate quality committee.

All PQOC cases are reviewed by appropriate QI clinical staff. All cases are forwarded to the Medical Director who makes a determination as to the appropriateness of the care delivered. Corrective action plans are then issued if appropriate and may include an off-cycle review by the Professional Review Committee (PRC), counseling or education to the provider by the Medical Director, staff education through Provider Services staff, submission of policy/procedure or improvement, practitioner response in writing to the issues identified.

PQOC and critical incident investigations are thoroughly conducted and are tracked and trended for potential negative patterns. Molina tracks the number and type of issue by practitioner at least quarterly and uses this data for ongoing monitoring and education of providers, re-credentialing, development of corrective action plans and other QI activities to improve the quality of care delivered to members.

PQOC reports are also discussed at various committees during defined time periods including the Clinical Quality Improvement Committee (CQIC), Professional Review Committee (PRC), Quality Improvement Committee (QIC), and Board of Directors (BOD).

10.5 Provider Preventable Conditions

1. Describe how you will ensure payment is not made for provider preventable conditions.

A monthly report will be reviewed by Molina's Manager of Data Integrity who will prepare a Quality of Care form for submission to and review by Molina's Quality Improvement department for all claims received with Provider Preventable Conditions. An initial review by Quality Improvement will be performed by a Registered Nurse with recommendations submitted to the Chief Medical Officer and/or Medical Director for a final determination of actions required, including non-payment.

For inpatient facility charges, Molina will accept the Present on Admission (POA) indicators as submitted on the UB-04 claim form. These POA indicators will determine whether or not the diagnosis will be used to determine the appropriate DRG to allow, ensuring that any HAC or Never Event will not be reimbursed. Molina uses a vendor, WebStrat, to validate all DRG codes billed by the provider against the diagnoses and other information submitted to determine the appropriate DRG to allow. Other Provider Preventable Conditions will be identified and tracked based on the diagnosis code or CPT Modifier submitted. These codes will identify the facility or professional care rendered for services including, but not limited to: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; or surgical or other invasive procedure performed on the wrong patient. These services will be denied as non-covered.

Molina health plans nationwide leverage innovative programs and partnerships to effectively reduce high Emergency Room utilization.

SECTION 11 – UTILIZATION MANAGEMENT

Please explain how you propose to execute Section 11 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP#MED-16-009, Scope of Work, Section 11 Utilization Management.

11.1 Utilization Management Programs

1. Describe in detail your utilization management program, including how you will operate and maintain the program.

Molina's Utilization Management program is supported by formal policies and procedures for benefit administration and efficacy, complaints and appeals, utilization review and integration with behavioral health, waiver services, long-term care and other services. Our Utilization Management program promotes the provision of quality, cost-effective and medically appropriate services across a continuum of care that integrates a range of services suitable to meet individual member needs. Molina's Utilization Management program is designed to influence member care by:

- Managing covered benefits effectively and efficiently without compromising the quality of care;
- Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized and measured for effectiveness;
- Coordinating, directing and routinely monitoring the quality and cost effectiveness of health care resource utilization, including Emergency Department use; inpatient, nursing facility and rehabilitation admissions; ancillary, out-of-area and out-of-network services; and behavioral health services; and
- Reviewing processes to ensure care is safe and accessible.

Molina manages covered benefits effectively and efficiently while ensuring quality care is provided through several authorization processes, such as Prior Authorization, concurrent review and discharge planning.

Accountability and Organizational Structure

The Molina Board of Directors has the ultimate authority and responsibility for utilization management activities and effects change through monitoring and analysis. The Board delegates the responsibility of utilization management oversight to the Chief Medical Officer, President, and the Executive Quality Improvement Committee. The Utilization Management Program structure is designed to assess, plan, implement and evaluate its utilization management activities based heavily on the gathering and analysis of utilization data. Data transformed into actionable information is at the core of the activities of the internal committees that review and/or participate in various utilization management functions.

Quality Improvement Committee – The Quality Improvement Committee is chaired by Molina's Chief Medical Officer. This committee is responsible for acting on findings, conclusions, recommendations, and outcomes reported to them by the Utilization Management Committee, the Delegation Oversight

Committee and the Pharmacy and Therapeutics Committee. The Medical Director or delegate represents the Utilization Management program as a member of the Quality Improvement Committee.

Utilization Management Committee - The Utilization Management Committee is chaired by Molina's Chief Medical Officer or their designee. The Utilization Management Committee meets quarterly and is accountable to the Quality Improvement Committee. The functions of the Utilization Management Committee include:

- Review and approve the Utilization Management program and criteria used to review decisions, annually;
- Review and assess Utilization Management practices for selected cases and diagnoses;
- Review and analyze data on outcomes and trend studies;
- Recommend actions based on Utilization Management findings;
- Conduct utilization monitoring by product and practice type;
- Monitor utilization trends and identify opportunities for improvement;
- Monitor consistency of Utilization Management decision making, including conduct of inter-rater reliability studies;
- Monitor compliance with external regulatory and accreditation bodies;
- Evaluate provider and member satisfaction with the Utilization Management program; and
- Review utilization information from delegated contractor, when applicable.

The Utilization Management Committee membership includes: Chief Medical Officer, Medical Director(s); Associate Medical Director(s); Director/VP, Healthcare Services; Director, Quality Improvement; Director, Behavioral Health; Managers, Healthcare Services; Managers, Specialized Healthcare Services Programs; Healthcare Data Analyst; Director, Pharmacy Services; and Contracted Providers. All of these committee members are selected to represent primary care, high volume specialists, and delegated provider groups.

Delegation Oversight Committee – The Delegation Oversight Committee is chaired by the Chief Medical Officer or designee. This committee meets monthly and reports directly to the Quality Improvement Committee.

Pharmacy and Therapeutics Committee – The Pharmacy and Therapeutics Committee is chaired by the Chief Medical Officer, Medical Director or the Director of Pharmacy Services. The Pharmacy and Therapeutics Committee meets quarterly and is accountable to the Quality Improvement Committee. The functions of the Pharmacy and Therapeutics Committee include:

- Pharmacy policy and procedure approval;
- Oversight of pharmacy Quality Improvement activities;
- Formulary management;
- Addition and deletion of formulary drugs;
- Evaluation of drug utilization patterns with development of intervention recommendations; and
- Oversight of communications about Pharmacy and Formulary to providers.

Committee membership includes: Chief Medical Officer; Medical Director; Manager Pharmacy Services; Outside Providers and Pharmacists; Contract Manager, Provider Relations; Director/VP, Healthcare Services; and Director, Quality Improvement.

Utilization Management Staffing

Staff responsible for utilization management decision making includes registered nurses (RNs), licensed practical nurses (LPNs), behavioral health professionals (typically master's prepared), social workers (SW), non-clinical support staff, the Behavioral Health Director and Medical Directors.

Utilization management activities are coordinated and conducted under the direction of the Medical Director, Behavioral Health Director (typically a psychologist or psychiatrist) and Utilization Management Director. Molina's Utilization Management staff of RNs, LPNs, social workers and behavioral health professionals obtains all pertinent clinical information and medical records necessary to determine the medical necessity of requested physical or behavioral health service authorizations.

Only RNs, LPNs and behavioral health professionals may conduct admission and concurrent hospital reviews. Molina ensures a physician, doctoral-level psychologist, certified addiction medicine specialist or pharmacist, as appropriate, reviews any behavioral health denials of care based on medical necessity. In cases where outpatient service requests may be reviewed by LPNs under the direction of an RN, licensed Utilization Management staff applies utilization review guidelines to each individual case and refers cases to the Medical Director when criteria are not met. See Exhibit 11.1.1-1 for a description of Molina's Utilization Management personnel and related responsibilities for authorization approvals and denials.

Exhibit 11.1.1-1 Personnel and Responsibility for Authorization Approvals and Denials

Utilization Management Personnel	Type of Request and Approval Requirements	Contingencies
Care Review Processor (non-clinical)	Authorization Not Required: (May advise a provider that no authorization is needed when provider calls or faxes an authorization request to Molina; advice based on a master list of services that do not require authorization)	If complex or special patient needs or delivery system issues are identified, staff may discuss said issues with the Care Review Clinician, Clinical Case Manager, Complex Case Manager, Utilization Management Director, Behavioral Health Director or Medical Director
Care Review Clinician (RN, LPN SW), Clinical or Complex Case Manager (RN or Behavioral Health professional)	Authorization After Clinical Review According to Defined Criteria	If complex or special patient needs or delivery system issues are identified, staff may discuss said issues with the Case Manager, Complex Case Manager, Utilization Management Director, Behavioral Health Director or Medical Director
Licensed health care professional – MD, DO, RPh, Behavioral Health professional (Doctoral level) or Dentist	Authorization After Review by a Medical Director	If complex or special patient needs or delivery system issues are identified, Medical Director can seek advice from a specialist or from inter-disciplinary consultations (e.g., Complex Case Manager)
Licensed health care professional – MD, DO, RPh, Dentist or Doctoral-level Psychologist	Denials	If complex or special patient needs or delivery system issues are identified, Medical Director or Behavioral Health Director can seek advice from a specialist or from inter-disciplinary consultations (e.g., Complex Case Manager)

Utilization Review Criteria

Molina's physical and behavioral health policies and procedures include documentation requirements for the use, periodic review and appropriate application of written, evidence-based clinical decision-making criteria. For consistency, Molina Medical Directors and Utilization Management staff use nationally recognized InterQual® Criteria by McKesson when reviewing the medical necessity of services for members. Molina's internally developed Medical Coverage Guidance is used to review the medical necessity of new technologies.

For consistent application of review criteria, Molina Medical Directors and Utilization Management staff use nationally recognized criteria for making decisions concerning medical necessity and appropriateness of services. The criteria sources used are one or more of the following:

- Molina Medical Coverage Guidance Determinations;
- McKesson InterQual® CareEnhance Criteria (Clinical Content, Level of Care Criteria and Care Planning Criteria); InterQual® Criteria is available to all Utilization Management staff in an online, web-based format;
- Apollo Managed Care Clinical Guidelines for Behavioral Health;
- American Society for Addiction Medicine Patient Placement Criteria;
- The Hayes Directory for New Medical Technologies;
- Comprehensive Medicaid Guidelines;
- Internally developed medical necessity criteria;
- Algorithms and guidelines from recognized professional societies;
- Advice from authoritative review articles and textbooks;
- Medicare guidelines;
- Health Plan-specific criteria; and
- Specialty consultations by a third party reviewer.

Physicians in active practice are involved in developing and adopting criteria specific to their area of expertise. When criteria are not available, Medical Directors use evidence-based reviews from medical literature or consultation with appropriate specialists.

Inter-Rater Reliability – To further ensure consistent application of review criteria, Molina trains, monitors and reviews Utilization Management staff on a regular basis. Policy and protocols guide the manner in which criteria are applied. Annual inter-rater reliability reviews and internal audits monitor the consistency of Utilization Management Medical Directors and staff in applying criteria.

Molina utilizes the McKesson Inter-Rater Reliability tool to assess the consistency of decisions made by Medical Directors and Utilization Management staff. The process includes assessment of the appropriateness and consistency of clinical information reviewed, criteria applied, and medical decision-making. Results are shared with our Medical Directors and Utilization Management Director and reported to the Medical Advisory Committee and the Quality Improvement Committee (QIC). When there is differentiation in decision-making, discussion and education will take place.

Quality audit reviews to determine appropriate application of Utilization Management policies and procedures are conducted at least monthly to review compliance with Utilization Management policies and procedures, such as documentation requirements and appropriate referrals to disease management and case management. The Utilization Management supervisory staff uses guided discussions to provide training and feedback on any deficient areas.

Medical Necessity Determination

Molina processes both inpatient and outpatient authorization requests based on the medical necessity of covered services using evidence-based criteria. Molina's licensed health care staff reviews each individual request based on chart notes submitted by or verbal communication from a provider. The submitted clinical information is then compared to the evidence-based criteria. If the criteria are not met the authorization is forwarded to a Molina Medical Director for further review and a final determination based on medical necessity. The Molina Medical Director may also utilize outside consultation to make a determination decision. Throughout the process, providers have telephonic access to the Medical Director to discuss medical necessity determinations. All Molina determinations of medically necessary services are considered final except in specific instances regarding appeals, hearings and independent review

Authorization of Services

Molina currently has Authorization of Services policies and procedures in place to ensure consistent application of review criteria for authorization decisions.

Molina requires prior authorization for many services, procedures, surgeries, devices, supplies, drugs and other treatments, and maintains a specific list of prior authorization requirements which are made available to all Molina contracted providers via the Provider Manual and the Molina website. Molina provides a detailed description of the authorization and referral process for available health care services and/or a detailed description of the processes used to determine whether health care services are medically necessary to anyone requesting such information.

Providers can make requests for authorization requirements by contacting the Utilization Management department by phone or fax. Utilization Management staff receives, reviews and facilitates delivery of requested information to providers via phone, fax or secure email.

Utilization review criteria, internal guidelines and nationally-recognized criteria and guidelines are used to determine approval of the requested service authorization. All information relevant to the individual member's care is used when making utilization management decisions. Molina may request specific clinical information such as clinical notes, consultation reports, imaging studies, lab reports, hospital reports, letters of medical necessity and any other clinical information deemed relevant to the case. All requested information is on a need-to-know, minimum-necessary basis. If insufficient information has been provided to make a medical necessity decision, the provider is contacted.

Molina's Medical Directors are physicians licensed in their applicable states to make medical necessity denial decisions for Molina members. Board certified specialty physicians from appropriate specialty areas also provide consultations as needed for medical necessity decisions.

Molina ensures a physician, doctoral-level psychologist or pharmacist, as appropriate, reviews all behavioral health denials of care based on medical necessity. Working in consultation with requesting providers when appropriate, only qualified Molina health care professionals with appropriate clinical experience in treating a member's specific disease or condition can make decisions to deny a service authorization request or to authorize a service in an amount, duration or scope less than originally requested.

Molina provides written notification to the member regarding a service authorization request denial or to authorize services in an amount duration or scope that is less than originally requested. Written in easily understandable language that will comply with Iowa High Quality Healthcare Initiative requirements, these notices include the specific utilization review criteria or benefits provisions used in the determination and provide information on the appeal process. Specifically, notices comply with 42 CFR 438.404(b)(1-3)(5-7), and include:

- The action Molina has taken or intends to take and the reason for the action specific to the individual member's case;

- An explanation of whether the member has any liability for payment;
- The toll free number to call if the member is billed for services;
- The member's and provider's right to request and receive, free of charge, a copy of the rule, guideline, protocol or other criterion that was the basis of the decision;
- Information regarding the availability of the State's designated ombudsman's office as referenced in the federal Affordable Care Act (Public Law 111-148);
- The member's right to file an appeal and procedures for doing so;
- Circumstances required for an expedited resolution and the process through which to request one; and
- Procedures for exercising the member's rights, including the member's right and means to request a continuation of benefits pending an appeal resolution, and conditions under which the member may be required to pay for services rendered by Molina.

Molina provides notice of determination to the requesting provider, either via phone or fax, or through letter notification. Furthermore, Molina will only deny a service as "non-covered" if DHS has determined the service to be non-covered under the fee-for-service program. Molina will direct members to and coordinate receipt of services that are excluded from the Contract but covered by DHS.

Authorization Decision and Notices Timeframes

Molina manages benefits effectively and efficiently while ensuring quality care is provided through different authorization processes and member/provider notification timeframes depending on the service request. Exhibit 11.1.1-2 below describes Molina timeframes for standard Utilization Management authorization and decisions, all of which either meet or are stricter than NCQA standards.

Exhibit 11.1.1-2 Utilization Management Authorization and Decision Timeframes

Type of Request	Molina Timeframes	NCQA
Non-urgent pre-service decisions	Within 7 calendar days of receipt of request Extension up to 14 additional calendar days (not to exceed 28 total calendar days) if: 1) Member requests the extension; or 2) Appropriate justification and documentation of need for additional information and how the extension is in the member's best interest	Within 15 calendar days Extension up to 15 additional calendar days (total not to exceed 30 days)
Urgent pre-service	Within 3 business days of receipt of request -OR- Within 1 hour for life-threatening conditions Extension up to 14 calendar days if: 1) Member requests the extension; or 2) Appropriate justification and documentation of need for additional information and how the extension is in the member's best interest	Within 72 hours (3 calendar days) of receipt
Urgent concurrent review (i.e., inpatient, ongoing ambulatory services)	Within 24 hours of receipt of request Extension up to 14 calendar days if: 1) Member requests the extension; or 2) Appropriate justification and documentation of need for additional information and how the extension is in the member's best interest	Within 24 hours (1 calendar day) of receipt; extension of up to 72 hours if two requests for additional information are made within the first 24 hours
Post-service decisions	Within 30 calendar days of receipt	30 calendar days

At the time of any denial action against a claim, Molina provides notice to a member in the event a denial of payment may result in payment liability for the member. Authorization or denial decisions in relation to the termination, suspension or reduction of a member's previously authorized services are made within 10 business days prior to such termination, suspension or reduction, except in those cases meeting criteria stated in CFR 431.213 and 42 CFR 431.214. Molina sends a notice of termination, suspension or reduction of the aforementioned services within three calendar days.

Molina makes standard authorization determinations within seven calendar days of receipt of requisite information and no more than 14 calendar days from receipt of a service request as required by 42 CFR 438.210(d)(1). Beyond the 14 calendar day period, Molina may employ an extension of up to 14 additional calendar days (28 calendar days total) to render an authorization determination, as allowed under 42 CFR 438.210(d)(1)(i-ii), if:

- The member or provider requests the extension; or
- Molina validates and documents the requirement of additional information and how said extension will best serve the member's health care needs.

When an authorization determination is extended, Molina provides a written notice to the member that includes a statement regarding the reasoning for the extension and information detailing the member's right to file a grievance if the member disagrees with the decision. Molina issues a determination as efficiently as the member's health care needs require and no later than the date the extension expires.

For expedited authorization, Molina makes a determination as promptly as the member's health requires and no later than three business days after Molina receives the initial request for service in the event a provider indicates, or Molina determines, that a standard authorization decision timeframe could jeopardize a member's life or health. Molina may extend the three business day timeframe by up to 14 calendar days, as allowed under 42 CFR 438.210(d)(2), if:

- The member requests the extension; or
- Molina validates and documents the requirement of additional information and how the extension will best serve the member's health care needs. Molina understands that it may be required to provide justification for an extension decision to DHS upon request.

In accordance with Scope of Work, Section 11.2.7.2.2 Expedited Timeframes, Molina understands that, unless otherwise provided by law, if Molina fails to respond to a member's prior authorization request within three business days of receiving all necessary documentation, the authorization will be deemed to be granted and that notice must be given.

Prior Authorization

Prior Authorization allows determination of medical necessity and appropriateness of services, procedures and equipment prior to utilization. It also provides an opportunity to verify covered benefits and identifies members who could potentially benefit from more intense Case Management services. Prior Authorization is an important function in Molina's integrated care management process, ensuring that members receive the right medical care, at the right time, and in the right setting. It also helps identify members with complex needs for case management and coordination of services. Prior authorization also fosters communication between the Care Management team, PCP, other providers, and the Interdisciplinary Care Team.

Requests for prior authorization are reviewed by licensed RNs, LPNs, Behavioral Health professionals, non-clinical support staff, and the Medical and Behavioral Health Directors utilizing established evidence-based medical criteria. Prior authorization requests related to long-term care are reviewed by a Molina Care Review Clinician or Case Manager who has experience in the implementation of long-term services and supports.

The list of services requiring prior authorization for physical health, behavioral health, psychosocial services and long-term care is made available through Molina's Provider Manual, the Molina website as well as upon request. Prior Authorization is required for the following health services as depicted in Exhibit 11.1.1-3 below.

Exhibit 11.1.1-3 Basic Services Requiring Prior Authorization

Physical Health	Behavioral Health	Long-Term Care	Self-Direction
• Inpatient admissions • Outpatient therapies • High dollar injectables and infused medications • Certain DME/Medical Supplies • Home Health Care • SNF/ICF admissions • MRI/MRA/CT Scans	• Inpatient acute Psychiatric admissions; • Partial hospitalization • Residential treatment services • Treatment foster care: levels 1 and 2 • Group Home • Adaptive Skills Building (autism)	• Adult day health • Assisted living • Behavior support consultation • Environmental modifications • Personal care services • Private duty nursing for adults	• Behavior support consultation • Environmental modifications • Related goods • Skilled maintenance therapy services • Specialized Therapies • Non-medical transportation

Services listed above requiring prior authorization are subject to change based on regulatory and contractual requirements. If the requested services do not meet criteria for medical necessity or covered services, the case will be referred to a physician reviewer for determination. Only Molina's Medical Director or Behavioral Health Medical Director may deny services. Molina does not require prior authorization for life-threatening, emergency medical or behavioral health conditions.

The Molina website includes a codification list to ensure providers and members clearly understand which services require prior authorization. If the requested services do not meet criteria as a covered benefit or for medical necessity, the case is referred to a Molina-employed physician for determination. Only Molina's Medical Director or Behavioral Health Director (when allowed per state regulations) may deny services. Molina does not require prior authorization for life-threatening, or emergency physical/behavioral health conditions.

Notices of Prior Authorization Changes, Payment Denials

In accordance with Scope of Work, Section 11.2.7.2.3 Notice of PA Changes, Molina will notify members in writing of decisions to terminate, suspend or reduce previously authorized covered services at least 10 calendar days before the date of action. Molina further understands that notices in the case of probable fraud as detailed at 42 CFR 431.214 may be shortened to five days advance notice, but that notice may occur no later than the date of the action under any of the exceptions from advance notice detailed at 42 CFR 431.213. Furthermore, in accordance with Scope of Work, Section 11.2.7.2.4, Molina will comply with 42 CFR 438.404(c)(2) and will give notice on the date of action when the action is a denial of payment.

Concurrent Review

Concurrent review determines the continued medical necessity and appropriateness for ongoing inpatient, transitional and home health care services. Members are identified for referral to specialty programs such as case management, disease management or behavioral health case management and care coordination. Discharge planning and facilitating transition to an appropriate setting also occurs.

Utilization Management nurses and behavioral health professionals obtain information from facility staff and providers on the clinical status, progress and care provided to members. If a member's clinical presentation satisfies the criteria for continued inpatient stay, the Utilization Management reviewer informs the provider of the authorization and the number of days before the next concurrent review.

Review results are documented in our multi-level medical management system, QNXT. If the Utilization Management reviewer is unable to authorize continued inpatient stay, the case is referred to the Medical Director to evaluate for medical necessity. At minimum, Utilization Management reviewers participate in weekly hospital case evaluations with the Utilization Management Manager and Medical Director to discuss the progress of hospitalized members, the continued appropriateness of inpatient care and the members' discharge needs for transition to lower levels of care. Utilization Management nurses also may participate in behavioral health multidisciplinary rounds with Case Managers, Behavioral Health Care Managers, the Medical Director and Behavioral Health Medical Director. These rounds promote integration and continuity of care for hospitalized members with co-occurring physical and behavioral health conditions.

During the course of an inpatient stay, frequent concurrent review is performed to make certain that the member is receiving appropriate care in an appropriate setting. All emergency admissions are also reviewed for appropriateness of the admission and length of stay. Internally developed Medical Coverage Guidance is used to review the medical necessity of new technologies.
Additional established criteria to be used by Molina for the Iowa High Quality Healthcare Initiative include, but are not limited to:

- Requirements stated in Iowa High Quality Healthcare Initiative Scope of Work, Section 5 Billing and Collections;
- Hayes Biomedical Directory;
- Behavioral Health Level of Care Guidelines;
- American College of Obstetrics and Gynecology clinical practice guidelines;
- American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care;
- U.S. Preventive Services Task Force Guide to Clinical Preventive Services;
- American College of Physicians practice guidelines;
- American Diabetes Association practice guidelines;
- Apollo Managed Care Clinical Guidelines for Behavioral Health; and
- American Society for Addiction Medicine Patient Placement Criteria.

Discharge Planning

Molina's Utilization Management Care Review Clinicians collaborate with hospital staff to create an appropriate discharge plan for the patient. They review the medical necessity and appropriateness for selected post-discharge services that may include home health care services, infusion therapy, durable medical equipment, skilled nursing facility placement, rehabilitative services, behavioral health intensive community case management or substance abuse treatment.

Adverse Determinations

Molina attempts to notify the requesting provider of an adverse authorization determination by phone or fax. Members and providers are also informed of this process and the established timeframes in their respective manuals.

Over and Under-Utilization

Molina monitors and evaluates provider and member utilization patterns of over- and under-utilization on an ongoing basis using data maintained in our QNXT medical management system and by Molina's Pharmacy Benefit Manager, CVS Caremark. QNXT data includes claims, membership, provider, authorization and other encounter data. Molina staff analyzes data gathered from QNXT, medical record reviews, HEDIS statistics and other utilization management records to generate reports that identify opportunities for improvement. Our Utilization Management Committee reviews and analyzes the data, interprets any variances and develops interventions based on their findings.

Pharmacy over- and under-utilization patterns are largely monitored through data generated by CVS Caremark. Molina's Pharmacy and Therapeutics Committee analyzes and trends pharmacy data and prior authorization activity to identify outliers in prescribing. Review of Drug Utilization trends may result in action by the Pharmacy and Therapeutics Committee to implement targeted interventions that affect and/or correct abnormal utilization. Initiatives are tracked by the Pharmacy and Therapeutics Committee at each quarterly meeting to document results and/or the need for further action or closure.

We consistently compare data to established thresholds to identify over- or under-utilization patterns, while other sources for data collection to monitor patterns include complaints from members or providers that suggest over- or under-utilization, denial trends and utilization reports. The following utilization reports are generated at a minimum annually and are designed to assist in monitoring quality and utilization trends, including:

- Inpatient Admissions:
- Average length of stay; and
- Bed days per thousand members per year (PTMPY), broken down by:
  - Surgical Bed Days
  - Medical Bed Days
  - Obstetrical Discharges
- Outpatient Visits, including Emergency Department visits:
  - Outpatient Office Visits (PTMPY);
  - Emergency Room Visits (PTMPY);
  - Ambulatory Surgical Procedures (PTMPY);
  - Rates of Top 10 diagnoses;
  - Outpatient Behavioral Health Authorization/Denial Rate (PTMPY);
  - Ad hoc reports on ancillary and specialty services such as imaging, durable medical equipment and certain specialties;
  - Percentage of members receiving mental health care (HEDIS);
  - HEDIS Well Child Exam Rates;
  - Special population ad hoc reports, such as children with special health care needs (CSHCN) and pregnant women;
  - Results of member surveys about access to specialists (e.g. CAHPS question 10, 24, or 25); and
  - Emergency Department high user reports
- Pharmacy:
  - Narcotic utilization;
  - Antibiotic utilization;
  - Psychotropic utilization;
  - Top drugs by volume and cost;
  - Utilization trends of individual drugs/classes; and
  - Prior authorization trending by drug.

While quantitative reporting is critical, effective utilization management analysis is incomplete without comprehensive qualitative analysis. Molina analysts and medical and utilization resources collaborate on qualitative analysis to draw conclusions regarding the causes, consequences and opportunities for

management. Methods may include fishbone diagramming or other tools to look for drivers and outcomes like interrelationship digraphs. To meet DHS contractual requirements, Molina will produce an annual report reflecting findings on quality and utilization measures as well as a detailed summary of completed or planned interventions to address over- or under-utilization patterns of care.

Member Utilization

Molina constantly monitors and evaluates member utilization data to detect variances such as over-and under-utilization, inappropriate pharmacy utilization and inappropriate Emergency Department utilization. For example, to effectively monitor and evaluate inappropriate Emergency Department utilization, Utilization Management staff evaluates an Emergency Department high user report at least monthly. Members who demonstrate frequent non-emergent Emergency Department visits, defined as greater than three (3) visits per month, are considered to be at-risk for avoidable hospital admissions. Molina sends these members an information packet with education materials written in easily understandable language describing the appropriate use of Emergency Department services. If, after initial contact, the member continues inappropriate Emergency Department usage, the Case Manager contacts the member to identify the member's motivation to misuse the Emergency Department and offers assistance to resolve the member's challenges. The Case Manager continues to support the member to ensure access to care in the right setting and reinforce the member's efforts to comply. This program may be revised based on potential DHS changes to the Emergency Services benefit.

Molina also produces reports to identify specific members who need preventive care or who may benefit from specialized programs such as disease management, care coordination, medical case management or complex case management. Molina uses its Clinical CareAdvance application to identify candidates for a variety of disease management and/or case management programs offered by Molina. Clinical CareAdvance mines the data on a schedule and identifies members based on programmed algorithms that utilize clinical data such as diagnoses and procedures.

Provider Utilization

Using our QNXT medical management system data or prescription data from Molina's Pharmacy Benefit Manager, CVS Caremark, provider-specific utilization data, such as hospital and Emergency Department utilization or prescription medication utilization, is compared to the average provider's utilization in the same category to flag outliers. Resources to establish comparable data include:

- Historic plan data from a single Molina health plan that establishes utilization patterns and thresholds;
- Historic plan data from other Molina health plans for similar lines of business, geographic regions, populations and provider types;
- NCQA Quality Compass;
- Percent Paid to Medicare;
- State Medicaid results;
- Other regional health reporting initiatives;
- Comparative data from companies that provide utilization review guidelines;
- Comparative data, thresholds and benchmarks provided by associations; and
- Evidenced-based utilization standards from medical literature.

By comparing individual provider utilization data to a larger group, Molina can identify providers whose utilization patterns are at the extremes. The Utilization Management Committee and Pharmacy and Therapeutics Committee evaluate utilization trends, identify anomalies, investigate specific details, when necessary, and initiate actions to address identified issues. Based upon situational circumstances, these two committees may recommend Provider Services staff conduct provider education to review contract requirements and resolve issues.

2. Describe your policies, procedures and systems to:

a. Assist utilization management staff to identify instances of over- and under-utilization of emergency room services and other health care services;

Molina's experienced Utilization Management staff detects, monitors, and evaluates under-utilization, over-utilization and inappropriate utilization of Emergency Department services and other health care services on an ongoing basis and implements processes to address opportunities for improvement. Provider performance is evaluated for under-utilization, over-utilization, and appropriateness, including place of service and level of care. On an ongoing basis, Molina obtains providers' hospital utilization and Emergency Department services utilization from claims data. Data are compared to the normal average practice utilization in the same practice category and a report is included in the provider's file. This data flags any over- or under-utilization outliers.

The key to strong quality and utilization management includes the gathering and analysis of utilization data to ensure opportunities for improvement have been identified and met. Useful reporting is based on quality data, which is dependent upon its completeness, accuracy and timeliness. Molina utilizes Utilization Management reports to perform analysis and gain analytical insight to drive improved management and health outcomes. Therefore, early and frequent collaboration between the analytic, medical and utilization management functions is the key to leveraging reports into information and subsequently translating that information into action. The internal committee structure supports the review, analysis, opportunity identification and targeted activities to improve outcomes.

Molina leverages multiple data sources and software tools available for utilization analysis, including:

- **QNXT** – QNXT is Molina's multi-level medical management system that includes claims, membership, provider, authorization and other encounter data including pharmacy data. The key features of the QNXT system include:
  - Simplified data retrieval from centralized database;
  - Synchronized data in one central location; and
  - Flexible, powerful and user-friendly Windows interface.
- **MedInsight –** MedInsight, developed by Milliman USA, is a comprehensive performance measurement tool that uses an established data warehousing approach and covers all aspects of health plan operations including utilization. It integrates Molina's existing data warehouse and synchronizes medical, operational and financial data for efficient utilization reporting.
- **Clinical CareAdvance –** Molina utilizes the Clinical CareAdvance application for Case Management/Disease Management. Clinical CareAdvance integrates all systems relating to Care Coordination, Case Management, Disease Management, Claims history, and Utilization Management functions, providing the integrated information sharing among appropriate staff. It provides a systematic and objective means to monitor, measure, and evaluate the care, services, and outcomes of Molina members at both the individual level and the systemic level. Clinical CareAdvance provides comprehensive health monitoring and reporting tools; Case Manager alerting; real-time member identification and stratification; customized real-time statistics and reports; and outbound communication methods tailored to the member. Individual health care plans maintained within Clinical CareAdvance are easily identifiable by the entire Case Management team ensuring member needs can be appropriately addressed for holistic Case Management. This total integration of systems benefits the member and provider when discussing issues relating to appropriate care and services. Molina documents information obtained from providers, members, Molina Care Coordination, Case Management, Disease Management, and Utilization Management data, in the Clinical CareAdvance system. Member adherence is documented in the appropriate secure health management data platform.

The effectiveness of interventions is monitored by Case Managers, as well as systematic review of encounter data by management to help improve outcomes and ensure quality and appropriateness of care and services.

The analyses produced are designed to answer questions related to appropriate utilization and optimal care delivery within the regional health care environment. Utilization metrics are further aggregated into specific levels, such as claim type or service category, episodic grouping, clinical classifications, diagnostic categories, major practice categories, Generic Product Identifiers (GPIs), and therapeutic classes. Analysis of these various categories provides options for in-depth understanding of the drivers of utilization, whether under-, expected-, or over-utilization.

Quantitative analysis is achieved by comparing collected data with internal and external normative and benchmark data and established thresholds and goals. If the comparative analysis indicates performance is under or over the threshold, Molina will monitor and drill into the data at deeper levels. Comparable data may include:

- Historical plan data that establishes utilization patterns and thresholds;
- Historical plan data from other Molina plans, comparable products, regions, providers and reports;
- NCQA Quality Compass;
- Milliman, Reden & Anders, Certitude, APC, % Medicare;
- State Medicaid results;
- Other regional health reporting initiatives;
- Comparative data from companies that provide utilization review guidelines;
- Comparative data, thresholds and benchmarks provided by associations and MCOs; and
- Evidenced based utilization standards from medical literature.

Reports that identify specific members who need preventive care or who may benefit from specialized programs such as disease management, care coordination, or case management, including Behavioral Health and Long-term Care Case Management, are also produced. Molina uses its Clinical CareAdvance application to identify candidates for a variety of Disease Management and/or Case Management programs offered by Molina. The Clinical CareAdvance mines the data on a schedule and identifies members based on programmed algorithms that include such clinical data as diagnoses and procedures.

While quantitative reporting is critical, analysis is incomplete without qualitative analysis. Analysts and medical and utilization resources collaborate on qualitative analysis drawing conclusions regarding the causes, consequences and opportunities for management. Methods may include fishbone diagramming or other tools to look for drivers and outcomes like interrelationship digraphs. Providers not meeting performance goals, including adherence to utilization guidelines, are contacted by Molina's Provider Services Representatives who reinforce performance objectives and the importance of partnering with Molina to deliver quality and appropriate care according to best practice guidelines.

b. Analyze emergency department utilization and diversion efforts;

Molina constantly monitors and evaluates member utilization data to detect variances such as over-and under-utilization, inappropriate pharmacy utilization and inappropriate Emergency Department utilization. For example, to effectively monitor and evaluate inappropriate Emergency Department utilization, Utilization Management staff evaluates an Emergency Department high user report at least monthly. Members who demonstrate frequent non-emergent Emergency Department visits, defined as greater than three (3) visits per month, are considered to be at-risk for avoidable hospital admissions.

Molina sends these members an information packet with education materials written in easily understandable language describing the appropriate use of Emergency Department services. If, after initial contact, the member continues inappropriate Emergency Department usage, a Molina Case Manager contacts the member to identify the member's motivation to misuse the Emergency Department and offers assistance to resolve the member's challenges. The Case Manager continues to support the member to ensure access to care in the right setting and reinforce the member's efforts to comply. This program may be revised based on any changes to the Iowa High Quality Healthcare Initiative Emergency Services benefit.

c. Identify aberrant provider practice patterns;

Appropriate physician utilization is achieved by analyzing service utilization patterns, including pharmacy and drug utilization reports. Molina utilizes comprehensive QNXT data, prescription data from CVS Caremark, Molina's Pharmacy Benefit Manager, along with provider-specific utilization data, such as hospital and Emergency Department utilization or prescription medication utilization, to compare outlier providers with the average provider's utilization in the same category. Resources to establish comparable data include:

- Historic plan data from a single Molina health plan that establishes utilization patterns and thresholds;
- Historic plan data from other Molina health plans for similar lines of business, geographic regions, populations and provider types;
- NCQA Quality Compass;
- Percent Paid to Medicare;
- State Medicaid results;
- Other regional health reporting initiatives;
- Comparative data from companies that provide utilization review guidelines;
- Comparative data, thresholds and benchmarks provided by associations; and
- Evidenced-based utilization standards from medical literature.

By comparing individual provider utilization data to a larger group, Molina can identify providers whose utilization patterns are at the extremes. The Utilization Management Committee and Pharmacy and Therapeutics Committee evaluate utilization trends, identify anomalies, investigate specific details, when necessary, and initiate actions to address identified issues. Based upon situational circumstances, these two committees may recommend Provider Services staff conduct provider education to review contract requirements and resolve issues.

Under- and over-utilization can signal quality of care issues that impact cost-effective health care delivery. Member complaints, site visits and quality of care concerns identified by staff; monitoring of licensure actions and sanctions; and audits of medical records are also used to identify provider behavior that deviates from standard-of-care expectations.

Aberrant provider practice patterns are further monitored through a formal program managed by Molina's Professional Review Committee. The Professional Review Committee meets monthly to review the severity and volume of aberrant provider behavior. Serious offenses are dealt with immediately. Based on the severity of the offense, the result may include the provider's removal from the Molina network and a filing of a report to the National Practitioner Data Bank and Division of Occupational and Professional Licensing.

Lesser infractions may warrant reminder letters, a request for a Corrective Action Plan, restrictions, penalties or other actions. Provider Service Representatives may deliver additional training or educational materials to physicians identified with negative behavioral patterns. All reported instances of aberrant

behavior become part of the provider's permanent credentialing file and unless resolved, are included in recredentialing considerations.

d. Monitor patient data related to length of stay and re-admissions related to hospitalizations and surgeries;

Molina leverages its robust Utilization Management system to identify, monitor and evaluate over-utilization, under-utilization and inappropriate utilization of medical/behavioral health care services, including important data points such as length of stay and re-admissions related to hospitalizations and surgeries, on an ongoing basis.

Molina utilizes reports to perform analysis and gain insight to assist in driving improved management and health outcomes. Early and frequent collaboration between the analytic, medical and utilization management teams is critical to creating valuable reports that are subsequently translated into action. The internal committee structure supports comprehensive review, analysis, opportunity identification and strategic, targeted activities to improve resource utilization and member care outcomes.

Molina consistently compares data to established thresholds to identify over- or under-utilization patterns, while other sources for data collection to monitor patterns include complaints from members or providers that suggest over- or under- utilization, denial trends and utilization reports. The following utilization reports are generated at a minimum annually and are designed to assist Molina in monitoring quality and utilization trends, including: Inpatient Admissions, including Average Length of Stay; and Bed days per thousand members per year (PTMPY), broken down by: Surgical Bed Days; Medical Bed Days; and Obstetrical Discharges.

e. Assure the appropriateness of inpatient care;

During the course of an inpatient stay, Molina performs frequent concurrent review to ensure our members are receiving the right care, at the right time, and in the right setting. All emergency admissions are also reviewed for appropriateness of the admission and length of stay.

Across its health plans nationally and the Commonwealth of Puerto Rico, Molina has established processes in place that meet exacting contractual requirements, state and federal regulations, and accreditation standards related to inpatient care and services for utilization review, continuity of care and quality of care. These standards also apply to Molina's onsite and telephonic review processes. All review decisions are supervised by qualified medical professionals, while all medical necessity denial decisions are strictly made by a Molina Medical Director.

When reviewing requests for inpatient admissions, Molina applies CMS regulations, CMS guidance, CMS coverage decisions and CMS processes as documented in applicable CFR sections, Medicare Manuals and CMS communications. Molina furthers uses written Utilization Review criteria guidelines that are based on sound medical evidence; are updated regularly, reviewed and approved annually; and are consistently applied within the context of CMS regulations, guidance and processes.

f. Ensure active participation of a utilization review committee;

Molina maintains written policies and procedures that ensure appropriate oversight and active participation of the Utilization Management Committee in all Utilization Management activities. At minimum, the Utilization Management Committee meets quarterly and is accountable to our Quality Improvement Committee. Key Utilization Management Committee functions include:

- Reviewing and approving the Utilization Management Program annually;
- Reviewing criteria used to make medically necessary decisions;

- Reviewing and assessing utilization management practices for selected cases and diagnoses;
- Reviewing and analyzing data on outcomes and trend studies;
- Making action recommendations based on utilization management findings;
- Conducting utilization monitoring by product and practice type;
- Monitoring utilization trends and identifying opportunities for improvement;
- Monitoring consistency of utilization management decision making, including reviewing inter-rater reliability study results;
- Monitoring compliance with external regulatory and accreditation bodies;
- Evaluating provider and member satisfaction with the Utilization Management Program; and
- Reviewing utilization information from a delegated contractor, when applicable.

Utilization Management Committee membership includes: Molina's Chief Medical Officer or designee; Medical Director(s); Associate Medical Director(s); Director of Utilization Management; Director of Quality Improvement; Director of Health Integration (WMIP, Behavioral Health and Direct Delivery Integration); Utilization Management Managers; Healthcare Data Analyst; and contracted providers selected to represent primary care, high volume specialists, behavioral health and chemical dependency practitioners and delegated provider groups. Contracted providers participate actively in the committee and are allowed to review and comment on Molina guidelines as they relate to a specific case. Provider comments or suggestions are reviewed for potential incorporation into Molina guidelines and then brought back to the committee for further review and potential approval.

g. Evaluate efficiency and appropriateness of service delivery;

Molina consistently evaluates the efficiency and appropriateness of its service delivery to ensure member receive the right care, at the right time, and in the right setting. Molina's regular process evaluation further ensures compliance with contractual requirements and accreditation standards related to care and services for utilization review, continuity of care and quality of care, including evaluation of onsite and telephonic review processes.

Molina's Quality Improvement and Utilization Management committees provide oversight and manage the evaluation of Utilization Management department functionality and efficacy. To assist with the consistent improvement of service delivery efficiency and appropriateness, committee duties include, but are not limited to:

- Review and Evaluation of utilization data reports to ensure appropriate and efficient allocation of Molina Healthcare resources and services;
- Evaluates quality and utilization related issues, develops Corrective Action Plans, and refers issues to the Quality Improvement Committee when indicated;
- Reviews, revises and approves Policies and Procedures applicable to HCS operations and functions;
- Annually reviews and evaluates Utilization Management Program performance; and
- Annually reviews and approves implementation of objective review criteria and guidelines which are based on sound reasonable medical evidence and are utilized by Molina Healthcare Services staff to assist with authorization determinations.

For the Iowa High Quality Healthcare Initiative, Molina will create written Utilization Review criteria in specific compliance with Contract and Scope of Work requirements. These criteria will be based on sound medical evidence; updated regularly, reviewed and approved annually; and consistently applied within the context of CMS regulations, guidance and processes. These criteria will further provide necessary guidelines for consistent monitoring and evaluation of Molina's service delivery to its members.

h. Incorporate subcontractor's performance data;

Molina will conduct all Utilization Management activities in-house, and at this time has not identified a need to delegate some or all of its Utilization Management activities, including prior authorization functions, to any subcontractor for the Iowa High Quality Healthcare Initiative. In the event of delegation, Molina would consistently conduct annual audits and ongoing monitoring to ensure the performance of its Utilization Management department complies with Contract requirements, Molina's written Utilization Management policies and procedures, and applicable state and federal law.

i. Facilitate program management and long-term quality; and

Leveraging the national experience of its 12 sister health plans across the United States and the Commonwealth of Puerto Rico, Molina's Utilization Management program will have policies and procedures and proven systems in place to assist its Utilization Management staff with facilitating program management and long-term quality and identify critical quality of care issues for our Iowa High Quality Healthcare members.

Our Healthcare Services Program is committed to comprehensive health care management for all members based on individualized needs and preferences. This focus, from prevention through treatment, benefits the entire care delivery system by effectively and efficiently managing existing resources to ensure quality care. It also ensures that care is both medically necessary and demonstrates an appropriate use of resources based on the severity of illness and the site of service.

Molina works in partnership with members and practitioners to promote a seamless delivery and coordination of healthcare services. Molina programs balance a combination of benefit design, reimbursement structure, information analysis and feedback, consumer education and active intervention that manages cost and improves quality across the healthcare continuum.

j. Identify critical quality of care issues.

Molina uses data from various information tools and systems to identify critical quality of care issues, including trends and areas for improvement so that targeted outreach and education can be supplied where it is most needed. Clinical CareAdvance is Molina's primary platform that allows for total integration of all systems relating to Utilization Management, Care Coordination, Case Management, Disease Management and Claims history functions, allowing for the integrated information sharing among appropriate staff.

Our Clinical CareAdvance system allows providers and caregivers representing multiple disciplines to collaborate with members to recognize critical quality of care issues, develop appropriate interventions, and achieve quality health outcomes by ensuring members are receiving necessary services. Clinical CareAdvance provides a systematic and objective means for our Utilization Management and Care Management teams to monitor, measure, and evaluate Molina member care, services and outcomes at both the individual level and the systemic level.

Quality of Care Issue Identification Utilizing [redacted]

CONFIDENTIAL

[redacted]

3. Provide a sample UM Work Plan.

In compliance with Scope of Work, Section 11.1.3 Work Plan, Molina will develop a Utilization Management (UM) Work Plan specifically to direct and support its Iowa High Quality Healthcare Initiative Utilization Management activities and processes. Our Utilization Management program description, Work Plan and program evaluation will be internally evaluated and updated as needed, and submitted to DHS annually for review and approval. Molina understands that the initial draft of these materials will be due within 30 days of Contract execution. Molina further understands and agrees that the Work Plan will not contain documentation from other state Medicaid programs or product lines operated by Molina. The Work Plan will identify required implementation steps along with a timeline with target dates, and will be submitted to DHS with incorporated Agency changes within 30 days after the first submission of the plan.

See Attachment 11.1.3-1 Sample UM Work Plan.

4. Describe if any UM functions will be delegated. If any functions will be delegated, describe proposed ongoing monitoring strategies of the delegated entity.

Molina Healthcare of Iowa will conduct all Utilization Management activities in-house, and has no plans to delegate some or all of its Utilization Management activities, including prior authorization functions, to any subcontractor for the Iowa High Quality Healthcare Initiative.

In the event Molina chooses to delegate any or all Utilization Management functions for the Iowa High Quality Healthcare Initiative, Molina's Delegation Oversight Committee would be responsible for monitoring our subcontractor's performance data and compliance with program and contract requirements. Molina's Corporate Compliance department and other key staff would also be responsible for monitoring subcontractors who provide health care services for the health plan to assure compliance with Molina policies and procedures and program requirements.

5. Describe the process for developing and updating practice guidelines.

Molina's policies and procedures include documentation requirements for the use, periodic review and updating, and appropriate application of written, evidence-based clinical decision-making criteria and practice guidelines. Physicians in active practice are involved in developing and adopting Utilization Review criteria and practice guidelines specific to their area of expertise. When criteria are not available, Medical Directors use evidence-based reviews from medical literature, or consultation with appropriate specialists. Molina uses internally developed Medical Coverage Guidance to review new technology.

These criteria reflect industry standards and best practices, meet NCQA standards, and are developed using published scientific evidence; input from practicing specialists and professionals; committee review and approval; and regular review and revision. Evidence-based criteria include appropriate use of new technology and the application of existing technologies related to medical, surgical and behavioral health procedures, equipment, devices and pharmaceuticals.

The Molina Healthcare Medical Coverage Guidance Committee meets at a minimum quarterly to review requests on new technology and/or treatments. This national committee is composed of all Molina Medical Directors and Chief Medical Officers, as well as legal staff. Following an in–depth review, a

CONFIDENTIAL

coverage guidance decision is developed and presented to the Molina Medical Advisory Committee for further review and acceptance at the local level.

Utilization Management criteria for all services, practices and technologies are reviewed, modified and adopted by the Utilization Management Committee at least annually. Long-term care and waiver policy and procedure changes are reviewed and modified by Case Management staff and approved by the Medical Affairs Committee at least annually.

6. Describe how your UM program will integrate with other functional units as appropriate and support the Quality Management and Improvement Program.

Critical data generated through Molina's Utilization Management program is an integral component of our established Quality Assessment and Performance Improvement (QAPI) Program which provides the organizational structure and supporting processes enabling Molina to achieve member-centered care that supports establishing health care goals, and engages the member's participation in self-determination.

Our QAPI Work Plans use data collected and processed through a number of mechanisms, such as electronic software and applications, manual collection processes, and external resources. The types of Utilization Management process data and internal monitoring used to identify opportunities for targeted performance and quality improvement interventions include, but are not limited to:

- Inpatient Admissions, including average length of stay and bed days per thousand members per year (PTMPY);
- Outpatient Visits, including Emergency Department visits:
  - Outpatient Office Visits (PTMPY);
  - Emergency Department Visits (PTMPY);
  - Ambulatory Surgical Procedures (PTMPY);
  - Rates of Top 10 diagnoses;
  - Outpatient Behavioral Health Authorization/Denial Rate (PTMPY);
  - Ad hoc reports on ancillary and specialty services such as imaging, durable medical equipment and certain specialties;
  - Percentage of members receiving mental health care (HEDIS);
  - HEDIS Well Child Exam Rates;
  - Special population ad hoc reports, such as children with special health care needs (CSHCN) and pregnant women;
  - Results of member surveys about access to specialists (e.g. CAHPS question 10, 24, or 25); and
  - Emergency Department high user reports
- Pharmacy, including narcotic utilization, antibiotic utilization, top drugs by volume and cost, utilization trends of individual drugs/classes, and prior authorization trending by drug.

Molina's QAPI Program applies an Outcomes-based Process model leveraging key data from our Utilization Management department and other key functional areas to analyze specific conditions, diagnoses, operational processes, services or populations for which measurable outcomes are desired. This process is used throughout the organization to help individuals improve procedures, systems, quality, cost, and outcomes related to their areas of responsibility. The process continues as a cycle of ongoing monitoring as outcomes are re-measured and the specific programs are enhanced with each cycle. Once approved for implementation, various departments and subcommittees continuously monitor the implemented activities and track the performance measures that have been defined.

7. Describe how the UM program will encourage health literacy and informed healthcare decision-making.

Molina collects and utilizes data in compliance with HIPAA regulations to enhance its health literacy and related outreach efforts targeting members and providers regarding missed services and other care gaps. Based on data monitoring and analysis, Molina generates target lists that consist of members and their associated providers who can be prioritized for outreach and quality initiatives with the goal of supporting more informed healthcare decision-making. For example, members with gaps in their well child visits are notified and incentivized to complete the recommended visits. Identifying service patterns by members provides Molina a mechanism for targeted member and provider outreach and education to increase utilization of needed services.

Molina notifies members, providers and Care Team participants about risk assessments and/or gaps in care via our QNXT medical management system, HEDIS Alert Program, Molina Web Portal, Interactive Voice Response (IVR) technology and its fulfillment service. Clinical CareAdvance, Molina's core case management system and a comprehensive health monitoring and reporting tool, also allows providers and caregivers representing multiple disciplines to outreach to and collaborate with members to achieve quality health outcomes through ensuring that members are receiving necessary services.

QNXT

Molina utilizes a secure, web-based, multi-level medical information management system that operates on a consolidated set of applications in the QNXT claims processing system to track referrals, service authorizations and care delivered. QNXT is Molina's core system application that includes claims, membership, provider, authorization and other encounter data, including pharmacy data. The key features of the QNXT system include simplified data retrieval from a centralized database; synchronized data in one central location; and a flexible, powerful and user-friendly Windows interface.

Alerts are activated in the QNXT multi-level medical management system to flag members who have missed services, and prompt Member Services Representatives to remind the member to obtain those services during incoming and outbound member calls. Molina's Member Services department also monitors the number of member no-shows for PCP appointments. Based on this information, calls are made to members and parents to identify barriers to keeping the appointments. Barriers are tracked and presented to the quality team for review and exploration of potential interventions.

HEDIS Alert Program

Molina's HEDIS Alert Program is an automated member treatment and appointment reminder system. Children and adults with special needs are tracked and monitored to ensure that follow-up care is provided at appropriate clinical intervals. Molina's Case Managers are accountable for improving non-compliance and are assigned to special needs members. Molina contacts members directly and assists them in scheduling the clinical intervention. All member treatment plans include preventive care requirements.

Molina's Web Portal

Molina offers a secure online provider and member Web Portal available 24 hours a day, 7 days a week. Molina identifies members with missed services and publishes the information via the Web Portal, so gaps in care are communicated to Molina providers. The secure provider Web Portal includes a monthly report of the provider's patients who need preventive services. Prompts about needed services are communicated to members in the secure member Web Portal when the member logs into the interactive Web Portal home page. The preventive health prompts are specific to the member's care needs and are age and gender appropriate.

Interactive Voice Response (IVR)

Interactive Voice Response (IVR), a Cisco-based platform that supports telephony rules/services for

member and provider contact, is used to notify members of gaps in care and provide preventive health care tips and information.

Fulfillment Service (Mail)

In addition to QNXT, the Web Portal and IVR, Molina also utilizes a Fulfillment vendor to communicate gaps in care via U.S. mail and provide educational resources to support its members in achieving quality health outcomes.

8. Describe strategies to monitor member access to preventive care and strategies to increase member compliance with preventive care standards. Describe how you will identify and address barriers which may inhibit a member's ability to obtain preventive care.

Molina monitors member access to preventive care and increases member compliance with preventive care standards through Utilization Management reports and technologies that identify specific members who need preventive care or who may benefit from specialized programs such as disease management, care coordination, or case management, including Behavioral Health and Long-term Care Case Management.

Molina uses its Clinical CareAdvance application to identify candidates for a variety of our innovative disease management and/or case management programs. Clinical CareAdvance mines the data on a schedule and identifies members based on programmed algorithms that include such clinical data as diagnoses and procedures. Our Clinical CareAdvance system allows providers and caregivers representing multiple disciplines to outreach to and collaborate with members to achieve quality health outcomes through appropriate preventive care measures ensuring that members are receiving necessary services. Clinical CareAdvance provides a systematic and objective means to monitor, measure, and evaluate Molina member care, services and/or potential barriers to services, and member outcomes at both the individual level and the systemic level.

Molina also uses sophisticated Business Intelligence and data-mining tools like [redacted] that allows Molina to comb through massive data collection and make connections in disparate data sets to discover trends, relationships and anomalies in data and turn them into valuable business insights. This technology supports Molina, from intervention lead generation to intervention coordination and outreach, and on to tracking these outreach results within the tool.

[redacted] provides advanced search features, including data visualization capabilities that improve the efficiency with which analysts can identify meaningful health care interventions, including preventive care services. [redacted] mapping functionality makes it very easy to see where non-compliant members are in order to facilitate related interventions. Also, it is much easier to use maps to identify the location of nearby health care facilities for coordinating outreach efforts.

The solution includes a provider outreach management component, which packages the results of the analyses described above into outreach reports that Molina can deliver to providers to coordinate interventions/follow-ups, including preventive care services.

[redacted] can be customized to generate reports that target precisely which providers are poor performers on preventive care or which clusters of members need the most preventive services. Molina is able to not only identify these providers, but identify the members affected and their address of record in relation to the provider responsible for their care.

9. Describe your UM Committee, including proposed committee composition and tasks.

Molina's Utilization Management Committee supports overall Utilization Management activities through the performance of the following functions:

CONFIDENTIAL

- Reviewing and approving the Utilization Management program and criteria used to review decisions, annually;
- Reviewing and assessing Utilization Management practices for selected cases and diagnoses;
- Reviewing and analyzing data on outcomes and trend studies;
- Recommending actions based on Utilization Management findings;
- Conducting utilization monitoring by product and practice type;
- Monitoring utilization trends and identifying opportunities for improvement;
- Monitoring consistency of Utilization Management decision making, including conduct of inter-rater reliability studies;
- Monitoring compliance with external regulatory and accreditation bodies;
- Evaluating provider and member satisfaction with the Utilization Management program; and
- Reviewing utilization information from the delegated contractor, when applicable.

The Utilization Management Committee is chaired by Molina's Chief Medical Officer or their designee. The Utilization Management Committee meets quarterly and is accountable to the Quality Improvement Committee. Membership of the Utilization Management Committee includes: Chief Medical Officer, Medical Director(s); Associate Medical Director(s); Director/VP, Healthcare Services; Director, Quality Improvement; Director, Behavioral Health; Managers, Healthcare Services; Managers, Specialized Healthcare Services Programs; Healthcare Data Analyst; Director, Pharmacy Services; and Contracted Providers selected to represent primary care, high volume specialists and delegated provider groups.

10. Describe any benefits which are proposed to require PCP referral and what services would be available on a self-referral process.

Molina network PCPs are able to refer a member to a contracted specialist for consultation and treatment without submitting a referral request to Molina, including consultation and treatment for members with chronic conditions requiring ongoing treatment.

Molina allows its members to self-refer for OB/GYN physician services directly from a Molina network obstetrician and/or gynecologist, or directly from a Molina network family practice physician or surgeon designated by Molina as a qualified provider of OB/GYN services. Molina strongly encourages its providers rendering services to members self-referring for OB/GYN services to communicate with the member's PCP regarding the member's medical condition, treatment, or any need for follow-up care.

11.2 Prior Authorization

Molina understands, agrees, and will comply with all requirements set forth in Iowa High Quality Healthcare Initiative RFP#MED-16-009, Scope of Work, Section 11.2 Prior Authorization.

1. Describe policies and procedures for processing authorization requests including when consultation with the requesting provider will be utilized.

Molina maintains written policies and procedures for processing prior authorization requests for various services, procedures, surgeries, devices, supplies, drugs and other treatments. Molina maintains a specific list of prior authorization requirements, made available to all Molina contracted providers via the Provider Manual and the Molina website. Upon request, Molina will make a detailed description of the authorization/referral process for healthcare services available to anyone who requests them.

Utilization review criteria, internal guidelines, and nationally recognized criteria and guidelines are used to determine approval of the requested service authorization. All information relevant to the individual member's care is used when making Utilization Management decisions. Molina may request specific clinical information such as clinical notes, consultation reports, imaging studies, lab reports, hospital reports, letters of medical necessity and any other clinical information deemed relevant to the case. All requested information will be on a need to know, minimum necessary basis. If insufficient information has been provided to make a medical necessity decision, the provider is contacted.

Molina will employ physicians licensed in the State of Iowa to make medical necessity denial decisions for its members enrolled in the Iowa High Quality Healthcare Initiative. Board certified physicians from appropriate specialty areas will provide consultations as needed for medical necessity decisions. Denial decisions will be communicated to the requesting provider and the member, in writing, as required by Contract and NCQA standards. These letters will include the specific utilization review criteria or benefits provisions used in the determination and provide information on the appeal process. Providers have telephonic access to the Medical Director to discuss medical necessity determinations.

Molina manages available benefits effectively and efficiently while ensuring quality care is provided through different authorization processes depending on the service request.

2. Describe mechanisms to ensure consistent application of review criteria for prior authorization decisions.

To ensure consistent application of review criteria, Molina Medical Directors and Utilization Management staff use nationally recognized criteria for making decisions concerning medical necessity and appropriateness of services. The criteria sources used are one or more of the following:

- Molina Medical Coverage Guidance Determinations;
- McKesson InterQual® CareEnhance Criteria (Clinical Content, Level of Care Criteria and Care Planning Criteria). InterQual® Criteria is available to all Utilization Management staff in an online, web-based format;
- Apollo Managed Care Clinical Guidelines for Behavioral Health;
- American Society for Addiction Medicine Patient Placement Criteria;
- The Hayes Directory for New Medical Technologies;
- Comprehensive Medicaid Guidelines;
- Internally developed medical necessity criteria;
- Algorithms and guidelines from recognized professional societies;
- Advice from authoritative review articles and textbooks;
- Medicare guidelines;
- Health Plan-specific criteria; and
- Specialty consultations by a third party reviewer.

Utilization management controls include the application of these nationally recognized decision support criteria to ensure the most rigorous standards of appropriate medical necessity and utilization are employed. These criteria apply an "if–then" logic relative to clinical information that are compared against requested services, procedures, hospitalizations and treatments, etc. Molina requires prior authorization for many services, procedures, surgeries, devices, supplies, drugs and other treatments. Molina maintains a specific list of prior authorization requirements, made available to all Molina contracted providers via the Provider Manual and the Molina website. Emergency services do not require utilization management review or authorization regardless of whether the provider is an in-network or an

out-of-network provider. If the member is admitted to the hospital subsequent to emergency treatment, a request for authorization must be submitted no later than the next business day.

Inter-Rater Reliability

To further ensure consistent application of review criteria, Molina trains, monitors and reviews Utilization Management staff on a regular basis. Policy and protocols guide the manner in which criteria are applied. Annual inter-rater reliability reviews and internal audits monitor the consistency of Utilization Management Medical Directors and staff in applying criteria. Molina utilizes the McKesson Inter-Rater Reliability tool to assess the consistency of decisions made by Medical Directors and Utilization Management staff. The process includes assessment of the appropriateness and consistency of clinical information reviewed, criteria applied, and medical decision-making. Results are shared with our Medical Directors and Utilization Management Director and reported to the Medical Advisory Committee and the Quality Improvement Committee. When there is differentiation in decision-making, discussion and education will take place. Quality audit reviews to determine appropriate application of Utilization Management policies and procedures are conducted at least monthly to review compliance with Utilization Management policies and procedures, such as documentation requirements and appropriate referrals to disease management and case management. The Utilization Management supervisory staff uses guided discussions to provide training and feedback on any deficient areas.

3. Describe processes for retrospective utilization monitoring for IDPH population services.

It is Molina's standard practice across all of its health plans to conduct retrospective review of services for which prior authorization was required but not obtained due to an unplanned circumstance (such as an emergent situation) prior to the delivery of service on a case-by-case basis. This enterprise-wide standard practice will be operationalized for Molina's IDPH population services retrospective utilization monitoring process for its members covered under the Iowa High Quality Healthcare Initiative. When appropriate, Care Review Clinicians request medical records and review the services for medical necessity and appropriateness based on InterQual® criteria, state and federal regulations, guidelines and Utilization Management policies. If the Care Review Clinician is unable to verify medical necessity, the case is referred to the Medical Director for a final determination. Written policies and procedures guide the manner in which all criteria related to retrospective review are applied. Annual inter-rater reliability reviews and internal audits monitor the consistency of decision making for each level of Utilization Management staff and Medical Directors in applying criteria and following Utilization Management policies and procedures. Results are presented to the Utilization Management Committee to seek external physician input and identify opportunities for improvement.

4. Describe required staff qualifications for UM staff.

Molina utilizes appropriately licensed health professionals whose education, training, and experience are commensurate with the reviews that they conduct and decisions they make to supervise all utilization management decisions. These include qualified medical professionals with specific experience required for each position, including a current license, where applicable, to practice without restriction.

Utilization Management staff includes registered nurses (RNs), licensed practical nurses (LPNs), behavioral health professionals (typically master's prepared), non-clinical support staff, and the Healthcare Services Directors and Medical Directors. Molina's Utilization Management staff of RNs, LPNs and Behavioral Health professionals will obtain all pertinent clinical information and medical record information necessary to assess requested service authorizations. Only RNs and Behavioral Health professionals may conduct admission and concurrent hospital reviews.

Outpatient service requests may be reviewed by LPNs under the direction of an RN. The licensed Utilization Management staff will apply utilization review guidelines to each individual case, and refer

cases to the Medical Director when criteria are not met. Non-licensed staff experienced in Utilization Management provides clerical support for inpatient, outpatient and case management areas and make utilization decisions that do not require licensed staff in accordance with pre-established authorization requirements for all service requests.

Only qualified physicians perform all medical necessity or behavioral health denials. Registered nurses and other licensed clinicians approve services based on established criteria. Licensed personnel perform utilization review for ambulatory and inpatient services and perform the post service reviews. Decisions requiring clinical judgments are performed solely by Molina medical professionals with the qualifications listed below.

Chief Medical Officer – Molina's Chief Medical Officer will hold a current, unrestricted physician license in the State of Iowa and report to the Plan President. Responsibilities include, but are not limited to:

- Representing the Molina Clinical Program throughout the organization and report to the Molina Board of Directors and the Plan President;
- Maintaining responsibility for oversight of clinical decision-making for the Plan;
- Chairing the Utilization Management Committee and participating in the Pharmacy and Therapeutics Committee;
- Leading the evaluation of new technology;
- Evaluating satisfaction with the Clinical Program on an annual basis and ensure completion of corrective actions;
- Coordinate Clinical Decision-making and Policies and Procedures with Provider Services;
- Maintaining authority, responsibility and accountability for denial determinations when acting as a clinical reviewer; and
- Evaluating Inter-Rater Reliability of physician reviewers.

Medical Director – Molina's Medical Director holds a current, unrestricted license in Iowa and report to the Chief Medical Officer. Responsibilities include, but are not limited to:

- Participating in the implementation of Care Management Program;
- When necessary, chairing the Utilization Management Committee and Clinical Quality Management Committee for development, approval and/or adoption of clinical decision criteria;
- Participating on the Molina Medical Coverage Guidance Committee;
- Conducting reviews and conducts clinical discussion with physicians;
- Maintaining authority, accountability and responsibility for denial determinations for lack of medical necessity;
- Consulting with board certified specialists of the specialty panel for review of behavioral health and other complex utilization issues;
- Serving as a consultant to Utilization Management personnel;
- Actively participating in staff development;
- Participating in individual case review; and
- Serving as a peer reviewer to practitioners to discuss potential denials.

Pharmacy Director – The Pharmacy Director has a current, unrestricted license in Iowa, reports to the Chief Medical Officer, and works in collaboration with the Healthcare Services department. Responsibilities include, but are not limited to:

- Ensuring operational execution of the Pharmacy Program and the administration of the prescription drug benefit in collaboration with other health plan medical leadership;
- Overseeing Drug Utilization Review Processes;
- Reviewing pharmacy Prior Authorization requests;
- Making recommendations and changes to the formulary as determined by the Pharmacy and Therapeutics (P&T) Committee; and
- Providing education to physicians, pharmacies, and members regarding the formulary.

Healthcare Services/Care Management Director – The Healthcare Services Director is a professional with appropriate experience who reports to the Plan President. Responsibilities include, but are not limited to:

- Implementing and maintaining Healthcare Services systems;
- Directing all activities related to the clinical review of ambulatory case management;
- Coordinating activities required to effectively interface with regulatory agencies, accrediting bodies, corporate representatives, regional leadership, the local Leadership Team, and other departments outside Healthcare Services;
- Facilitating, establishing and achieving the Healthcare Services Program's annual goals;
- Managing fiscal and human resources within the Healthcare Services department;
- Overseeing the development, implementation and updates to Healthcare Services department Policies and Procedures;
- Providing ongoing clarification of policy and procedure issues on a daily basis;
- Overseeing the development and implementation of education and training programs for internal staff and external audiences; and
- Participating in the oversight of all delegated operations.

Healthcare Services Manager – The Healthcare Services Manager is an RN with a current and unrestricted license in Iowa or a health care professional with appropriate experience who reports to the Healthcare Services Director. Responsibilities include, but are not limited to:

- Managing and coordinating daily operations and supervision of respective staff;
- Ensuring collaborative work with Healthcare Services staff in other areas of the department;
- Representing the Healthcare Services department in meetings at the direction of the Director;
- Taking a lead role in identifying opportunities for continuous improvement of department processes;
- Ensuring staff adheres to department and company policies and regulatory requirements;
- Identifying opportunities for training;
- Supporting the execution and assessment of the efficacy of the Healthcare Services Program; and
- Generating and monitoring Healthcare Services data reports.

Medical Claim Review Manager – The Medical Claim Review (MCR) Manager reports to the Healthcare Services Director. Responsibilities include, but are not limited to:

- Managing and training all MCR staff to meet all timeliness and regulatory required measures related to resolution of utilization management to claims payment issues, member appeals of medical necessity or benefit denials, and provider disputes of payment denials that are due to medical necessity denials;
- Representing the state in the Fair Hearing process and providing information as requested; and
- Collaborating with other departments as needed to resolve authorization for claims issues.

Healthcare Services Supervisor – The Healthcare Services Supervisor(s) reports to the Healthcare Services Director/Manager. Responsibilities include, but are not limited to:

- Coordinating daily operations and supervision of staff to facilitate proactive care coordination;
- Ensuring collaborative work with Healthcare Services staff in other areas of the department;
- Representing the Healthcare Services department in meetings at the direction of the Director;
- Ensuring adequate staffing and service levels, and maintaining customer satisfaction by implementing and monitoring staff productivity and performance indicators; and
- Supporting program related initiatives, and managing and completing work plan objectives and projects.

Healthcare Transitions Supervisor – The Healthcare Transitions Supervisor reports to the Healthcare Services Director. Responsibilities include, but are not limited to:

- Coordinating, overseeing and monitoring the Care Transitions team responsible for safely and effectively transitioning members from acute/inpatient settings to home;
- Managing and evaluating team members in the performance of various care transition interventions to ensure they are meeting the member's needs; and
- Monitoring information daily to ensure the team is consistently supporting cost-effective continuity of care and preventing unnecessary readmissions, wherever possible.

Healthcare Transitions Coach – Healthcare Transitions staff reports to the Healthcare Transitions Supervisor. Responsibilities include, but are not limited to:

- Safely and effectively transitioning members from acute/inpatient care to lower levels of care and/or home in a cost effective manner;
- Providing assessment, planning, implementation, coordination, monitoring and evaluation of services for the member as they transition between care settings, and following their progress for at least thirty (30) days; and
- Conducting hospital and post-hospital visits and calls based on program requirements.

Care Review Clinicians (Concurrent Review and Discharge Planning) – Care Review Clinicians report to the Healthcare Services Supervisor/Manager. Responsibilities include, but are not limited to:

- Providing daily review and oversight of inpatient admissions using applicable medical decision criteria to assure appropriateness of admission, level of care and length of stay, taking into consideration individual medical/social needs and medical necessity of admission;
- Providing healthcare transition support, prior to and at the time of admission, to ensure appropriate services are provided that are necessary to facilitate a safe discharge or placement in the appropriate lower level of care in the least restrictive environment possible;
- Supporting the execution and assessment of the efficacy of the Healthcare Services Program;
- Identifying members that are high utilizers of resources, in a high-risk category, or have a condition that is considered high-cost, and refer to case management to promote cost-effective resource utilization;
- Providing oversight for members receiving LTSS and waiver services in an institutional setting or while residing in the community with waiver coordination.
- Understanding the parameters and limitations of position responsibilities, and knowing when to seek the direction of the Healthcare Services Supervisor, Healthcare Services Manager, Healthcare Services Director and/or Medical Director;
- Ensuring that data and records are current and appropriately recorded;
- Participating in Interdisciplinary Care Team meetings;

- Communicating with practitioners and members regarding Healthcare Transition plans;
- Coordinating services when applicable;
- Participating in department quality initiatives; and
- Supporting the execution and assessment of the efficacy of the Healthcare Services Program.

Care Review Clinicians (Prior Authorization) – Care Review Clinicians report to the Healthcare Services Supervisor/Manager. Responsibilities include, but are not limited to:

- Managing member care within Healthcare Services department guidelines using good clinical judgment, appropriate criteria, and as directed by management;
- Ensuring authorization requests comply with medical necessity guidelines;
- Ensuring Continuity of Care (COC) needs are addressed;
- Participating in Interdisciplinary Care Team meetings;
- Coordinating services when applicable;
- Understanding the parameters and limitations of position responsibilities, and knowing when to seek the direction of the Healthcare Services Supervisor, Healthcare Services Manager, Healthcare Services Director and/or Medical Director;
- Ensuring that data and records are current and appropriately recorded;
- Participating in department quality initiatives; and
- Supporting the execution and assessment of the efficacy of the Healthcare Services Program.

Healthcare Services Case Manager – Healthcare Services Case Managers report directly to the Healthcare Services Supervisor/Manager. Responsibilities include, but are not limited to:

- Assessing, coordinating, care planning, implementing, monitoring and evaluating multiple services to meet complex member/family needs;
- Conducting assessments and interventions telephonically and/or in the member's home, as appropriate, to appropriately support the member's situation and case complexity;
- Assessing, determining and coordinating LTSS services in the community;
- Facilitating, communicating and providing a personalized case management care plan designed to meet individual member needs;
- Supporting the execution and assessment of the efficacy of the Healthcare Services Program;
- Providing daily review and oversight of inpatient Behavioral Health admissions using applicable medical decision criteria to assure appropriateness of admission, level of care and length of stay, taking into consideration individual medical/social needs and behavioral health necessity of admission;
- Providing discharge planning at the time of admission to ensure appropriate services are provided that are necessary to facilitate a safe discharge or placement in an appropriate lower level of care;
- Participating in Interdisciplinary Care Team meetings;
- Coordinating outpatient behavioral health benefits;
- Communicating with practitioners and members regarding Transition of Care plans; and
- Coordinating services between the member's Medicare and Medicaid benefits when applicable.

Delegation Oversight Nurse – Delegation Oversight Nurses are RNs or LVN/LPNs with a current unrestricted license in the State of Iowa who report to the Delegation Oversight Manager/Supervisor. Responsibilities include, but are not limited to:

- Coordinating and performing pre-delegation and annual delegated oversight audits, and monitoring delegated activities and health plan partners, as appropriate;

- Participating in the Delegation Oversight Committee (DOC) and reporting all delegation oversight activities and intervention plans to the DOC and Healthcare Services Committee; and
- Supporting the execution and assessment of the efficacy of the Healthcare Services Program.

Medical Claim Review Nurse – Medical Claim Review Nurses report to the Medical Claim Review Manager. Responsibilities include, but are not limited to:

- Resolving claims/ authorization issues, including respective clinical review and bill audits;
- Resolving member appeals of utilization management clinical or benefit denials; and
- Resolving provider dispute payment denials due to Utilization Management, bill audit or authorization coding issues.

5. Describe proposed utilization management clinical standards, including the use of any nationally recognized evidence based practices.

For consistent application of review criteria and clinical standards, Molina Medical Directors and Utilization Management staff use nationally recognized, evidence-based resources for making decisions concerning medical necessity and appropriateness of services. Evidence-based resources used are one or more of the following:

- Molina Medical Coverage Guidance Determinations;
- McKesson InterQual ® CareEnhance Criteria (Clinical Content, Level of Care Criteria and Care Planning Criteria). InterQual® Criteria is available to all Utilization Management staff in an online, web-based format and in hard copy;
- Apollo Managed Care Clinical Guidelines for Behavioral Health;
- American Society for Addiction Medicine Patient Placement Criteria;
- The Hayes Directory for New Medical Technologies;
- Comprehensive Medicaid Guidelines;
- Internally developed medical necessity criteria;
- Algorithms and guidelines from recognized professional societies;
- Advice from authoritative review articles and textbooks;
- Medicare guidelines;
- Health Plan-specific criteria; and
- Specialty consultations by a third party reviewer.

Concurrent review is the review of the medical appropriateness and medical necessity of continued hospitalization. The review is conducted prior to the end of an assigned length of stay, using criteria to evaluate the appropriateness of continued hospital level of care. During the course of an inpatient stay, frequent concurrent review is performed to make certain that the member is receiving appropriate care in an appropriate setting. All emergency admissions are also reviewed for appropriateness of the admission and length of stay. Internally developed Medical Coverage Guidance is used to review the medical necessity of new technologies. Additional established criteria used by Molina includes:

- Centers for Medicare and Medicaid (CMS) criteria and guidelines;
- Medicaid Inpatient and Outpatient Provider Manual;
- Hayes Biomedical Directory;
- Behavioral Health Level of Care Guidelines;
- American College of Obstetrics and Gynecology clinical practice guidelines;

- American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care;
- U.S. Preventive Services Task Force Guide to Clinical Preventive Services;
- American College of Physicians practice guidelines;
- American Diabetes Association practice guidelines;
- Apollo Managed Care Clinical Guidelines for Behavioral Health; and
- American Society for Addiction Medicine Patient Placement Criteria.

6. Describe how you will identify those services that will be reviewed for medical necessity determination. Provide a list of services for which prior authorization would be required.

Prior authorization allows determination of covered benefits, medical necessity and appropriateness of services, procedures and equipment prior to utilization. It provides a method to identify members that could benefit from focused care management intervention. Prior authorization is an important function in integrated care management, as it both notifies and records receipt of services that the care management team can then communicate to others on the member's comprehensive treatment team. Requests for prior authorization are reviewed by licensed RNs, LPN's, Licensed Master Level Clinicians, non-clinical support staff, and the Medical and Behavioral Health Directors utilizing established evidence-based criteria.

Exhibit 11.2.6-1 Basic Services Requiring Prior Authorization

Physical Health	Behavioral Health	Long-Term Care	Self-Direction
• Inpatient admissions • Outpatient therapies • High dollar injectables and infused medications • Certain DME/Medical Supplies • Home Health Care • SNF/ICF admissions • MRI/MRA/CT Scans	• Inpatient acute Psychiatric admissions; • Partial hospitalization • Residential treatment services • Treatment foster care: levels 1 and 2 • Group Home • Adaptive Skills Building (autism)	• Adult day health • Assisted living • Behavior support consultation • Environmental modifications • Personal care services • Private during nursing for adults •	• Behavior support consultation • Environmental modifications • Related goods • Skilled maintenance therapy services • Specialized Therapies • Non-medical transportation

Services listed above requiring prior authorization are subject to change based on regulatory and contractual requirements. If the requested services do not meet criteria for medical necessity or covered services, the case will be referred to a physician reviewer for determination. Only Molina's Medical Director or Behavioral Health Medical Director may deny services. Molina does not require prior authorization for life-threatening, emergency medical or behavioral health conditions.

7. Describe your prior authorization request tracking system.

Molina currently tracks and reports prior authorization requests and level of care (LOC) determinations in electronic format from date of receipt to date of completion. Molina utilizes its QNXT multi-level medical management system which includes recipient, provider, authorization, call tracking, eligibility, and conditions. This platform allows Utilization Management to access all available recipient data from all systems. QNXT provides Molina with the capability of tracking prior authorization requests and LOC assessments and reassessments from the date of receipt to the date of the decision notice.

Molina leverages the UM/K2 utilization management system, a comprehensive web-based workflow application that automates the entire life cycle of prior authorization, concurrent review, and case management faxes from receipt to delivery and back to the provider. The application has built-in features to enforce turnaround time as faxes move electronically between clerks, coordinators, nurses and the medical director. It has an extensive set of fax editing features that allows Molina to annotate/stamp electronically on faxes, and stitch separate faxes and electronic documentation into a single file. The application is integrated with Interqual to help Molina assess medical necessity. The utilization management system keeps track of the Interqual reviews and associates it with the case in UMK2. Additional UM/K2 functionality includes:

- Robust security enforces role based privileges and ensures recipients' protected health information is not compromised.
- An integrated search feature provides the ability to track a case or pull up historical information with the click of a button.
- Reporting dashboard provides the ability to manage day to day operational needs. The application is integrated with Molina's core claims system QNXT to obtain claims, eligibility, and demographic information. This allows users to progress through the workflow without disruption or accessing other applications for reference information. Prior authorizations are automatically selected by QNXT claims process during adjudication based on Authorization settings and match criteria. If QNXT does not find a matching prior authorization, claim adjudication continues to process the claim. If the benefit or contract configuration requires a prior authorization for the claim line, the appropriate edit will trigger if configured. The system provides a completely paperless solution that reduces administrative hours, increases staff productivity and allows more time to interact with providers and recipients.

Molina generates a wide range of reports from QNXT to track and report timelines. Turnaround times for prior authorizations are consistently within regulation timeliness standards and Molina maintains this level of compliance for LOC assessments as defined by the contract.

8. Provide sample notices of action as described in Section 11.2.7.

See Attachment 11.2.8-1 Sample Prior Authorization Request Notice of Action.

In accordance with Scope of Work, Section 11.2.7 Notice of Actions for Services, Molina understands, agrees, and will comply with the requirement that Notices of Actions for Services to Iowa High Quality Healthcare Initiative members are to follow language and formatting requirements designated in Scope of Work, Section 8.2 Member Communications.

9. Indicate if your organization elects not to provide, reimburse for or provide coverage of a counseling or referral service because of an objection on moral or religious grounds.

Molina affirms that it does not, and will not, elect not to provide, reimburse for or provide coverage of a counseling or referral service for the Iowa High Quality Healthcare Initiative because of an objection on moral or religious grounds.

10. Describe your program for ongoing training regarding interpretation and application of the utilization management guidelines.

All Molina Healthcare Services staff and members of Molina's Interdisciplinary Care Team (ICT) receive orientation and ongoing training on the appropriate interpretation and application of utilization management guidelines specific to applicable state and federal requirements. Initial training is conducted

at the time of hire; ongoing training is scheduled at minimum annually thereafter or more frequently as appropriate.

For the Iowa High Quality Healthcare Initiative, our Utilization Management training program will be developed to ensure Healthcare Services staff and ICT members have the knowledge and resources necessary to provide quality care and services for our Initiative members and related programs. Additional modularized training may cover a wide spectrum of topics including, but not limited to: ICT composition and roles; member eligibility; benefits; assessments; coordination of care; authorization; care planning processes for Integrated Care Management, including LTSS, social services, and other community-based services; clinical/functional software and system training; and all relevant Molina Healthcare Services operations policies and procedures.

Ongoing utilization management training for our Healthcare Services staff and ICT members will further focus on professional development according to staff responsibilities. Training may vary based on professional competency requirements, regulatory requirements, program and/or client specific requirements, and/or improvement opportunities identified through quality monitoring. Training sessions may be conducted through a variety of forums including, but not limited to:

- As part of Continuing Education for Professional License Maintenance/Renewal;
- Staff meetings;
- Group/individual mentoring;
- Attendance at vocational development conference attendance;
- Web conferencing; and
- Material review conducted for groups and/or individuals.

As is standard practice for every one of its sister health plans, Molina will document staff attendance during all utilization management training sessions specific to ensuring compliance with Iowa High Quality Healthcare Initiative Contract requirements. Staff members who do not complete required training or fail to meet competency measures will be subject to progressive disciplinary action. Healthcare Services supervisory staff will be responsible for ensuring all staff members successfully complete their training schedules and are competent in the performance of their responsibilities.

Additionally, Molina Healthcare Services staff will be audited quarterly by Healthcare Services supervisory staff to evaluate comprehension and consistent application of approved criteria and guidelines and to ensure policies and procedures are followed. On a monthly basis, Healthcare Services supervisory staff will also have a predetermined number of QNXT authorizations reviewed by supervisory staff for compliance with Molina Healthcare documentation, Iowa High Quality Healthcare Initiative Contract requirements, and NCQA and CMS standards.

Molina Healthcare of XXX

Healthcare Services (HCS) Work Plan & Evaluation 2015

VP of Healthcare Services _____ Date_____

Chief Medical Officer Approval _____ Date_____

Plan President Approval _____ Date_____

Contents

1. Coverage Determination/Authorization Requirements- PA 3
2. Coverage Determination/Authorization Requirements- CCR 10
3. Coverage Determination/Authorization Requirements- MDs 12
4. Appeals/ Medical Claims Review Processing 14
6. Care Management Programs 19
7. Disease Management Programs 23
8. Molina Transitions of Care (ToC) Program 26
9. Emergency Department Program 28

1. Coverage Determination/Authorization Requirements- PA

Streamline, modify, and communicate coverage determination/authorization requirements annually for Prior Authorization Staff. Ensure turnaround times are met. Ensure production standards for staff are met.

M= Members **P=** Practitioners **B=** Both Members and Practitioners

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Annual update of coverage determination (CD)/prior authorization (PA) guidelines for all lines of businesses. Target Date: 10/1/15 Project Lead: XXX	B	B	B	B	Consistent PA list for all product lines	XXX PA posted on XXX website			

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Develop coverage determination/ prior auth codification list for accurate claims payment. Target Date: 12/1/15 Project Lead: XXX	B	B	B	B	Ensure PA codification list is updated annually and properly configured in claims payment system.	XXX staff ensure proper configuration occurs with MHI claims liaison			
Communicate coverage determination/ prior authorization list to provider network and appropriate health plan departments. Target Date: 10/1/2015 Project Lead: XXX	P	P	P	P	Annual notice per contract for providers. Approp. notice and training for provider and member service depts.	XXX Provider Services team to send PA change notice to IL providers with # day notice.			

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Ensure XXX coverage determination/ prior auth turnaround time (TAT) and compliance % requirements are met. Target Date: Monthly Review Project Lead: XXX	B	B	B	B	Expedited/ Urgent requests within 72 hours Standard/ Routine requests within 14 days	Monthly/ Quarterly review of XXX PA TAT & Compliance %	**1Q '15** PA TAT Routine Age: ### PA Routine Comp%: ##% PA TAT Urgent Age: ### PA Urgent Comp%: ##%		

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Ensure Advanced Imaging (AI) team coverage determination/ prior auth turnaround time (TAT) and compliance % requirements are met. Target Date: Monthly Review Project Lead: XXX	B	B	B	B	Expedited/ Urgent requests within 72 hours Standard/ Routine requests within 14 days	Monthly/ Quarterly review of XXX PA TAT & Compliance %	**1Q '15** PA TAT Routine Age: ### PA Routine Comp%: ##% PA TAT Urgent Age: ### PA Urgent Comp%: ##%		

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Ensure Inter-rater Reliability activities occur annually for PA Nurses, SW, & CRPs annually. Ensure Quality Reviews are occurring for PA Nurses, SW, & CRPs monthly per policy. Ensure corrective action plans for staff below thresholds are established and closed appropriately. Target Date: Monthly Review Project Lead: XXX	B	B	B	B	90%	An audit of 4 cases per PA staff is conducted each month Annually 40 cases for the XXX team needs to be reviewed for the PA team and submitted to the Utilization Committee and ultimately NCQA	**1Q '15** PA CRC Avg: ##% PA CRP. Avg: ##%		

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Conduct analysis of member and provider satisfaction with the care access & monitoring/ utilization management process. Target Date: 8/1/15 Project Lead: XXX	B	B	B	B	Health Plan specific *(6% improve in CAHPS &/or Provider Service surveys is typically a sign. improvement)*	CAHPS Survey Provider Satisfaction Survey			

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Ensure 2015 CAM policies are approved by the MHXX Utilization Mgmt Committee. House policies at a MHXX SharePoint site where staff have read only access for day to day reference. Target Date: 4/1/15 Project Lead: XXX	B	B		B	4/1/15	XXX specific information inserted into MHI CAM policies templates & approved at XXX UMC committee.			

2. Coverage Determination/Authorization Requirements- CCR

Streamline, modify, and communicate coverage determination/authorization requirements annually for Concurrent Review Staff. Ensure turnaround times are met. Ensure production standards for staff are met.

M= Members **P=** Practitioners **B=** Both Members and Practitioners

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Ensure XXX coverage determination/ concurrent review (CCR) turnaround time (TAT) and compliance % requirements are met. Target Date: Monthly Review Project Leads: XXX	B	B	B	B	All requests within 72 hours	Monthly/ Quarterly review of XXX Inpt TAT & Compliance %	**1Q '15** CCR TAT Urgent Age: ### CCR Urgent Comp%: ##%	QNXT system does not have a time stamp in military time. Only way to track inpt data is based on attribute tracking in QNXT. Some MHIL staff are forgetting to fill out denial date attribute.	Coach staff on attribute tracking system. Ensure system in place for weekend and holiday staff coverage for MHIL

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Ensure Inter-rater Reliability activities occur annually for CCR Nurses, SW, & CRPs annually. Ensure Quality Reviews are occurring for CCR Nurses, SW, & CRPs monthly per policy. Ensure corrective action plans for staff below thresholds are established and closed appropriately. Target Date: Monthly Project Leads: XXX	B	B	B	B	90%	An audit of 4 cases per PA staff is conducted each month Annually 40 cases for the XXX team needs to be reviewed for the PA team & submitted to the Utilization Committee & ultimately NCQA	**1Q '15** CRC Avg: ##% Care Review Proc. Avg: ##%		

3. Coverage Determination/Authorization Requirements- MDs

Streamline, modify, and communicate coverage determination/authorization requirements annually for Medical Directors. Ensure turnaround times are met. Ensure production standards for staff are met.

M= Members **P=** Practitioners **B=** Both Members and Practitioners

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Ensure inter-rater reliability activities occur for MDs annually. Ensure corrective action plans for staff below thresholds are established and closed appropriately. Target Date: XXX Project Lead: XXX CMO	B	B	B	B	90%	Annually 40 cases for the XXX MD team needs to be reviewed for the & submitted to the Utilization Committee & ultimately NCQA			

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Ensure weekly rounds of inpt cases are occurring, productive, and a good use of time. Target Date: Monthly Project Lead: XXX CMO	B	B	B	B	Rounds at a minimum of twice a week. Recommend Tues/Thurs. Bed days per1000 = goal of XXX	XXX UM Dtr/ or CCR Lead to attend rounds. CMO and MD collaboration with staff			

4. Appeals/ Medical Claims Review Processing

Ensure appeals and medical claims review policies are followed. Ensure turnaround times are met. Ensure production standards for staff are met.

M= Members **P=** Practitioners **B=** Both Members and Practitioners

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Ensure appeals policies are updated annually with proper provider notifications of changes. Target Date: 2Q15 Project Lead: XXX	B	B	B	B	All policies approved at UMC with proper notifications by 2Q15	XXX specific information inserted into MHI Appeals policies templates and approved at XXX UMC committee.			

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Ensure appeals cases are being reviewed with XXX CMO at least weekly Target Date: Weekly MD Review Project Lead: XXX	B	B			XXX MD staff giving direction on appeals payments	Weekly mtg between CMO and XXX Appeals Staff			
Ensure D-SNP and MMP Appeals monthly appeal reports are being received at the XXX health plan and reviewed. Target Date: Monthly Review Project Lead: VP/Dtr HCS			B	B	Monthly oversight by XXX team on MHI Medicare Appeals team	Report from MHI Staff to VP of HCS monthly			

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Ensure adequate staff are assigned to reviewing claims that are in pend status for medical input and meeting appropriate turnaround times (TAT). Target Date: Monthly Project Lead: VP/Dtr HCS	P	P	P	P	30 day or less TAT	XXX Medical Claims Review staff to report monthly on medical claims review volumes and TAT			

5. Health Risk Assessment

Ensure Medicare members receive an initial and annual health risk assessment to improve member health and link members to Molina care management programs. **M=** Members **P=** Practitioners **B=** Both Members and Practitioners

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Telephonic Health Risk Assessment (THRA) or Telephonic or Face to Face Comprehensive Needs Assessment (TCNA/FCNA) completed for appropriate members. Individual care plan (ICP) updated for members after assessment. Target Date: Weekly Review Project Lead: XXX			M	M	80% assess. comp. rate for D-SNP & MMP 100% all members assessed within 90 days or 3 attempts made and mailed HRA sent to member.	MHI HCS team to complete initial assessment and complete the individualized care plan. Level 2, 3, & 4 referrals to state health plans for follow up.	**Initial Adjusted Assessments Rates** Jan '15 = XX% Feb '15 = XX% Mar '15 = XX% April '15 = XX% May '15 = XX% June '15 = XX% July '15 = XX% Aug '15 = XX% Sept '15 = XX% Oct '15 = XX% Nov '15 = XX% Dec '15 = XX% **Initial Unadjusted Assessments Rates** Jan '15 = XX% Feb '15 = XX% Mar '15 = XX% April '15 = XX% May '15 = XX% June '15 = XX% July '15 = XX% Aug '15 = XX% Sept '15 = XX% Oct '15 = XX%		

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
							Nov '15 = XX% Dec '15 = XX%		
Individual care plan (ICP) updated for members after assessment. Target Date: Monthly Review Project Lead: XXX			M	M	100% of assessed member to have an ICP	Molina staff create care plan in case mgmt system.	**Care Plan Completion % After Initial Assessments** Jan '15 = XX% Feb '15 = XX% Mar '15 = XX% April '15 = XX% May '15 = XX% June '15 = XX% July '15 = XX% Aug '15 = XX% Sept '15 = XX% Oct '15 = XX% Nov '15 = XX% Dec '15 = XX%	Multiple staff priorities	

6. Care Management Programs

Ensure care management programs are functioning according to Molina policy. Ensure adequate numbers of Molina members are being case managed. Ensure auditing of staff is occurring quarterly.

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Case management caseloads are meeting required staffing ratios. Target Date: Monthly Review Project Lead: XXX	M	M	M	M	Level/ Ratio 1: 1 to 600 2: 1 to 350 3: 1 to 85 4: 1 to 60	CCA Custom Report 104	**Jan '15** Level 2: ### Level 3: ### Level 4: ### ### **Feb '15** Level 2: ### Level 3: ### Level 4: ### ### **Mar '15** Level 2: ### Level 3: ### Level 4: ### ### **1Q'15** Level 2: ### Level 3: ### Level 4: ### ###		

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Interdisciplinary care team (ICT) meetings are occurring regularly for Level 4 imminent-risk members. Member and providers are invited to the ICT meeting. ICT follow up documents are sent to PCP & to appropriate members of the care team. Target Date: Monthly Review Project Lead: XXX			B	B	80% of Level 3 and 4 imminent-risk members have annual ICT meeting documented in CCA.	CCA Custom Report 120-filtered for ICT form	Jan '15 ##/## = % Feb '15 ##/## = % Mar '15 ##/## = % 1Q '15 ##/## = %		

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Audits of waiver members activities. Target Date: Monthly Review Project Leads: XXX				M	100% audit of waiver member care managemen t activities for first 60 days 1 case audited per CM per month	XXX CM supervisors to audit CM cases each month MHI standardized audit tool with State specific section	Jan '15 ##/## = % Feb '15 ##/## = % Mar '15 ##/## = % 1Q '15 ##/## = %		
Complete home visit shadow audits for case management staff. Target Date: Quarterly Review Project Lead: XXX	M	M	M	M	Home visits occurring with a high level of professional ism, effectivenes s, and safety.	Each case manager supr/mgr to shadow each case manager on a home visits 1 per quarter.	1Q '15 ##/## = %		

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Complex case management satisfaction surveys are sent to members regularly. Feedback is compiled and reviewed annually. Target Date: Monthly Review Project Lead: XXX	M	M	M	M	All levels 2, 3, and 4 members in Case mgmt to get a survey each quarter 50% response rate Minimum of 50 survey responses per year	Standardized case mgmt/disease management satisfaction survey sent to all XXX members in active case mgmt levels 2-4 quarterly	1Q '15 ##/## = %		

7. Disease Management Programs

Ensure Molina members are offered asthma and diabetic disease management programs in accordance with NCQA and Molina standards.

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Asthma disease management program is offered to eligible members in accordance with NCQA standards-Level 1. Target Date: Quarterly Review Project Lead: XXX	M	M	M	M	Eligible members are identified and sent appropriate welcome letters and materials by MHI Central Programs Staff	MHI Health Management staff to identify members work with members and send written materials monthly. MHI Health Management staff send monthly reports to XXX. XXX staff review work done by MHI staff and address any issues.			

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Diabetic disease management program is offered to eligible members in accordance with NCQA standards-Level 1. Target Date: Quarterly Review Project Lead: XXX	M	M	M	M	Eligible members are identified and sent appropriate welcome letters and materials by MHI Central Programs Staff	MHI Health Management staff to identify members work with members and send written materials monthly. MHI Health Management staff sends monthly reports to XXX. XXX staff review work done by MHI staff and address any issues.			

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Disease management satisfaction surveys are sent to members regularly. Feedback is compiled and reviewed annually. Target Date: Monthly Review Project Lead: XXX	M	M	M	M	All members in disease managemen t programs to receive a satisfaction survey at least annually. 50% response rate Minimum of 50 survey responses per year	Standardized case mgmt/disease management satisfaction survey sent to all XXX members in disease management programs.	Jan '15 ##/## = % Feb '15 ##/## = % Mar '15 ##/## = % 1Q '15 ##/## = %		

8. Molina Transitions of Care (ToC) Program

Ensure appropriate care is rendered in an appropriate setting, providing continuity of discharge planning activities and ensuring appropriate care after discharge care.

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Telephonic Transitions Program Target Date: Quarterly Review Project Lead: XXX			M	M	75% assess. completion rate for all time frames Re-admission rates below 10%	Telephonic Outreach while member is in the hospital and at discharge (d/c). -at hospital -2 days from d/c -7 days from d/c -14 days from d/c Program activities documented in Transitions Assessment in Clinical Care Advance (CCA).			

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Face to Face Transitions Program Target Date: Quarterly Review Project Lead: XXX			X	X	Re-admission rates below 10%	-hospital visit -home visit 7 days from d/c -home visit 14 days from d/c			

9. Emergency Department Program

Achieve ER Visit goals set and improve appropriate access to medical care for members with frequent ED use.

Activity/ Project	Medicaid	CHIP	D-SNP	MMP	Goal	Methods	Results	Constraints	Future Plans
Emergency Department Over-Utilization Outreach Program Target Date: Quarterly Review Project Lead: XXX	M	M	M	M	ER visits/K 800 or less	XXX to develop ER diversion program based on state and federal guidelines			

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Notice of Denial of Medical Coverage

Date: **Member number:**

Name:

Provider name:

Date of service:

Your request was denied

We've {Insert appropriate term *denied, stopped, or reduced*} the medical services/items listed below requested by you or your doctor:

Why did we deny your request?

We {Insert appropriate term: *denied, stopped, or reduced*} the medical services/items listed above because {Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage provisions to support decision}:

You have the right to appeal our decision

You have the right to ask Molina Medicare to review our decision by asking us for an appeal.

Appeal: Ask Molina Medicare for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: [[CA][<(800) 665-0898>]][[FL][<(866) 553-9494>]][[IL][<(855) 966-5462>]][[MI][<(800) 665-3072>]][[NM][<(866) 440-0127>]][[OH][<(866) 472-4584>]][[TX][<(866) 440-0012>]][[UT][<(888) 665-1328>]][[WA][<(800) 665-1029>]][[WI][<(855) 315-5663>]] to learn how to name your representative. TTY users call 711. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us.

Important Information About Your Appeal Rights

There are 2 kinds of appeals

Standard Appeal – We'll give you a written decision on a standard appeal within **30 days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 days**.

Fast Appeal – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision.

We'll automatically give you a fast appeal if a doctor asks for one for you or supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.

How to ask for an appeal with Molina Medicare

Step 1: You, your representative, or your doctor must ask us for an appeal. Your written request must include:

- Your name
- Address
- Member number
- Reasons for appealing

- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal.

For a Standard Appeal:	Address:	Molina Medicare ATTN: Grievance and Appeals P.O. Box 22816 Long Beach, CA 90801-9977
	Fax:	(562) 499-0610
For a Fast Appeal:	Phone:	(866) 553-9494
	Fax:	(562) 499-0610

What happens next?

If you ask for an appeal and we continue to deny your request for a service, we'll send you a written decision and automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

Get help & more information

- **Molina Medicare Toll Free: [[CA][<(800) 665-0898>]][[FL][<(866) 553-9494>]][[IL][<(855) 966-5462>]][[MI][<(800) 665-3072>]][[NM][<(866) 440-0127>]][[OH][<(866) 472-4584>]][[TX][<(866) 440-0012>]][[UT][<(888) 665-1328>]][[WA][<(800) 665-1029>]][[WI][<(855) 315-5663>]], 7 days a week, 8 a.m. – 8 p.m., local time. TTY users call: 711**
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116

Molina's state- and federally-compliant Fraud, Waste, and Abuse programs will be modified for the Iowa High Quality Healthcare Initiative to ensure program integrity from Day One.

SECTION 12 – PROGRAM INTEGRITY

Please explain how you propose to execute Section 12 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Molina understands, agrees and will comply with all Program Integrity requirements in accordance with Section 12 of Attachment 1—Scope of Work.

1. Describe your procedures for avoiding, detecting, and reporting suspected fraud and abuse to the State.

Molina has a comprehensive fraud, waste, and abuse program that operates in accordance with federal and state statutes, regulations and contract requirements. The program emphasizes prevention and detection activities, which are aimed at reducing incidents of fraud, waste, and abuse. Molina's Director of Compliance is responsible for implementing and overseeing Molina's Fraud, Waste, and Abuse Plan, with support from Molina's centralized Special Investigation Unit (SIU).

In accordance with requirements set forth in Scope of Work, Section 12.2 Program Integrity Plan, see Attachment 12.1-1 Draft Compliance Plan and Attachment 12.1-2 Draft Fraud, Waste, & Abuse Plan.

Avoiding, Detecting and Reporting to the State Suspected Fraud, Waste, and Abuse

Molina uses various types of controls and automated approaches as part of its comprehensive internal system to prevent and detect potential or suspected fraud, waste, and abuse. These measures include: monitoring federal and state enforcement actions; reviewing the annual U.S. Health and Human Services Office of Inspector General's (HHS OIG) work plan for trends; reviewing Molina employees, providers and vendors against the OIG excluded individuals and entities list; monitoring Molina's provider network for terminated providers and determining if these terminations were related to fraud, waste, and abuse; including information on fraud, waste, and abuse and how to report issues in subcontract provisions, the Provider Manual and the Member Handbook; credentialing of practitioners and facilities, which includes checking for appropriate licensure; pre- and post-payment processing review of service claims (claim data mining); provider record reviews; a comprehensive utilization management system, including prior authorization, care management, and various automated reports to identify utilization issues; offering an anonymous toll-free reporting hotline; identification of fraud, waste, and abuse by Molina employees; and sending explanations of benefits to members to verify that paid services were received.

An integral part of Molina's prevention and detection of potential fraud, waste, and abuse is the Special Investigation Unit (SIU), which supports the Director of Compliance in preventing, detecting, investigating and reporting all suspected or confirmed fraud, waste, and abuse to DHS. As part of its processes for deterring and preventing fraud, waste, and abuse, the SIU uses a fraud analytics tool. This dedicated resource for program integrity allows the SIU to identify coding and billing outliers. The tool is a proprietary forensic editing system that combines multi-axis and rules-based analytics to conduct a detailed and global-level analysis of medical claims. The system is useful in identifying areas of risk with claims data, such as inaccurate payments, overpayment, and non-compliance with state and federal regulations. The system applies thorough and detailed analysis for each transaction while applying

comparative multi-axis analytics that identify relationships between different claims. The claim is broken down to each transaction line and is compared across three separate axes using the historical universe of claims submitted by Molina.

The SIU further uses this system to monitor service patterns through data analysis to identify aberrant service patterns; potential areas of overutilization or underutilization; changes in provider behavior; and possible improper billing schemes. Data analysis processes provide a comparative data review on a provider, member and global basis. With the assistance of resources made available to the SIU, comparative data can be composed. Data analysis has the ability to:

- Establish a baseline to enable the SIU to recognize unusual trends, changes in utilization, and/or schemes to inappropriately maximize reimbursement;
- Identify specific provider and common billing patterns;
- Identify high-volume or high-cost services;
- Identify provider and patient utilization patterns; and
- Identify provider referral patterns.

In addition, data matching, trending and statistical analysis are conducted on a continual basis for each of the following defined areas:

- Peer-to-peer comparisons by cost of service;
- Peer-to-peer comparisons by service type within a geographic area;
- Peer-to-peer provider comparisons by diagnosis types;
- Member-to-member comparisons by costs of services by service type;
- Member-to-member comparisons by quantity of services by service type;
- Comparison analysis of procedures, which are commonly over-abused; and
- Comparison analysis of common diagnoses by population.

Molina's SIU also uses analysis applications that regularly screen for the following:

- Emergency services that are not considered emergent;
- Readmissions or surgeries within 30 days of the original procedures for case management review;
- Claims submitted for Sundays and holidays (non-urgent or non-emergent);
- Services provided by a PCP that is not the member's PCP of record;
- Provider's changing billing patterns and amounts for CPT codes that may indicate the provider may be fishing for maximum payment amount (improper billing);
- Durable Medical Equipment (DME) rental costs exceed the actual cost of the item;
- Excessive referrals to specific providers;
- Frequency of visits based on diagnosis;
- Medical bills show treatment on days immediately prior to member termination date;
- Provider frequently uses unusual codes;
- Psychological testing procedures and diagnosis;
- Referring provider and medical provider belong to the same professional corporation or share the same address;
- Services with extended lengths of time;
- Services that reflect the most variation and frequency for a provider; and

- Profile therapy visits to identify providers billing consistently and whether the average number visits per member has increased.

In the event potential fraud, waste, or abuse is identified by Molina's SIU, the matter will be expeditiously reported to DHS in compliance with DHS requirements.

Investigating Fraud, Waste, and Abuse

As part of its procedures, Molina's SIU conducts investigations related to detecting, preventing and reducing fraud, waste, and abuse. Investigations may be based on referrals received through Molina's AlertLine system; data mining of unusual claims/provider billing behaviors; enforcement actions/sanctions; and federal and state fraud, waste, and abuse reports, including work plans.

The SIU may conduct a fraud, waste, and abuse investigation based on a referral made to the unit, or based on outliers identified in the fraud analytics system. When either occurs, the SIU conducts a preliminary investigation, which includes fact gathering (e.g., license verification, court records, claims history) to determine if the allegation presented to the SIU has merit. The SIU also reviews its system to see if the suspect(s) have been previously investigated by the SIU to determine if there is a pattern of behavior indicative of intent to engage in unlawful activities. If it is determined that further investigation is necessary in order to validate the allegation, the matter will then go through the extensive investigation process.

During the extensive investigation, the SIU requests medical records and/or other supporting documentation. The SIU reviews medical records and/or other supporting documentation to determine if services billed were supported and if they were provided as indicated in the claim. The SIU may also contact members directly to verify and validate services, as the information provided by members may be useful in determining if services were provided.

If it is determined during the extensive investigation that potential fraud may have occurred, the matter will be reported to DHS, and the SIU will take any necessary actions to recover funds that were inappropriately paid as a result of the potential fraud. If the matter involves waste or abuse (e.g., billing error), the SIU will send the provider an audit results letter detailing the findings of the audit (to include educational materials as needed) and any corrective action required by the provider, along with the identified overpayment amount due from the provider.

Additional Strategies to Combat Fraud, Waste, and Abuse

Molina has implemented additional successful strategies to combat fraud, waste, and abuse in order to prevent and deter inappropriate billing practices while increasing employee awareness of these issues. Molina's SIU provides program integrity services to multiple Molina health plans in multiple states, and is keenly aware of and involved in efforts to stop health care fraud, waste, and abuse. The SIU participates in state regulatory program integrity meetings and provides its expertise in these forums to address ways in which to minimize and stop illegal activity.

Along with conducting proactive investigations based on data analysis, Molina's SIU is at the forefront when it comes to educating its network providers who have been audited by the SIU. After the SIU conducts a provider audit that has resulted in deficiencies, the SIU works with the provider to address the identified issues. In most cases, the SIU requires the provider to submit a corrective action plan indicating how the provider will achieve coding and/or billing compliance moving forward.

If during an audit, the SIU identifies quality of care issues that may be negatively impacting the member's care, the SIU closely collaborates with Molina's Quality Improvement department, which then performs a quality of care review. One recent example of this successful collaboration was when the SIU identified multiple coding and billing anomalies involving a network provider in one of Molina's sister health plans. Of special concern was the number of narcotics being prescribed by the provider with little or no documentation to support those prescriptions. This issue was forwarded to Quality Improvement, which

conducted a quality of care investigation. Quality Improvement found the provider was inappropriately prescribing narcotics when they were not medically necessary nor supported by the member's presenting condition. As a result, the SIU and Quality Improvement issued their findings to the provider, and the results of the review were referred to the state's Medicaid Program Integrity office. The SIU and Quality Improvement continue to monitor this provider to make certain the issues identified have been addressed by the provider.

Program Integrity efforts planned for Molina Healthcare of Iowa, include:

- Program Integrity Collaboration with DHS staff – Molina, through its Director of Compliance and with support from the SIU, will initiate quarterly meetings with DHS program integrity staff to foster communications pertaining to fighting health care fraud, waste, and abuse in government programs like Medicaid. These meetings will discuss opportunities for closer cooperation and collaboration in program integrity matters and will include such topics as:
  - Fraud, waste, and abuse detection;
  - Streamlined reporting of fraud, waste, and abuse through one-time reports submitted via a SharePoint portal to eliminate redundant reporting to DHS;
  - Program integrity provisions in health care reform and their impact on fee-for-service and managed care plans;
  - Service verification procedures; and
  - Trends in health care fraud, waste, and abuse impacting Molina Healthcare of Iowa.
- Molina will also participate with DHS in quarterly meetings where best practices and fraud, waste, and abuse cases under investigation are discussed.

2. Provide examples of outcomes achieved in other states regarding program integrity efforts.

Molina's SIU was formally developed and implemented at Molina in January 2012. The SIU provides program integrity services to Molina Healthcare, Inc. subsidiary health plans that mandate the use of an SIU or have specific fraud, waste, and abuse requirements that can only be fulfilled by an SIU. From January 1, 2012 through December 31, 2014, the SIU has achieved the following positive outcomes:

- Opened 503 Medicaid cases and 202 Medicare cases;
- Closed 668 cases;
- Made 101 referrals to law enforcement or regulatory agencies;
- Issued 331 audit results letters to providers;
- Identified approximately $1.76M in overpayments;
- Recovered over $1M;
- Reviewed 95 provider appeals; and
- Identified through a claims edits review process overpayments totaling $4M with recoveries at approximately $2.49M.

In addition, Molina has been able to demonstrate program integrity compliance based on the work conducted by the SIU. The documents created and maintained by the SIU (e.g., Fraud, Waste, and Abuse Plan; SIU Policies and Procedures) have been reviewed and approved for use by multiple state health plan regulators. These documents have also been provided to the Centers for Medicare and Medicaid Services (CMS) Medicaid Integrity Group during program integrity reviews they have conducted. During one such review in the State of New Mexico in 2014, CMS indicated that Molina had "excellent" program integrity measures in place.

3. Describe methods for educating employees, network providers and members on fraud and abuse identification and reporting.

Molina uses multiple methods to educate and train its employees, providers, and members on issues related to fraud, waste, and abuse, including identification and reporting. Fraud, waste, and abuse training is reviewed annually and revised as necessary to ensure the topics covered are relevant and current.

Educating Employees on Fraud, Waste, and Abuse Identification and Reporting

Molina provides training for employees, including the Director of Compliance, on identification, detection, prevention and reporting of suspected activities of fraud, waste, and abuse. In addition, Molina maintains a written "Code of Business Conduct and Ethics" that addresses Molina's commitment to detecting, preventing and investigating health care fraud, waste, and abuse.

In accordance with Molina's Anti-Fraud and Deficit Reduction Act policy, all new employees are required to complete training on fraud, waste, and abuse through New Employee Orientation within 60 days of employment. This training stresses the duty of all employees to report suspicious activity. To facilitate the prevention, detection, and reporting of potential fraud, waste, and abuse, the training covers:

- The definitions of fraud, waste, and abuse;
- Examples of types of fraud, waste, and abuse that employees might encounter;
- How to report suspected cases of fraud, waste, and abuse; and,
- Mechanisms in place for confidential and anonymous reporting.

Molina requires all employees, including board members and Molina's Director of Compliance, to successfully complete the annual fraud, waste, and abuse online training program through the Molina iLearn system. The annual Molina fraud, waste, and abuse training reinforces and expands upon the fraud, waste, and abuse training provided to new employees during employee orientation and includes information on the False Claims Act, as required by the Deficit Reduction Act. After taking the online course, all employees must complete an electronic post-test. For employees to receive credit for the training year, they must pass the post-test with a score of 100 percent. Employees who fail the post-test must continue to retake the exam until achieving a passing grade. Compliance maintains electronic logs of employee training and test results in order to track compliance with Molina's training requirements. Employee feedback on Molina's fraud, waste, and abuse training is used to analyze course content and make improvements where necessary.

In addition, all Molina employees also receive an annual in-person program integrity update from the Director of Compliance. This in-person update gives employees the opportunity to ask questions, increase their knowledge about compliance issues, and build familiarity with Compliance staff.

Molina will schedule and complete executive level training and key personnel training within 120 days of the effective date of the contract. Key personnel include those working in claims processing, utilization management, quality assurance, grievances and appeals, data collection, provider enrollment/disenrollment and encounter data.

The Molina Code of Conduct, its Compliance Plan, Fraud and Abuse Plan, and Deficit Reduction Act and False Claims Act policies and procedures are all available to employees on the Compliance intranet site. These documents contain references related to reporting employee non-compliant conduct. Retaliation against employees for reporting non-compliant behavior is not tolerated and will be handled as appropriate based on internal policies and procedures, including the possible termination of the individual who retaliated against the employee. Non-compliant behavior is investigated by compliance staff and, based on the results of the investigation, will be referred to Human Resources staff for further disciplinary actions, including immediate termination, should that be warranted.

Educating Providers on Fraud, Waste, and Abuse Identification and Reporting

For providers, Molina makes available an array of information about fraud, waste, and abuse that is published in multiple mediums. Fraud, waste, and abuse is a covered topic during the provider orientation training sessions conducted by the Provider Services department. The Provider Manual and provider Web Portal also provides educational information on fraud, waste, and abuse; how to report suspicious behavior; and information about the Deficit Reduction Act and False Claims Act. Subcontractors can also access this information on the provider Web Portal. Specific information about anti-fraud issues is provided upon request.

Educating Members on Fraud, Waste, and Abuse Identification and Reporting

For members, Molina includes educational information on identifying and preventing fraud, waste, and abuse and how to report suspicious behavior in its Member Handbook, which is also available electronically on Molina's website. Also, information on health care fraud, waste, and abuse is included at least annually in the member newsletter.

4. Describe internal controls to ensure claims are submitted and payments are made properly.

One of Molina's Special Investigation Unit's (SIU) ongoing activities is to mine claims data to identify suspected fraud, waste, and abuse. Molina's claims payment system utilizes system edits and flags to: 1) validate elements of claims are billed in accordance with standardized billing practices; 2) ensure claims are processed accurately; and 3) ensure payments reflect the service performed as authorized.

When Molina receives claims for reimbursement, pre-payment analysis is conducted. First, claims are put through an initial set of edits present in the claims payment system. Claims are then run against another set of local and national edits in a secondary system before being released for payment.

Molina also uses a third party software tool through its vendor, Verisk, to monitor inappropriate billing practices and perform cost savings. Physician billings and outpatient claims are processed through this tool. These claims pass through a series of edits, which verify the appropriateness of each line item of the claim. The first stage of edits verifies that the billing meets the appropriate state guidelines. The next stage of edits verifies the payment against the CMS guidelines, National Correct Coding Initiative (NCCI) edits, American Medical Association edits, as well as additional industry association edits as appropriate. The software tool produces a cost savings during the time of initial payment rather than obtaining re-payment through a recovery process.

As a final assurance, the SIU reviews claims data post-payment review by utilizing a fraud analytics system employing multiple algorithms aimed at identifying billing outliers and patterns of behavior. This allows the SIU to monitor service patterns by conducting data analysis to identify aberrant services patterns; potential areas of overutilization or underutilization; changes in provider billing behavior; and possible improper billing schemes. The SIU conducts data matching, trending and statistical analysis through the fraud analytics system, which allows for peer-to-peer provider comparisons for cost, service type and diagnosis type. The fraud analytics system has proven effective in identifying questionable billing practices involving upcoding, modifier utilization, service inconsistency, unbundling and numerous other scenarios.

5. Describe methods for verifying whether services reimbursed were actually furnished to members as billed by providers.

Molina has a process in place to verify if members received services billed by providers. Each month, Molina conducts a mailing of Explanation of Benefits (EOBs) to four-tenths of one percent of members comprising the paid claims universe for the previous month. This sample of members is contacted

regarding the services they received. Members chosen for verification are chosen at random, and certain services of a sensitive nature are excluded from this process.

Members who report they did not receive indicated services are directed to contact Molina's Member Services department. Member Services screens incoming calls and determines if the matter is a misunderstanding or requires preliminary review by the SIU. Preliminary and extensive investigations are then conducted by the SIU as needed to determine whether services reimbursed were furnished to the member as billed by the provider.

Molina Healthcare's state-of-the-art information systems operate on an integrated platform that is compliant with federal standards and conditions, and enable rapid implementation of new programs and program changes.

SECTION 13 – INFORMATION TECHNOLOGY

Please explain how you propose to execute Section 13 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Molina understands, agrees and will comply with all Information Technology requirements set forth in accordance with Section 13 of Attachment 1—Scope of Work.

Molina's HIPAA-compliant Management Information System (MIS), which is currently operational in 11 states and the Commonwealth of Puerto Rico, will support all Iowa High Quality Healthcare Initiative requirements, including management and care coordination functions, in a secure and confidential manner through the use of an integrated suite of industry standard and custom developed IT applications. Molina ensures that it is capable and prepared to submit all required data and reports in the format specified by DHS required to support of the Iowa High Quality Healthcare Initiative. Our MIS solution is capable of performing the data receipt, transmission, integration, management and system analysis tasks describe in the RFP and defined in the Scope of Work.

13.1 Information Services & System

1. Provide a general systems description and a systems diagram that describes how each component of your information system will support and interface to support program requirements.

Molina ensures that we will comply with the provision of Medicaid services as specified in Attachment 1 – Scope of Work, Section 13.1 – Information Services & Systems, and will support and interface with the appropriate State and DHS systems, as required and appropriate. Our MIS solution is fully capable of performing all functions indicated in the Scope of Work, subsection 13.1.1 – Required Functions, and meets the requirements of subsection 13.1.2 – General System Requirements.

Molina's HIPAA-compliant MIS will support all Iowa High Quality Healthcare Initiative requirements, as indicated in the Scope of Work, and will comply with all applicable state and federal laws, rules and regulations. Our core information systems are fully integrated, scalable and compliant with all EDI and HIPAA requirements for privacy, security and data exchange.

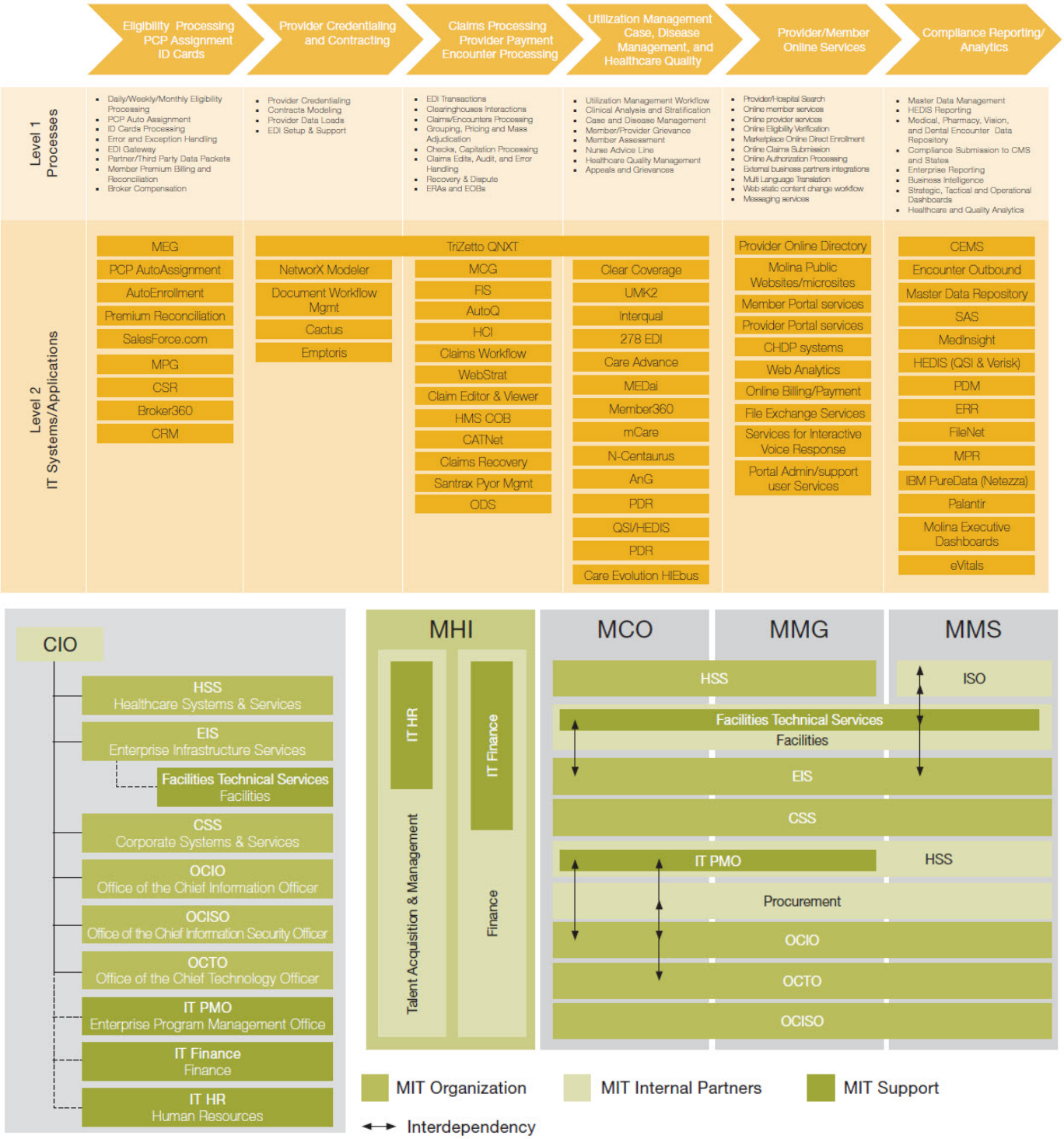
General MIS System Overview

Molina operates an MIS program that ensures that its information systems have the capability and capacity to accept, transmit, process, maintain and report on information in support of all health plan management functions. These functions include but are not limited to membership management, provider management, care management, provider payment management, encounter data management, program integrity management and customer service. Molina's integrated suite of IT solutions has been built over many years based on products from well-established solution providers, such as TriZetto, Oracle, MEDai and Milliman. Molina has also developed custom solutions, such as a feature-rich Web Portal that supports both members and providers that improve Molina's interactions with its customers and allows Molina to achieve considerable operational efficiencies.

Exhibit 13.1.1-1 illustrates the information systems by major business function that make up Molina's integrated IT suite. All of these systems are currently in use supporting Medicaid products in 11 states and

the Commonwealth of Puerto Rico. Release updates and upgrades to these systems are conducted periodically in accordance with Molina's system refresh plan and its change management processes. Furthermore, all of these systems are fully integrated, i.e., they communicate with each other either in real time or in accordance with standardized batch updates.

Exhibit 13.1.1-1 Molina's Information Technology Suite
Information Systems Supporting Major Business Functions



Throughout its history Molina has valued IT as a legitimate core competency. In addition to its managed health care line of business, Molina also offers health information management and business process outsourcing solutions to state Medicaid programs through its Molina Medicaid Solutions (MMS) subsidiary. MMS holds Medicaid Management Information Systems (MMIS) contracts in Idaho, Louisiana, Maine, New Jersey and West Virginia. These IT capabilities place Molina in a unique position among health insurance companies and demonstrate its commitment to leveraging the power of IT to its fullest.

Eligibility, Enrollment, and Disenrollment Management and Data Exchange
Molina's eligibility/enrollment process is completely automated including processes such as PCP auto assignment, ID card and welcome packet generation. Molina's inbound eligibility/enrollment process leverages a custom-developed, highly-integrated technology solution utilizing .NET and Microsoft BizTalk to provide extensibility and scalability for managing and processing inbound eligibility data before it is loaded into QNXT, Molina's core administration system. Molina can accept HIPAA-standard 834 enrollment data files as well as files based on proprietary formats.

Molina's eligibility/enrollment process is completely automated including processes such as PCP auto assignment, ID card and welcome packet generation. Molina's inbound eligibility/enrollment process leverages a custom-developed, highly-integrated solution utilizing .NET and Microsoft BizTalk to provide extensibility and scalability for managing and processing inbound eligibility data before it is loaded into QNXT, Molina's core administration system. Molina can accept HIPAA-standard 834 enrollment data files as well as files based on proprietary formats.

The whole life cycle of member enrollment is ultimately recorded and managed out of QNXT. This includes enrollment lapses, disenrollments, changes in family composition, changes in eligibility category which may determine access to certain benefits or cost-sharing requirements and movement in and out of an Iowa region. When applicable, Molina also transmits member eligibility/enrollment data securely to the File Transfer Protocol sites of its subcontractors.

Provider Credentialing and Contracting
The QNXT Provider module allows Molina to manage all aspects of provider records including demographic data, information about which providers participate in different lines of business and networks, relationships between providers, payment terms and conditions and membership assignments.

QNXT is fully capable of supporting the wide array of Iowa provider types and relationships including IPAs, PCPs, specialty providers, institutional providers such as hospitals and skilled nursing facilities, public or publicly supported providers such as 330 centers and municipal diagnostic and treatment centers, home and community-based service providers, behavioral health providers, ancillary providers, pharmacies and transportation providers.

For provider credentialing, Molina utilizes the Visual Cactus credentialing management application which allows business users to define and store custom provider attributes to maintain provider licenses, certifications and education and malpractice information. Visual Cactus also tracks Drug Enforcement Administration (DEA), Clinical Laboratory Improvement Amendments (CLIA) and National Association of Boards of Pharmacy (NABP) documentation, as applicable, as well as National Provider Identification (NPI) IDs. Visual Cactus also has a robust security module to protect confidential information. Molina currently obtains approximately 80 percent of its credentialed provider information in the form of electronic applications from the Council for Affordable Quality Healthcare (CAQH) or through spreadsheets provided by groups delegated for credentialing.

After verifying provider affiliations and credentials, Molina configures all provider demographic data and payment terms and conditions, as negotiated, into QNXT.

Molina will be able to transmit provider network data to DHS at the frequency required by the contract. Molina regularly reports provider network information in all 12 medical assistance health plan accounts.

Member and Provider Information Access
Molina maintains a secure electronic portal (Web Portal) for customer interactions and dissemination of information to members and providers. The Web Portal provides general and up-to-date information about Molina's Plan, including the Provider Network, Customer Services, Program Service Line, and the Grievance System and Complaint Process.

The Web Portal comprises of a provider portal, member portal and File Management System. The Web Portal provides a HIPAA-compliant secure site that is available 24 hours a day, 7 days a week and allows members, members' authorized representatives and providers a repository of customized information.

Molina' secure Web Portal provides information and extensive member and provider-oriented functionality including the following:

- View and print a member's Care Plan;
- Provide feedback to a Case Manager;
- View a member's service utilization profile;
- Authorization and utilization history for all review types;
- View a member's Care Team participants and contact information;
- Member eligibility verification;
- Prior Authorization (PA) submission and inquiry;
- Claim submissions and inquiry;
- Online provider directory;
- Member benefit descriptions; and
- Member ID card requests.

Molina's Web Portal processes approximately one million transactions per month.

Report Generation and Transmission
Molina's Business Intelligence and Analytics (BI&A) systems also support reporting requirements of all health plan operations and allows the development of ad hoc reports to enable plan management and DHS to make intelligent decisions regarding Molina health plan activity. Molina's BI&A systems have the capability to generate reports in various formats. All reports can be generated as hard copy or in an electronic ASCII format and transmitted automatically to a secure FTP site or e-mail address; they can also be posted on Molina's Web Portal. Furthermore, Molina's BI&A systems obtain data feeds continually from QNXT's claims, financial, enrollment/eligibility, provider and utilization management modules. Molina's BI&A systems include the following:

- **Molina Operational Data Store (ODS)** – ODS is a system of records for capitated Medical, Dental, Vision and Prescription Encounters, and HIPAA non-compliant encounter data. It is also an extension of the QNXT PLANDATA database for Fee-For-Service (FFS) claims and reference data (e.g., member and provider data). ODS provides data to the Claims Encounter Management System, Claim Viewer, and the Claim Editor.
- **Enterprise Reporting Repository (ERR)** – ERR serves as a comprehensive and centralized data hub that supports healthcare reporting and analytics. It is a unified data repository for capitated Medical, Dental, Vision, and Pharmacy Encounters; FFS finalized claims; master data; and other miscellaneous data.

- **Data Warehouse** – The Data Warehouse is a one-stop shop to provide data for reporting and analytics across the enterprise, which includes built-in data models. Together these capabilities improve the availability of data for much more efficient and standardized reporting and analytics while creating a foundation for improved data quality.
- [redacted]
- **QNXT Reporting** – The QNXT Custom Report Administrator reporting tool is utilized to simplify and enhance cataloging, viewing and printing reports, forms, cards and letters. Users can access the reporting tool through the Reporting Services link available via QNXT to generate call tracking, claims activity and care management activity reports, among others.

Case Management Systems

Molina currently utilizes the following integrated applications to support case management:

- **Clinical CareAdvance System** – Supports Case Management and Disease Management processes. Clinical CareAdvance also accepts data from other key information systems such as QNXT (member, physician, claims), CVS CareMark (pharmacy), MEDai (predictive modeling) and Quest Diagnostics (lab).

  The application is highly customizable to meet growing information demand. Data is processed through an Analytic Rules Engine (ARE) designed to identify and stratify members based on specific criteria (e.g., predictive risk score, number of inpatient admissions, number of emergency department visits, number of co-morbidities, and high dollar claim costs directed at targeted diagnoses such as asthma, cardiovascular disease, diabetes, hypertension, and others) enabling Case Managers to focus on critical clinical tasks and improve care management quality by fostering guideline compliance.
- **UM/K2 System** – Custom developed state-of-the-art application that supports prior authorization workflow management, from receiving authorization requests to qualified and adjudicated responses, for Molina Utilization Management staff;
- **Visual Cactus System** – Third-party credentialing management application to maintain provider credentialing. Provider demographic and credentialing information is then exported to QNXT via export feeds;
- **Interactive Voice Response (IVR)** – Cisco-based platform that supports telephony rules / services for member and provider contact. Some of the services offered over IVR for members and providers include: verification of the member's eligibility, check authorization and claim statuses, request for PCP change and ID card replacement requests;
- **Web Portal** – Molina offers a secure online provider and member portal available 24 hours a day, 7 days a week. Provider Web Portal services allow providers to conduct member eligibility inquires, search for other contracted providers, submit new authorization requests, inquire about the status of existing authorizations, check claims receipt and/or status, generate a listing of patient panels and download forms. Web Portal is Molina's web-based member and provider portal that imports and displays information from QNXT and Clinical CareAdvance and allows members, caregivers and providers to view and print a member's Care Plan, provide feedback to the Case Manager, view a member's profile including inpatient and outpatient visits, prescriptions, HCBS and Long-Term Services and Supports (LTSS) authorizations and utilization history, and view a list of the member's Care Team participants and contact information.

CONFIDENTIAL

- **MEDai** – Molina's Risk Navigator/Clinical Predictive Risk Score application allows Molina to predict members at risk with the highest accuracy available, identify specific cost drivers for high-risk populations, forecast future health plan costs, evaluate member patterns over time, monitor near real-time compliance around evidence based medicine guidelines, engage physicians by providing patient-specific compliance and medical history information, and identify actionable members most likely to benefit from proactive interventions;
- **E-Centaurus** – Provides Nurse Advice Line disposition triage guidelines that direct members to appropriate levels of care. Core member data is fed from QNXT to the ECentaurus application nightly. Member charts are posted on Molina's Web Portal for physician review and member engagement as needed; and
- **HEDIS Reporting** – All eligible Molina health plans collect, calculate and report HEDIS measures to NCQA. Cutting edge NCQA-certified HEDIS software from Catalyst Technologies ensures the validity and quality of results.

Molina uses TriZetto's Clinical CareAdvance application in QNXT for Case Management/Disease Management functions to track and manage service coordination activities. Clinical CareAdvance integrates all systems relating to:

- Care Coordination;
- Case Management;
- Disease Management;
- Claims History;
- Utilization Management;
- Integrated information sharing among the clinical staff;
- Information about provider referrals;
- Previously authorized services and hospitalizations;
- Risk scores;
- Lab results;
- Member Eligibility;
- Health Risk Assessment Results; and
- Primary Care Physician (PCP) assignment.

The CareAdvance application provides a systematic and objective means to monitor, measure, and evaluate the care, services, and outcomes of Molina members at both the individual level and the group level and provides comprehensive health monitoring and reporting tools.

Claims Encounter Management System (CEMS)
Molina's Claims Encounter Management System (CEMS), a customized web-based application, offers Molina staff a 360-degree view of claims and encounters and allows data to be collected from all systems beginning at the gateway entry (the eligibility data file) through submission to the state.

- State of the art front-end application (Claims/Encounters Management System – CEMS) was developed to increase end-to-end visibility of EDI processes for claims and encounters. This application:
  - Provides a 360 degree view of Claims/Encounters within Molina;
  - Provides rich GUI interfaces to view claim information within all Molina Sources, even on legacy paper forms (1500 and UB forms);
  - Provides clear understanding and easy access to the life cycle of claims/encounters within Molina;

- Provides systematic drill down capabilities with rich built in data analytics feature;
- Extensive reporting capabilities; and
- Provides Enterprise level Metrics on Claims/Encounters.

- CEMS includes Encounters Workflow for encounters submission to Medicaid State:
  - Before an encounter has been extracted for submission to Medicaid, the encounter undergoes internal validation edits. If any errors are identified the encounter enters Workflow's appropriate queue and must be worked within CEMS to mark the issues resolved before it can be submitted.
  - In addition, any errors received from Medicaid will enter workflow and need to be resolved and marked as resolved before resubmission to the State will occur.
  - Error values for encounters will be displayed when viewing encounter records in applicable work queues.

Encounters Reports
Molina offers any number of custom reports for encounters ("dashboard" reports) for review by Molina senior management. These encounters dashboard reports (depicted below) are also shared with Molina's partner agencies and detail the status of encounter submissions and submission errors. Sample reports currently available include:

- Encounter Trending Submitter Last 10 Submissions – identifies number of encounters accepted, rejected or identified as duplicates by submission file;
- Submitter Encounter Summary Report – shows encounter errors (code, description and count) for each submission;
- Encounter Top 5 Errors – shows categories and counts of top 5 errors;
- Encounter Inbound and Outbound Key Performance Indicator Reports – generated as needed either daily, weekly, monthly, quarterly, annually, etc.; and
- Encounter Inbound Volume by State and Submitter – provides encounter volumes by state, submitter and file type, weekly, monthly, quarterly, and annually, etc.

Financial Management and Accounting Activities
Molina utilizes QNXT as its core claims processing system, and JD Edwards Enterprise Resource Planning as its core financial system. All JD Edwards Enterprise Resource Planning system modules are robust and facilitate the flow of financial information. The system has a customizable interface with a script language that automates routine tasks as well as custom business alerts based on identifiable criteria that allow management to monitor financial performance at all levels. All data extracted from the Finance Subsystems can be published using Microsoft Excel, PDF, or HTML for further reporting analysis.

Claim Payment Process Flow - The Payment Manager/Financial Subsystem module within QNXT consists of wizards to help process payments and generate fee-for-service and capitation payments, print checks for providers or members, void erroneous payments, generate remittance advice, and manage payment advances for providers.

Molina's Accounting department manages the payment process. The payment or check write process gathers all claims payment, denial and reversal/advances information based on the adjudication date specified by the Payment Analyst. The check write process has the flexibility to generate checks/remits by line of business, provider, adjudication date and time, receipt date, or date of service; accounting processes payment for claims adjudicated up through the previous business day. This allows the Claims staff an opportunity to correct any pre-payment errors identified through audits prior to the payment process.

The check write process is managed by an external vendor, FIS Global. In the QNXT payment module, the Payment Analyst selects 'skip check print' option, this converts the payments to a PAID status. The process steps include:

- A file is created from QNXT based upon a predefined SQL process in the Payment Module;
- The file is transmitted via secure FTP to the vendor, FIS;
- FIS converts the file into a PDF version of the Remittance Advice, along with a paper check and posts to a shared website (shared between FIS and Molina personnel);
- The information is then reviewed by the Molina Payment Analyst, and approved through the website; and
- The vendor then prints all remits and checks, collates them and mails them to the Providers. For providers that receive electronic payments instead of a physical check, an ACH transaction file is submitted from FIS to the designated financial institution.

In addition to standard claims information (such as Payee, Date, Claim ID, member information, and service codes/descriptions) the remittance advice also provides information on appeal submission guidelines if the provider contests the claim processed.

Finance Process – While QNXT remains the primary system for eligibility, authorization, and claims administration, financial payment data is fed from QNXT into JD Edwards. The integration of claims check information into JD Edwards creates a single environment for combined reporting of claims and non-claims payment activities. This helps to streamline reporting for GAAP, tax (including 1099), and certain ad hoc uses of data. The import of data from QNXT into JD Edwards is accomplished via manual interface. Conversion of this data into JD Edwards is controlled and verified for completeness and accuracy through a comprehensive system of internal controls. Key internal controls include formal approval processes, formal and routinely performed reconciliation processes, segregation of duties and internal audit review.

While data from QNXT comprises the largest expense category posted to the JD Edwards system, there is a wide range of other transactions handled in JD Edwards in order to reflect the complete financial activities of the company. These include, but are not limited to:

- Premium capitation ACH transfers from DHS to Molina are reconciled against the remittance advice files, roster files, and QNXT eligibility data prior to journal entry posting;
- Premium receipts from members or employers who have a premium share are posted through the Accounts Receivable Cash Receipts module;
- Medical expense payments that are not configurable in QNXT are paid through the Accounts Payable module;
- Most administrative expenses (other than payroll) are also paid through the Accounts Payable subsystem module;
- Payroll and benefit expenses are posted through Journal Entries using data extracts from ADP, Molina's payroll administrator. Data received from ADP is reconciled with the financial data processed by the bank and with data maintained within the JD Edwards Human Resources subsystem module; and
- Information collected from internal reports and outside sources is used for various estimates that require accrual according to Generally Accepted Accounting Principles (GAAP) and NAIC standards.

JD Edwards has a standard set of financial reports such as balance sheets, income statements and budget related reports, with budget variance, year-to-date and period-to-date report capabilities, and can be used for all general ledger, accounts payable and financial statement presentations in conformity with GAAP. JD Edwards also allows for the creation of user defined reports. Molina has also developed a package of standardized reporting that accesses data from the back-end of the system.

2. Describe data back-up processing plans including how data is stored at an off-site location.

Molina ensures that we will comply with the provision of Medicaid services as specified in Attachment 1 – Scope of Work, Section 13.1 – Information Services & Systems, subsection 13.1.2.3 – Back-up of Processing and Transaction Files, and will comply with all timelines for data backup as specified in the Scope of Work.

Data Backup, Storage, and Recovery

Molina has implemented stringent policies and robust safeguards to ensure public records backup and retention medical records and other protected health information (PHI) in accordance with applicable state and federal rules. This includes administrative, physical and technical safeguards to ensure the confidentiality, integrity and availability of medical records and PHI in all formats, including paper and electronic formats. Molina has systems in place to maintain and safeguard the confidentiality of recipient and financial information and is committed to compliance with state and federal laws protecting the privacy of the personal and health information of TPA-UR recipients.

Molina safeguards PHI stored in a paper format through two layers of physical security:

- Access to Molina's facilities is restricted to Molina's workforce, authorized business associates/contractors, or visitors who signed in and are escorted; and
- PHI is further secured in locked closets or file cabinets, only designated staff have keys. Paper records containing PHI are destroyed and disposed of in accordance with the Secretary of Health and Human Services (HHS) standards for Secured PHI. Any off-site storage facilities are required to sign business associate agreements.

Molina leverages industry-leading solutions from Symantec, including NetBackup, NetBackup PureDisk and Enterprise Vault, to retain copies of electronic records and data. Molina's Data Center Operations team regularly backs up data critical to the organization. All data backup media are stored offsite in a secure location. Data recovery from back-up media is tested on a regular basis.

Physical LTO-4 media is encrypted using hardware-based encryption with Quantum Encryption Key Management (Q-EKM) software consisting of two synchronized key servers that provide encryption services for the physical LTO-4 tape libraries within the environment. All media subject to offsite rotation must be LTO-4 media from an encryption enabled library.

Molina's electronic data are backed up to tapes while removable devices are encrypted with a minimum of FIPS-140-2 compliant, 256-bit encryption. Accordingly, all such data meets the United States Department of Health and Human Services' (HHS) standards for Secured PHI. No data backup media is removed or sent to offsite storage or any other location from Molina's Data Center without data encryption on the backup media or removable devices. Any third party that stores PHI on Molina's behalf must sign a business associate agreement. Backups are sent offsite on Wednesdays, after duplication of weekly backup images is completed. Multiple copies of each backup image are kept in the following digital formats:

- A VTL (Virtual Tape Library) image is replicated to the disaster recovery site; and
- Multiple copies of each backup image are created when the image is duplicated from VTL to physical tape. One copy is kept onsite with a five-week (35 day) retention; an additional copy is created in the designated offsite pool.

The data backup and recovery plan is kept current through a formal change management process. The plan is reviewed at least annually or whenever major business or technical changes occur within Molina's environment. Events that result in a plan update include:

- Acquisition/development of new applications, databases, etc. storing data that needs to be regularly backed up and backup recovery tested;
- Change in IT support personnel;
- Significant changes to technical or physical infrastructure;
- Change in key suppliers (e.g., hardware, software, storage media, offsite backup storage vendors, etc.); and
- Newly identified significant change in threats to facilities or information systems.

All PHI data is disposed of in accordance with Molina media reuse and disposal standards including Department of Defense-level erasure and physical destruction.

Data Backup and Recovery Plan

The data backup and recovery plan includes procedures to create and maintain retrievable, exact copies of all electronic information including Protected Health Information (ePHI) that is maintained, used and disclosed by Molina.

- **Backup Schedule:**
  - Non-Database Server Backups:
    - Full weekly backups of all administrative files are performed after normal business hours on weekends as requested.
    - Daily differential backups are performed on any day when a full back up is not performed.
  - Database Backup Schedule:
    - Full weekly backups are performed on all production database servers as requested.
    - Daily incremental backups are performed on any day when a full back up is not performed.
  - Database Refresh Process:
    - The process of placing a database refresh request from start to completion is automated. PaaS Operations - DBA personnel view all the assigned database refresh requests.
    - If necessary, IaaS Infrastructure Operations personnel restore database backups from tapes per the approved requests.
  - Backup Method (The backup method is based upon the requestor):
    - Full;
    - Incremental; and
    - Differential.
  - The first full backup of the month is sent off-site for not less than 10 years.
- **Recovering Files**
  - Use the following procedure if a user needs to recover a file or database from a backup:
    - Open a ticket with the Help Desk with the following information:
      - The name of the files or databases, including the host and full system path.
      - The date on which the files may have been backed up.
      - The destination for the restored files.

- **Administrative File and Database Server Backups**
  - Incremental daily backups are performed on all administrative file and database servers after normal working hours on weekdays as requested.
  - Full backups are performed weekly as requested.
  - Daily and Full backups are written to disk storage in the Data Center, and duplicated to disk storage at the DR location.
  - The first Full backup of the month of all administrative file and database servers is duplicated from disk storage to tape at the Data Center, which is maintained in off-site storage for not less than 10 years.
- **Remote Backups**
  - Backups of data from non-data center facilities are written to local disk based storage and replicated to disk based storage in the Data Center. Procedures outlined in section 3 are followed otherwise.
- **Media Encryption**
  - Physical LTO-4 media is encrypted using hardware-based encryption with Quantum Encryption Key Management (Q-EKM) software. Molina's Q-EKM environment consists of two synchronized key servers that provide encryption services for the physical LTO-4 tape libraries within the environment. All media that is subject to offsite rotation must be LTO-4 media from an encryption enabled library.
  - All Molina's electronic data are backed up to tapes or removable devices and are encrypted with a minimum of 256-bit encryption. No data backup media is removed or sent to off-site storage or any other location from Molina's Data Center without data encryption on the backup media or removable devices.
- **Offsite Process**
  - Backups are sent offsite on Wednesdays, after duplication of "Weekly" backup images is completed. The process for retaining multiple copies of each backup image is:
    - A disk based backup image is replicated to the disaster recovery site. Both images have a five week (35 day) retention.
    - The disk based backup image is replicated to tape. The tape is sent to offsite storage for not less than 10 years.
  - The data backup and recovery plan is kept current through a formal change management process. The plan is reviewed at least annually or whenever major business or technical changes occur within Molina's environment.
  - Events that result in a plan update include:
    - Acquisition/development of new applications, databases, etc., storing data that needs to be regularly backed up and backup recovery tested.
    - Change in IT support personnel.
    - Significant changes to technical or physical infrastructure.
    - Change in key suppliers (for example, hardware, software, storage media, off-site backup storage vendors, etc.).
    - Newly identified significant change in threats to facilities or information systems.

Molina annually tests the business continuity disaster recovery plan to ensure it meets requirements and can be executed.

3. Describe how clinical data received will be used to manage providers, assess care being provided to members, identify new services and implement evidence-based practices.

Molina ensures that we will comply with the provisions of service specified in the Attachment 1 – Scope of Work, Section 13.1 – Information Services & Systems, subsection 13.1.3 – Data Usage. Molina will utilize the clinical date that it receives to adequately and appropriately mange the care being provided to members.

Molina has detailed processes and procedures in place to review and monitor clinical data, including utilization, claims-based and HEDIS data, for many purposes and across many departments. Clinical data is reviewed by for a wide variety of purposes by multiple committees across many departments. For example, Molina's Healthcare Services Committee (HCSC) uses utilization data to identify trends and to develop appropriate interventions, such as provider training and program education.

Our Healthcare Services, Quality Improvement and Provider Services departments are linked by review of surveys, reports, trends and studies of various departmental practices. Data collection is reported and clinical data is reviewed through the committee process. Committees may include providers and community resources in the review process for insight, as necessary and appropriate. Clinical Data is returned to the Quality Improvement department for development of practice standards and quality improvement plans, to improve outcomes and to assess the care being provided to members.

HEDIS data is also reviewed to assess the care being delivered to our members and identify opportunities for improvement in performance. When low performance trends are identified, such as low rates in certain measures, Molina will develop and implement targeted interventions to improve performance on the clinical measures. Molina also utilizes provider scorecards to monitor provider performance on key HEDIS clinical measures. The monthly scorecards provide information on the provider's improvement over time and progress towards goals through a comparative view of a provider's current year performance against previous year performance and goals. Molina's Provider Engagement Teams will provide training to provider sites to help meet Molina performance goals and improve quality of care delivered to members. Tools and resources are shared with providers including clinical practice guidelines, screening tools, and other best practices tailored to each clinical measure to help providers improve performance. HEDIS performance and trends are also discussed at the Quality Improvement Committee.

The Quality Improvement and Healthcare Service departments also utilize data to collaborate in the monitoring of utilization patterns across practices and provider sites including primary care practitioners and high volume specialists. These activities include monitoring all potential quality issues related to over or under utilization of services, and to ensure member access to care. Data is reported to the HCSC for review and discussion on a quarterly basis. The committee recommends interventions when a trend is identified and monitors the efficacy of the intervention taken.

Molina also utilizes clinical data to review the clinical appropriateness of new medical technologies or application of existing technologies to provide new evidence-based practices through the use of our Medical Coverage Guidelines. This process helps to increase the member's access to services and helps to provide cost-effective treatments and improve member outcomes.

4. Submit a draft Information Systems Plan as described in Section 13.1.5.

Molina agrees, understands and will comply with the provisions of service specified in the Attachment 1 – Scope of Work, Section 13.1 – Information Services & Systems, subsection 13.1.5 – Information System Plan. If awarded a contract under the Iowa High Quality Healthcare Initiative, Molina ensures that our Information Systems Plan will be tailored to meet the specific requirements of the program. Accordingly, Molina has provided its preliminary draft Information Systems Plan below.

The following information provides content detailing how Molina will meet the specific Information Systems Plan requirements of the Iowa High Quality Healthcare Initiative, as indicated in Attachment 1 – Scope of Work.

Draft Information System Plan

Molina's draft Information System Plan details our processes and procedures for receiving, creating, accessing, storing and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 160, 162 and 164 and the HIPAA Security Rule at 45 CFR 164.308). The draft plan also identifies the steps to be taken and includes a timeline with target dates.

See Attachment 13.1.4-1 Project Implementation Plan for Molina's draft Project Implementation Plan, which includes the IT timeline and target dates to meet the requirements of Section 13.1.5 of the Scope of work.

Molina will submit a final plan, incorporating any changes requested by the DHS, to the Agency within 30 days after the official submission of the plan, which will occur within 15 days of Contract execution. Molina will execute, adhere to, and provide the services set forth in the Agency-approved plan. We acknowledge and understand that all changes to the plan must receive prior approval from the Agency, and we will make any updates to maintain a current version of the plan.

13.1.5.1 Planning, developing, testing and implementing new operating rules, new or updated versions of electronic transaction standards, and new or updated national standard code sets;

Molina has an Enterprise Project Management Office (EPMO) which provides a methodology for the planning and implementation of all enterprise projects. In the event that HHS/CMS issues a new Final Rule or Interim Final Rule to implement a new HIPAA EDI transaction, NCPDP transaction or CAQH-based Operating rule, the Molina Healthcare Compliance organization submits a project request to the Project Oversight Committee (POC) a subdivision of the EPMO). This request estimates the manpower, time and resources required to implement the project.

Once the project is approved the project management methodology used at Molina requires that a series of documents be prepared as part of the planning, development, testing, production, roll out and post-production support. These documents include a Charter, Business Requirements, Communication Plan, Design Specifications, Testing Plan and Implementation Plan. The appropriate cross-functional team members are assigned to the project and a Business and IT project manager oversees the project.

The project plan encompasses all trading partners, contracted providers, business associates and government agencies that need to be involved in the development and testing phases. Extensive testing and collaboration must occur with Medicare agencies and/or Medicaid agencies in addition to clearinghouse partners and major providers and business associates.

Upon completion of all internal and external testing, the new code and processes required to implement the new transaction/operating rule are placed into production. All trading partners who have completed testing and have been certified to be complaint with the new requirements are setup/configured in Molina's production environment to be allowed to submit and/or receive the new or modified transaction.

The process described is used on all enterprise projects at Molina Healthcare including the following major transaction/code set/operating rule projects:

- 4010 to 5010 HIPAA EDI Implementation;
- NCPDP implementation of D.O.;
- ICD-9 to ICD-10 Conversion;
- CAQH Core defined Operating Rules (Affordable Care Act) for Eligibility (270/271), Claim Status

(276/277), Electronic Remittance Advice (835) and Electronic Funds Transfer;

- 275 Claims Attachment Transaction; and
- Remaining Operating Rules upon final approval by HHS.

13.1.5.2 Concurrent use of multiple versions of electronic transaction standards and codes sets;

Molina has adopted an architectural model which calls for distinct infrastructure components (software versions, servers, databases, etc.) to support concurrent versions of HIPAA EDI and code set standards. This parallel architectural model allows Molina to implement and test new versions of a standard while providing uninterrupted support for the existing flow of transactions using a previous version of a standard.

This architecture was used during the major healthcare industry transition from the ASC X12 4010 EDI standard to the ASC X12 5010 version of the EDI standard. The 4010 and 5010 environments operated in parallel but were implemented with distinct and separate infrastructure components and production processes. Molina found this to be a necessary architectural step given the issues of supporting a wide range of industry partners whose timing relative to migrating to a new standard varied significantly. A similar approach is being followed in Molina's preparation to migrate from the ICD-9 code set to the ICD-10 code set standard.

13.1.5.3 Registration and certification of new and existing trading partners;

Molina has a detailed process in place for the registration and certification of new and existing trading partners. An overview of this process steps is as follows:

7. Business Associate Agreement signed.
8. Trading Partner Questionnaire is sent to new Trading Partner to complete. The questionnaire consists of the following (attached document also):
   a. Trading Partner Demographics(Name, Address, TIN, Line of Business)
   b. Testing Contact Details
   c. Naming conventions
   d. File Submission Frequency
   e. Link to Companion guides
9. Connectivity is established between the Trading Partner and Molina to exchange files.
10. There are 3 rounds of testing that occurs
    a. First round of testing for set of files with HIPAA Compliance
    b. Second round of testing for void and adjustment claims
    c. Third round of testing for verifying more number of claims (100 and above claims)
11. After successful testing occurs and signed off, production exchange\agreement is setup to allow for production files to come in.

13.1.5.4 Creation, maintenance and distribution of transaction companion guides for trading partners;

The Health Insurance Portability and Accountability Act (HIPAA) require that Medicaid and all other health insurance payers in the United States comply with the EDI standards for health care as established by the Secretary of Health Services. The ANSI X12N implementation guides have been established as the standards of compliance for HIPAA EDI transactions.

Molina has a well-defined process for maintaining, updating and publishing the transaction companion guides. The companion guides are published to our external website (www.molinahealthcare.com) in order to provide maximum availability to our customers and partners. The companion guides published by Molina Health care exist in two formats:

- A 5010 EDI Companion Guide which is a comprehensive document detailing the specific requirements that customers and partner should follow when submitting 5010 EDI transactions. This document contains material on all applicable 5010 transactions and applies to all external entities submitting inbound transactions to Molina;
- State by state companion guides which detail specific requirements that each state Medicaid agency has defined in terms of a health plan submitting transactions outbound to the agency.

These companion guides are updated 1) when new transactions or new versions of the transaction set are introduced by HHS through new legislation; 2) when legislation is passed that introduces changes to the transactions as is the case with the Affordable Care Act Operating Rules; and 3) When state agencies define new requirements in their companion guides.

Molina has a process led by Information Technology and supported by Compliance and various business areas to review, update and publish new versions of the companion guides as industry changes dictate. Strict version control is maintained and all companion guide changes must be reviewed and approved by all appropriate business areas (Change Control Process).

The information contained in Molina's companion guides serve only to supplement the HIPAA ANSI X12N implementation guides. The use of the companion guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the X12N implementation guide.

Additional information on the Final Rule for Standards for Electronic Transactions can be found on the Department of Health and Human Services website. The HIPAA Implementation Guides can be accessed on the WPC website.

13.1.5.5 Staffing plan for electronic data interchange (EDI) help desk to monitor data exchange activities, coordinate corrective actions for failed records or transactions, and support trading partners and business associates;

Molina Healthcare EDI Team operates between the hours of Mon-Friday 8:30AM – 5:30PM PST. The EDI Help Desk can be reached via phone at (866)409-2935 or through email EDI.Claims@MolinaHealthCare.com. In addition to the EDI Help Desk, Molina Healthcare Business Automation Team provides connectivity support\setup for data exchange activities with trading partners. The Business Automation Services (BAS) team operates between the hours of 6:0AM – 6:00PM PST and can be reached at (886) 472-9495 or email PaaS-Operations-BAS@MolinaHealthCare.Com.

Monitoring oversight is achieved within Molina's Enterprise Command Center (ECC) leveraging the CA Service Operations Insight (SOI) tool. It is a comprehensive service operations management solution designed to help manage the availability of online services. SOI is integrated directly with Molina's Incident Management system. When failures occur, incidents tickets are auto generated and assigned to the corresponding IT group (i.e., Healthcare Systems and Services-Operations and Maintenance (HSS-OM) Eligibility, and Enterprise Infrastructure Services-Platform as a Service (EIS-PaaS), etc.) for research and resolution.

For example, when an eligibility file (i.e., 834 file) is posted from a state agency into QNXT, Molina's core administration system, the file is downloaded on a pre-agreed schedule for eligibility system processing. If the file cannot be parsed, a job failure notification process is initiated. SOI creates an iServe incident that is auto assigned to the documented IT assignment group. Based on the severity/priority assigned to the job in Autosys, (e.g., an automated job control system used by Molina for scheduling,

monitoring and reporting), the incident is escalated accordingly. The assigned IT group reviews the failure and provides a solution or remediation. The BAS team is notified to re-run the job or, if it is determined to be a "bad file" the job is terminated and the state agency is notified.

See Attachment 13.1.4-2 File Exchange Mechanism and Failure Handling for a flowchart detailing Molina's file exchange mechanisms and the personnel/teams responsible for records and/or transactions failure handling and the coordination of corrective action and resolution.

13.1.5.6 Compliance with all aspects of HIPAA Privacy and Security rules;

Molina is committed to ensuring the privacy and confidentiality of member and patient Protected Health Information (PHI) including their medical records. The mission of the Molina HIPAA Privacy and Security is to:

- Provide consistency in privacy and security practices throughout Molina Healthcare;
- Protect patient and member PHI and ensure compliance with HIPAA, and other applicable laws, regulations and contractual requirements; and
- Provide an easy-to-use and understand "how-to" document for all individuals involved in information privacy and security management at Molina.

The HIPAA Program Management Office (PMO) serves as the HIPAA compliance office for Molina Healthcare, Inc. and its affiliates and subsidiaries. Its primary role is to facilitate and oversee compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Administrative Simplification Provisions, other applicable laws pertaining to the privacy and security of health information, Medicare and Medicaid contractual requirements and appropriate privacy and security practices given Molina's specific business needs.

<u>Molina's HIPAA Program Management Office: Scope of Responsibilities</u>
The HIPAA PMO develops and administers Molina's enterprise-wide HIPAA Compliance Program, including Molina's Information Privacy and Security Management Program. Protecting the privacy of our Medicare and Medicaid beneficiaries (members) and patients is a paramount function of the HIPAA PMO. The Department performs a variety of activities in support of HIPAA compliance and other privacy and security laws, contractual requirements and standards including HIPAA transaction and code sets and national identifiers compliance.

Privacy and security compliance includes:

- Project management
- PHI access management
- Privacy and security incident management and breach notification (where applicable)
- Review of privacy grievances and complaints
- Policy and procedure development, review and amendment
- Risk analysis
- Workforce member privacy and security training
- Periodic and annual audit
- Disaster recovery and emergency mode operations planning, update and testing
- Physical/facility security management
- Oversight of technical infrastructure that supports appropriate security practices
- HIPAA transactions, related complaints and inquiries
- PHI entity or individual authentication

- Business associate and data sharing agreement review and management
- National Committee for Quality Assurance (NCQA) standards pertaining to the privacy of PHI; and
- Analysis of proposed and enacted or promulgated privacy and security statutes, regulations and contractual provisions.

The following Exhibit 13.1.4-3 summarizes how the HIPAA PMO contributes to accomplishing the corporate mission of Molina.

Exhibit 13.1.4-3 Molina's HIPAA PMO Responsibilities

Mission Statement	Key Privacy & Security Activities	Key Outcomes
• Promote health and provide health services to low-income families and individuals covered by government programs.	• Protect Member/Patient PHI • Achieve and maintain compliance with HIPAA, federal and state privacy laws, contract requirements and appropriate industry standards	• Enhanced member health • Preservation of Molina's brand • High level of compliance with HIPAA federal and state privacy laws, contract requirements and appropriate industry standards. Enhanced reputation of Molina with government programs, other stakeholders and individuals served

13.1.5.7 Strategies for maintaining up-to-date knowledge of HIPAA related mandates with defined or expected future compliance deadlines;

Molina and its Compliance Organization have a myriad of processes and strategies for maintaining a real-time awareness of proposed or approved legislation that affect HIPPA related mandates. From a Molina health plan perspective, these strategies include 1) direct senior management interaction with State and Federal agencies; 2) Government contract interaction with state Medicaid and Medicare agencies; 3) Direct participation in major healthcare organizations (e.g., AHIP, WEDI, etc.).

As stated above, The HIPAA Program Management Office (PMO) serves as the HIPAA compliance office for Molina Healthcare, Inc. and its affiliates and subsidiaries. In this capacity, the HIPAA PMO actively pursues several approaches to stay current with any changes in state or federal legislation that effect HIPAA and the healthcare industry. Molina has designated a Privacy Official who is responsible for the development and implementation of Molina's policies and procedures regarding the privacy and confidentiality of PHI. Molina will designate a Security Official who is responsible for the development and implementation of Molina's policies and procedures regarding the security of electronic PHI. These individuals and their staff are actively involved with major industry groups (e.g., WEDI, AHIP, CAQH, etc.) to stay current on pending legislation.

The HIPAA PMO is directly involved with most major user organizations in the healthcare industry. The Privacy Officer and PMO staff participates in monthly/recurring conference calls conducted by WEDI, AHIP, CMS, etc. The PMO has established accounts with WEDI and NCPDP and have direct contact with consultants who are members of WEDI and CAQH. The PMO staff receive email feeds from CMS, CAQH, WEDI, etc. on a real-time basis and continually consult the CMS and CAQH website for updated news releases and newly published documentation.

Molina is currently actively tracking the statue of the Affordable Care Act (ACA) Operating Rules. CAQH committees have released some of the new rules to NVCHS. NVCHS will make its recommendations to the Secretary of Health and Human Services (HHS) and the Secretary will release an approved Interim Final Rule for various Operating Rules and The ACA Attestation (First Certification) of

Compliance. Molina and the HIPAA PMO have approved projects in place to initiate implementation of these new rules once final federal approval is issued.

Molina uses a standard project plan template to plan and track initiatives related to new or changed operational rules, EDI versions or transaction code sets in a manner consistent with HIPAA standards for electronic exchange, privacy and security requirements.

5. Describe your proposed information systems staffing model.

Molina ensures that it will comply with the provisions specified in Attachment – Scope of Work, section 13.1.6 – IS Staff.

Information Systems Staffing Model

Molina employs a robust IT support staff comprised of multiple teams, consisting of the following:

- Enterprise Service Desk (ESD)
- Facilities Technical Services (FTS)
- Enterprise Infrastructure Services (EIS) Operations and Delivery,
- Infrastructure as a Service (Iaas) Contact Center Delivery Services,
- Security Administration, and
- Security Computer Incident Response Team (CIRT).

Enterprise Service Desk (ESD)
The ESD is the first line of defense for all enterprise-wide IT incidents. It provides external and internal end user telephone support and serves as the single point of contact (SPOC) for all incidents and service requests for all Molina lines of business. The ESD supports products such as VPN/SSL support, password resets, voicemail and WebEx in addition to communicating all scheduled maintenance notifications to the enterprise. ESD also provides external web portal support for user ID/password recovery, verification of security questions, system errors pertaining to web portal registration, provider website errors including certificates and browser settings and provides remote support utilizing Bomgar.

Facilities Technical Services (FTS)
The FTS team provides hand-on and phone-based support for customer computing (PC, Laptop, VDI, BYOD mobile, and enterprise mobile devices). FTS performs the last mile of hardware and telephone delivery during the onboarding process and is available to provide hand-on assistance to new workforce members. The FTS also provides hands-on support of collaboration technologies (conference phones and telepresence) in conference and training rooms. FTS staff act as proxies for standard preventative maintenance activities, assists in the care of the MDF and IDF rooms, and function as smart-hands resources during outages.

Enterprise Infrastructure Services (EIS) Operations and Delivery
The EIS Operations and Delivery team is responsible primarily for detection and mitigation of incidents on IT systems and equipment. Through the establishment of alternate work schedules, they provide 16/7 supervised support coverage and incorporating nights and weekend on-call, 24/7 incident response year-round.

Infrastructure as a Service (Iaas) Contact Center Delivery Services
The IaaS Contact Center Delivery team, which is part of EIS, provides support for all contact centers enterprise-wide. The team supports various aspects off the Cisco platform that includes call routing, skill based agents, Finesse Agent Desktop and overall contact center reporting based on call metrics defined by our business partners. The team also supports third party applications as they relate to workforce management and call recording functionality. They also provider carrier level reporting related to

blockage and calls offered at the carrier level. The team is responsible for managing relationships between multiple carriers' and operational and delivery support doe troubleshooting issues at the carrier and Cisco level.

Security Administration
The Security Administration team consists of IT Security Analysts responsible for customer account management to internal and external applications such as QNXT, Clinical CareAdvance, UMK2, Appeals & Grievances, Encoder Pro, Interqual, Member360, Claims Workflow, and miscellaneous other responsibilities, e.g., Service Accounts, Security Groups and Web Security.

Security Computer Incident Response Team (CIRT).
The CIRT team consists of analysts who investigate, detect and respond to real-time cyber threat activity on the enterprise network. The prime directive is to uphold Molina's Security Incident Response Plan (IRP) in order to help develop a workflow to immediately address real-time malicious activity before malware outbreaks and/or maturity of breach outcomes.

6. Describe your plan for creating, accessing, transmitting, and storing health information data files and records in accordance with the Health Insurance Portability and Accountability Act's mandates.

Molina will comply with the provisions specified in Attachment 1 – Statement of Work, section 13.1 – Information Services & Systems, subpart 13.1.7 – HIPAA Compliance, and ensures that we will receive, create, access, store and transmit health information data in a manner that is compliant with HIPAA standards. Accordingly, Molina will comply with all applicable state and federal laws, rules and regulations. Our core information systems are fully integrated, scalable and compliant with all EDI and HIPAA requirements for privacy, security and data exchange.

Molina ensures that its MIS system will allow adequate access to all member health information in a secure and confidential manner. Additionally, to ensure the accuracy of member information within its MIS system, Molina has engineered and implemented an eligibility data management methodology and technology solution for the resolution of discrepancies that may exist between member eligibility files and internal membership records.

Molina's HIPAA-compliant System for Information Exchange

Molina operates an MIS program that ensures that its information systems have the capability and capacity to accept, transmit, process, maintain and report on information in support of all health plan management functions. These functions include but are not limited to membership management, provider management, care management, provider payment management, encounter data management, program integrity management and customer service. Molina's integrated suite of IT solutions has been built over many years based on products from well-established solution providers such as TriZetto, Oracle, MEDai and Milliman. Molina has also developed custom solutions, such as a feature-rich Web Portal that supports both members and providers that improve Molina's interactions with its customers and allows Molina to achieve considerable operational efficiencies.

Ensuring Information Security and Data Exchange Compliance

Molina's core systems are fully integrated and compliant with all EDI and HIPAA requirements for privacy, security and data exchange, including data transfer and acquisition. Highlights of Molina's compliance include:

- **5010 and ICD-10 Compliance** – Molina is 5010 compliant and on track to comply with ICD-10 published deadlines.

- **EHR and Health Information Exchange** – Molina fosters provider adoption of certified EHRs with appropriate security protections and works with HIE entities to ensure data sharing agreements align with emerging federal and local standards.
- **Molina EDI Gateway** – The Molina EDI Gateway complies with all EDI and HIPAA requirements for data transfer and acquisition, including secure FTP channels and 24/7 monitoring with automation to eliminate human errors.
- **Medicaid Infrastructure Technology Architecture (MITA) guidelines** – Molina has aligned its Architecture and Development guidelines with MITA in areas such as information security management and data governance.
- **Compliant Security Processes and Tools** – Molina employs advanced security applications and policies to protect member data.
- **HIPAA Security and Privacy Training** – Molina trains all employees on the privacy and security of PHI.
- **Business Continuity Management (BCM) Testing** – BCM testing was performed using the concept of social distancing to respond to H1N1 preparedness planning.
- **Periodic Audits** – Molina engages in annual internal and external audits and several state audits that oversee IT controls for administrative, physical and technical security.

Molina has stringent policies and robust systems in place to maintain and safeguard the confidentiality of member and financial information (i.e., electronic and hard copy records). Molina leverages industry leading solutions from Symantec – NetBackup and Enterprise Vault – to retain copies of electronic records and data and routinely backs up data critical to the organization as part of the scope of Molina's Infrastructure as a Service (IaaS) Operations Team. All data backup media are stored offsite in a secure location. Data recovery from backup media is exercised on a regular basis.

Physical LTO-4 tape media is encrypted using hardware-based encryption with Quantum Encryption Key Management (Q-EKM) software consisting of two synchronized key servers that provide encryption services for the physical LTO-4 tape library within the environment. All media subject to offsite location must be LTO-4 tape media from an encryption enabled library. Molina's electronic data is backed up to LTO- 4 tapes encrypted with 256-bit Advanced Encryption Standard (AES) encryption. No data backup media is removed or sent to offsite storage or any other location from Molina's Data Center without data encryption on the backup media. Tape media is sent offsite on Wednesdays for long-term secure storage after duplication of weekly backup images is completed. Multiple copies of each backup image are kept.

Backup images taken in the primary data center are stored on a DataDomain device within that data center, where they are retained for 35 days. These same backup images are replicated to a DataDomain device at the co-location data center, where they are also retained for 35 days. Images requiring long-term storage, typically monthly and critical weekly backups, are duplicated from the DataDomain in the primary data center to tape media, which are sent off-site for long-term secure storage.

The data backup and recovery policy is kept current through a formal change management process. The policy is reviewed at least annually or whenever major business or technical changes occur within Molina's environment.

7. Describe your proposed electronic case management system and all information which is tracked in such system.

Molina will comply with the provisions specified in Attachment 1 – Statement of Work, section 13.1 – Information Services & Systems, subpart 13.1.11 – Electronic Case Management System. Molina currently maintains an MIS solution that includes fully-integrated electronic case management solutions

that includes the functionality to ensure compliance with the State's 1915(c) HCBS waiver and 1915(i) program laws.

Molina's Case Managers utilize technology efficiently and effectively to improve the care and services delivered to members. The primary tools Molina uses include an integrated care management system (Clinical CareAdvance), Molina's secure Web Portal, mobile computing with virtualized desktops, predictive modeling (MEDai) and tele-monitoring.

Case Managers are able to ensure timely communication, share information, track and monitor progress, identify issues and ensure appropriate care planning using a comprehensive integrated care management system, TriZetto's Clinical CareAdvance. Clinical CareAdvance provides a single source for assessments, configurable care planning, consent tracking, task and team management, alerts, progress tracking, communication creation, and ongoing monitoring. The comprehensive view available through Clinical CareAdvance enables the Case Manager to create targeted interventions and ensure appropriate services based on a member's entire health profile rather than on a single diagnosis or event, resulting in improved health outcomes and increased member satisfaction; better coordination of care between providers, payer, and members; and the management of medical costs while ensuring quality of care.

TriZetto's web-based integrated platform enables a member-centric view for clinical users by aggregating data from a variety of sources. For example, the system contains a rule engine that identifies and stratifies members that are appropriate candidates for Care Management through system-based rules that consider certain medical conditions, utilization, claims, pharmacy, laboratory data, the Member Evaluation Tool and other available data.

To facilitate communication and align care planning efforts between Case Managers, members, and providers (including PCMH and Health Homes), Molina offers a secure online provider and member Web Portal available 24 hours a day, 7 days a week that imports and displays information from Molina's claims processing system and Clinical CareAdvance. The Web Portal allows members, caregivers, and providers to view and print a member's Care Plan; provide feedback to the Case Manager; view the member's profile; and view a list of the member's Care Team participants and contact information.

When conducting assessments on-site, Molina gathers required information electronically in a secure and friendly interaction with the member. This information is used to populate the required assessment forms and update Care Plans which are stored in Clinical CareAdvance and shared with the member's care team through the Web Portal. Molina Case Managers can enter information and access data about the member while out in the field, including claims, pharmacy, laboratory results, past assessments, visit logs and current Care Plan information, using mobile computing through a virtualized desktop that feeds directly into Clinical CareAdvance.

MEDai is a predictive modeling solution used to help identify high-risk members and flag members for monitoring and enrollment in care management programs. Using claims, encounter, referral and authorization, pharmacy, assessments and other available data, MEDai analyzes information to provide clear direction for assigning resources and making decisions.

Molina has partnered with home health agencies that provide telemonitoring services. Telemonitoring is the remote monitoring of members, including the use of audio, video, and other telecommunications and electronic information processing technologies to monitor member status at a distance. The program provides daily remote nursing management of vital signs to identify early warning signs of a worsening condition. Communication with the Molina Care Management Team assists with identifying appropriate services for members as their conditions change.

8. Indicate if an Electronic Visit Verification (EVV) System is proposed and what methodologies will be utilized to monitor member receipt and utilization of HCBS.

In compliance with Attachment 1 – Statement of Work, Section 13.1 – Information Services & Systems, subpart 13.1.12, Electronic Visit Verification System, Molina will implement and utilize an Electronic Visit Verification (EVV) to monitor member receipt and utilization of HCBS. Molina understands that our approach is subject to DHS review and approval, and we will implement and adhere to the DHS-approved approach following the execution of the Contract. Molina's system enables electronic visit verification for HCBS and tablet technology for sharing visit data and can support sharing of integrated Care Plans.

The EVV system is a telephone-based time and attendance system that captures in-home service visits, interfaces with third party scheduling systems, and has a web interface to provide time and attendance tracking of services delivered. EVV captures service data using global positioning technology, biometric voice authentication of the provider, and date and time stamps to document service date and start and stop times. The tool reports and measures the performance of home and community-based services (HCBS) providers, including:

- **Transparency of Service Delivery** – real-time jurisdictional view of service activities, allowing providers to manage worker activities and Molina administrators to oversee provider activity;
- **Compliance** – The Electronic Visit Verification (EVV) toll is a comprehensive scheduling, billing, and reporting system that offers compliance tracking to ensure providers follow proper protocols for background checks, licensing and certifications of caregivers;
- **Improved Program Management** – supports program transparency and tightens audit controls by providing access to home care services data to effectively audit providers; and
- **Fraud Deterrence** – EVV minimizes time reporting errors, inaccuracies and potential abuse, provides actionable data to support the development of corrective action processes and mechanisms to resolve vulnerabilities and thwart fraudulent practices.

Potential fraud and abuse may be identified by Molina's Case Managers, nurses, support brokers, Quality Improvement department, or Compliance department. Molina will monitor the self-direction process to identify services that fall outside the scope of member needs, including requests for additional funding budgets that are outside the participant's level of care allocation or over the range of rates for services. Molina will develop a log for issues and resolutions that will be maintained daily by the Molina Healthcare Services department and will ensure identified potential fraud, waste, or abuse cases are referred to Molina's Director of Compliance via the existing fraud, waste, and abuse referral form.

Potential fraud, waste, and abuse may also be identified by the FMA. Molina will work collaboratively with the FMA to develop policies and procedures to prevent, detect and report fraud, waste and abuse. The FMA will be required to notify Molina immediately upon suspecting fraud, waste and abuse. Molina will train the FMA, members, EORs and authorized agents on their responsibilities for reporting and the various reporting mechanisms available.

Molina maintains a confidential toll-free Compliance Hotline, a compliance e-mail box, and a toll-free compliance fax number to report suspected fraud, waste, and abuse. Individuals reporting potential fraud, waste, and abuse have the right to remain anonymous. Molina's Director of Compliance maintains the confidential hotline, e-mail box and toll-free fax line, and checks them daily to ensure reported incidents are addressed in a timely manner. The Director of Compliance will work in collaboration with Molina's Special Investigation Unit to conduct preliminary investigations.

9. Describe in detail how clinical records, as described in Section 13.1.13 will be maintained in your information system.

Molina will comply with the provisions of service as specified in Attachment 1 – Scope of Work, Section 13.1.13 – Clinical Records, and will maintain in our Management Information System (MIS) all necessary information and data sets required to assist in the authorizing and monitoring of services. Molina's MIS system will provide the data necessary for quality assessment and other evaluative activities. In accordance with the provisions, Molina acknowledges and understands that all clinical records generated and stored in its system as part of the Iowa High Quality Healthcare Initiative will become the property of DHS, and ensure that upon request we will transfer the records to DHS at no additional cost.

QNXT is Molina's core system application that includes claims, membership, provider, authorization and other encounter data including pharmacy data. QNXT is used by Molina's clinical staff to record services requested, authorized, substituted, and provided as well as services not authorized, reasons for non-authorization and missed services.

Molina utilizes TriZetto's Clinical CareAdvance application for Care Management/Disease Management. Clinical CareAdvance integrates all systems relating to Care Coordination, Case Management, Disease Management, Claims History, and Utilization Management functions, providing the integrated information sharing among appropriate staff. Member data captured includes diagnosis, level of functioning, treatment planning, medication management, interdisciplinary care treatment (ICT) and discharge planning.

Molina's QAPI Program

Molina has implemented a robust Quality Assessment and Performance Improvement (QAPI) Program. QAPI is committed to the provision of accessible, appropriate, cost-effective, high quality, integrated health care services for its members throughout the entire range of care with the primary goal of improving health outcomes and quality of life for its members. Molina assists members as they move through the managed care system, coordinating care across different health care settings, reducing barriers to care, and supporting members in maintaining independence and reaching optimal health. The QAPI Program provides the organizational structure and supporting processes that enable Molina to fulfill its commitment to achieving clinical and operational excellence.

Data and Monitoring

Molina utilizes multiple data sources to monitor, analyze and evaluate the QAPI Program and planned activities. Molina monitors internal data as well as external reports to guide program recommendations and identify clinically relevant, priority service and support needs of its members. The following are examples of how we incorporate data with a variety of resources to design, implement, monitor, and evaluate quality assurance activities in the QAPI Program:

- Evaluation of the continuity and coordination of care through analysis of data to assess:
  - Transition of Care processes and the effectiveness of inter-provider communications;
  - Provider adherence to medical record keeping, confidentiality and documentation standards;
  - Tracking program referral and enrollment for timeliness and appropriateness;
  - Facilitation and arrangements with community and social service programs; and
  - Coordination with other health plans and providers of service.
- Monitoring over-utilization, under-utilization, and appropriate utilization reviewed by interdisciplinary teams and the provider network through:
  - Electronic Visit Verification, service authorization and care management reports addressing service delivery processes;

- Quantitative analysis of medical, behavioral health, pharmacy and utilization profiles requested and received from other health plans; and
- Facility site reviews to ensure quality, ADA compliance, and safety of care settings.

- Evaluation of access and availability of care and service through:
  - Geographic access to community-based long-term care services and supports, and taking action to address gaps in the network; and
  - Evaluation of Customer Support Services telephone access, including access for the hearing impaired.
- Member satisfaction measurement and member participation in improvement activities:
  - Review of all sources of member satisfaction including, but not limited to, CAHPS surveys, disenrollment information, grievances and appeals, and identify opportunities for improvement; and
  - Monitor observance of applicable antidiscrimination laws, including reasons for disenrollment.
- Evaluation of the effectiveness of Quality Improvement activities in producing measurable outcomes and improvements in the care and service provided to members:
  - Organization of Interdisciplinary Care Teams (ICTs) to analyze service and process improvement opportunities, determine actions for improvement and evaluate results;
  - Track the progress of quality activities through appropriate quality committee minutes and review/update the Quality Improvement work plan quarterly; and
  - Revise interventions as required based on analysis.

Outcomes

Molina employs standard metrics for measuring effectiveness and demonstrated improvement in QAPI Program activities. These include: utilization metrics; grievances, complaints and appeals; and access and availability standards. Appropriate adjustments are made to account for seasonality, health risk or disease prevalence, geographic area and data completion. Population analysis may identify specific adjustments needed to appropriately interpret results. Member continuity with the plan or provider, benefit design and special needs program participation are additional factors considered. Similarly, provider analysis profiling facilities and providers may assist in adjustments needed to interpret results or identify aberrant patterns.

Analyses may include various geographic groupings, such as eligibility, provider type, contract types, member cohorts based on disease, and health risk groupings. Such analyses are designed to answer questions related to appropriate utilization, performance improvement and optimal care delivery within the health care environment. Analysis of these various categories provides options for in-depth understanding of the drivers of care and service.

Overall effectiveness and demonstrated improvement are achieved through quantitative analysis of comparable data collected from internal and external normative and benchmark data and established thresholds and goals. If the comparative analysis indicates performance is under or over the baseline threshold, Molina will perform root cause analysis and investigate underlying barriers to achieving the desired performance level or behavioral change. Comparable data may include:

- Historical plan data that establishes utilization patterns, thresholds and performance goals, including plan data from other Molina plans, comparable products, regions and providers;
- Consumer Assessment of Healthcare Providers and Systems (CAHPS);
- HEDIS reporting data;
- NCQA Quality Compass and National Benchmarks;
- Accessing Care of Vulnerable Elders (ACOVE) quality measures;

- Regulatory standards and requirements;
- External Quality Review Organization (EQRO) requirements;
- Member complaint/grievance and appeals data;
- Nationally accepted industry standards and comparative data provided by associations;
- State Medicaid results and State and National Medicare results; and
- Evidenced-based standards from medical literature.

Reports are designed to identify opportunities for improvement to support comparisons of specific populations. Analytic methods include measuring performance on a monthly basis, comparing results to year-to-date, prior period, same period prior years, rolling three, six, or 12 months, thresholds such as upper and lower control limits, goals, and benchmark data. Analysis of percent change and percent difference from thresholds and goals also supports identification of opportunities.

While quantitative reporting is critical, analysis is incomplete without qualitative analysis. Analysts and interdepartmental resources collaborate on qualitative analysis drawing conclusions regarding the causes, consequences, and opportunities for management and improvement.

Molina considers it essential to distribute reports and analyses into the hands that can effect change. Our QAPI Program structure is designed to assess, plan, implement, and evaluate its activities based heavily on the gathering and analysis of utilization data. Data transformed into actionable information that is continuously measured and evaluated is at the core of the improvement activities of all Molina internal Quality committees.

Clinical Records Turnover Plan

Molina understands that all clinical records generated in our MIS system will become the property of DHS upon conclusion of the contract, and we will work with DHS to develop a robust Turnover Plan to ensure all clinical records are transferred to DHS, as appropriate and at no additional cost.

In the event a Turnover Plan needs to be executed, Molina will work closely with designated DHS representatives, providers, as well as DHS and Molina subcontractors to ensure and mitigate any disruption of services to members during this transition phase. In addition to providing any and all necessary data files, and books and records, Molina will prioritize and safeguard the members' data elements and records by adhering to its detailed, compliant Personal Health Information (PHI) and HIPAA guidelines to protect the members' information. Molina will divide the Turnover Plan into three distinct phases.

The first phase of the Turnover Plan will be development of the work plan to execute a successful transition of data transfer to DHS or a successor contractor. This phase will also include a series of initial conference calls and/or meetings to outline the objectives and goals of Turnover Plan to ensure the Work Plan meets the expectations of DHS and/or the successor contractor. This phase will also ensure that the Turnover Plan is compliant with all regulatory entities.

The Turnover Plan will be a shared document to be viewed by all affected parties. In addition to the overall goal of protecting member, provider and DHS information, Molina will also address the following safeguards as it constructs the Turnover Plan, including, but not limited to:

- **Confidentiality** – preserving authorized restriction on information access and disclosure, including means for protecting personal privacy and proprietary information;
- **Integrity** – guarding against improper information modification or destruction, and includes ensuring information nonrepudiation and authenticity; and
- **Availability** – ensuring timely and reliable access to and use of information.

The Turnover Plan will contain a Work Plan, which is a detailed project/task list along with measurable milestones to evaluate Molina's successful progress toward a smooth transition and data transfer. The work plan will also facilitate the opportunity to address any gaps in data exchanges and complete the checklist to ensure all items in the project/task list are addressed. Within phase one, Molina along with DHS will categorize the data files and elements to be transferred into the following three data classifications:

- **Confidential Data/Information** – Sensitive data that must be protected from unauthorized disclosure or public release based on state or federal law or other constitutional, statutory, judicial or legal agreements. Examples may include (but not limited to): Personally Identifiable Information, Medical Records, Copyrights, Patents and Trade Secrets.
- **Health Plan Sensitive Data** – Sensitive data that may be subject to disclosure or release and that requires some level of protection. Examples include (but not limited to): Operational information, Personnel Records, Information Security Procedures, Internal Communications.
- **Public Information** – Information intended or required for public release.

Once the Turnover Plan is developed, the second phase will commence, emphasizing on implementing the Turnover Plan. During this second phase, Molina, along with DHS and/or its contractor, will begin executing the Turnover Plan, which will include the exchange of member data and demographic information, members' authorization information and claims history, enrollment files and other files for the purpose of generating ID cards, development of member and provider communications, member rosters by provider, and if necessary, in addition to sharing of Molina's network of providers to ensure continuity of care for the members. This phase will also include, at a minimum, weekly conference calls with the key parties at Molina, DHS and/or successor contractors to ensure the implementation phase is progressing as planned.

After the second phase is completed to the satisfaction of DHS, it will trigger the third and final phase of the Turnover Plan, focusing on post data transfer. This phase will ensure the checklist items have been developed in phase one and executed during the second phase to ensure they are completed and signed off by Molina and DHS. During this final phase, Molina will continue to provide minimal customer service support for transitioning members to assist them with issues they may encounter during the change to ensure continuity of care and minimal disruption of service, as well as alleviate any administrative burdens to the provider community during the turnover.

10. Submit system problem resolution plans and escalation procedures.

See Attachment 13.1.10-1 Molina Information Technology (MIT) Enterprise Problem Management Procedure.

Molina will comply with the provisions of services specified in Attachment 1 – Scope of Work, Section 13.1.14 – System Problem Resolution, and 13.1.15, Escalation Procedures. Molina understands that our problem management procedure is subject to DHS review and approval, and we will implement and adhere to the DHS-approved plans following the execution of the Contract. Accordingly, Molina confirms that it will obtain DHS approval prior to making any changes to these procedures or approach.

11. Submit sample release management plans.

See Attachment 13.1.11-1 Sample Release Management Plans.

Molina will comply with the provisions of services specified in Attachment 1 – Scope of Work, Section 13.1.16 – Release Management. We will submit official draft plans within 15 days of Contract execution. Molina understands and will incorporate any changes requested by DHS into its final plan, which will be submitted to DHS within 30 days after the official submission of the plan. Molina will execute, adhere to,

and provide the services set forth in the DHS-approved plan. Accordingly, Molina confirms that it will obtain DHS approval prior to making any changes to the plan, and will make any updates to maintain a current version of the plan.

13.2 Contingency and Continuity Planning

1. Provide a detailed disaster recovery plan and contingency and continuity planning documents.

In accordance with the provisions specified in Attachment 1 – Scope of Work, Section 13.2 Contingency and Continuity Planning, Molina will develop and implement a robust Business Continuity and Disaster Recovery (BC-DR) Plan that will ensure continuity of service for the Iowa High Quality Healthcare Initiative. Molina will ensure that its plan will encompass all activities, processes and resources necessary to continue and maintain necessary business functions and processes in the event of a disaster.

See Attachment 13.2.1-1 Sample BC-DR Plan for the Iowa High Quality Healthcare Initiative. If awarded a contract, we will tailor the BC-DR Plan to meet the specific requirements of the Iowa High Quality Healthcare Initiative.

Molina understands that we are responsible for ongoing maintenance and execution of the State accepted contingency and continuity plan. We will submit official draft plans within 30 days of Contract execution, and will incorporate any changes requested by DHS into its final work plan, which will be submitted to DHS within 60 days after the official submission of the plan. We will execute, adhere to, and provide the services set forth in the DHS-approved plan. Accordingly, Molina confirms that it will obtain DHS approval prior to making any changes to the plan, and will make any updates to maintain a current version of the plan.

Molina's Business Continuity Management Program

Our approach to business continuity and disaster recovery – its Business Continuity Management program – is comprehensive and captures all mission-critical information systems and associated infrastructure. The Business Continuity Management program consists of Emergency Management, Business Continuity, and IT Disaster Recovery plans and provisions.

Development and ongoing refinement of this program is based on continuously updated Risk Assessments (RA) and Business Impact Analysis (BIA). The RA identifies internal and external risks that could potentially impact business operations. The BIA is a tool used to identify business functions, downtime procedures, staffing, and recovery strategies. In addition, the BIA captures the IT applications and equipment required to support the business function. As part of the BIA, Molina analyzes the impact of interruptions to key service requirements, and can perform cost/benefit analysis to determine the optimal approaches to risk mitigation and disaster preparedness. Finally, the BIA is used to set Recovery Time Objectives (RTO), staffing requirements and business recovery strategies for individual systems. The RA and BIA are updated at least annually.

The Business Continuity and Disaster Recovery (BC-DR) plan which results from the RA and BIA includes continuous testing of system functions. The BC-DR Plan ensures Molina is accessible to provide access to critical information related to provider and customer support services, and delineates protocols to follow in order to notify providers and the appropriate government agencies if an incident were to impact business.

Molina maintains a master BC-DR plan and customized subsidiary BC-DR plans for all of its medical assistance health plan accounts; these plans conform to very strict state and federal requirements and guidelines.

Molina conducts both periodic and ad-hoc tests of its BC-DR Plan through simulated disasters and lower level failures, onsite business continuity exercises with the Incident Management Team (IMT), and BC-DR testing of critical system functions. Results of exercises and testing to DHS are available upon request. These exercises and tests are conducted at least once per calendar year.

The strength of Molina's BC-DR plan is based on the investments Molina has made in its IT infrastructure. Molina's information and telecommunications systems, including Internet and telephone-based functions and information, are available to its system users twenty-four (24) hours a day, seven (7) days a week except during periods of scheduled system unavailability as agreed to by Molina's state partners. Molina ensures that other mission-critical systems are continuously available to its users during designated business hours, Monday through Friday. Moreover, Molina has built redundancy and business continuity into its operating environments across the nation. For instance, Molina's servers are distributed across its data centers. Having servers distributed across data centers increases redundancy and high availability, enables effective load balancing, guards against local broadcast storms and possible configuration problems, and provides a truly redundant operating environment for Molina's information and telecommunications systems.

Additionally, Molina has implemented a state-of-the-art Data Center and Network Operation Center (NOC) with staff that monitors all systems, including but not limited to, applications, databases, network, and routers/switches. Molina's NOC staff also implemented an enterprise monitoring tool which provides proactive monitoring to enhance its monitoring capabilities; and has established an Incident Management process via IT Service Management program, which allows for timely resolution of business critical incidents. Molina's NOC staff also provides appropriate communication to impacted staff of incidents affecting business users and provides updates on regular basis until the issue is resolved. Furthermore, the NOC provides a dashboard to view information on a real-time basis including the network activity from its Data Center to Molina office locations.

Finally, Molina employs the following solutions to ensure system availability:

- RecoverPoint Disaster Recovery technology (used by the Federal Reserve Bank) that enables recovery of core systems to its data hot site;
- Symantec's NetBackup Technology for automated backup and off-site storage;
- Virtual Machine server technology (VMware) with server clustering technology;
- Voice Over Internet Protocol (VoIP) telephony systems from Cisco Systems; and
- Interactive Voice Response (IVR) systems based on Cisco Systems technology.

Molina's Business Continuity Management (BCM) team oversees and administers the BC-DR plan. The Business Continuity Director and Disaster Recovery Manager have a combined 30 years of experience in Information Services and Technology and 20 years of experience in business and continuity planning. The Business Continuity Management Team is responsible for maintaining the most up-to-date business processes and information across the Molina enterprise.

13.3 Data Exchange

1. Describe your process for verifying member eligibility data and reconciling capitation payments for each eligible member.

Molina agrees, understands and will comply with the provisions of Medicaid services as specified in Attachment 1 – Scope of Work, Section 13.3 – Data Exchange. In accordance with subsection 13.3.1.2 – Reconciliation Process, Molina will reconcile its eligibility and capitation records monthly. Upon discovery of a discrepancy in eligibility or capitation, we will notify DHS within thirty (30) calendar days

of discovery and no more than ninety (90) calendar days after DHS delivers the eligibility records. Additionally, we will return any capitation or overpayments to DHS within forty-five (45) calendar days.

Verification of Member Eligibility

Molina offers many methods for providers to verify member eligibility/enrollment and identify a member's PCP. Providers may select the most convenient verification method from the following:

- **Provider Web Portal** – the Portal supplies a fast and easy way to allow providers to verify membership eligibility online 24/7.
- **Call Center** – Molina's bilingual Call Center enables providers to have a single point of contact for assistance in meeting the busy needs of provider offices, including prompt and accurate verification of eligibility.
- **Interactive Voice Response (IVR) System** – Providers and office staff can call Molina's IVR service and are instantly connected to Molina's interactive teleprompt system, which is available 24/7. The IVR service offers providers the ability to verify one member or multiple members' eligibility on a single call. This service provides the member name, date of birth, eligibility status and PCP information.
- **Clearinghouse** – Molina also sends daily eligibility extracts to Emdeon (clearinghouse) to make it easy for providers to check eligibility using automatic or manual methods.

Resolution of Eligibility/Enrollment/Membership File Discrepancies

Molina has engineered and implemented an eligibility data management methodology and technology solution for the resolution of discrepancies that may exist between member eligibility files and the internal membership records. The system has external means via the State's eligibility files and a dedicated Enrollment/Eligibility staff member to maintain its accuracy.

Molina's eligibility/enrollment data intake process is completely automated and triggers downstream processes including but not limited to PCP auto assignment (when applicable), ID card generation, and Welcome Packet generation through system jobs that download HIPAA-compliant 834 and/or proprietary eligibility data file(s) into QNXT, Molina's core administration system. Molina's inbound eligibility/enrollment process leverages a custom-developed, highly-integrated technology solution utilizing .NET and Microsoft BizTalk to provide extensive and scalable model for managing business rules and processing inbound eligibility data before it is loaded into QNXT.

Molina runs the following reconciliation jobs and reports to ensure enrollment data is accurately loaded into all of its health plan administration systems including QNXT:

- **Enrollment record on eligibility file but not in Molina's systems:** This report looks at the full/audit eligibility file received monthly and compares the information to Molina's system. Any discrepancies are produced on the report for manual review by Molina's Enrollment team. Any updates are entered manually into the system to ensure accurate coverage.
- **Enrollment record in Molina's systems but not on eligibility file:** This report looks at Molina's system and compares eligibility to the enrollment files. If Molina's system houses coverage that is not found on the full/audit file the Enrollment unit will validate coverage for the member and send discrepancies to the state as required.
- **Other comparison reports:** Molina also runs comparison reports between daily eligibility files received against the full/audit file. This enables Molina to notify discrepancies to the sender of the enrollment records if a member was on a daily file and the information is not represented on the full/audit file.

The Enrollment staff will investigate the eligibility and enrollment information for each Member identified on the reports by using one of DHS's systems, the point of service eligibility verification system or the fiscal agent. Once the discrepancy is identified and corrected in the QNXT system the Supervisor or Manager of the Enrollment Unit will notify Molina to continue the enrollment process. The

MIS Coordinator is responsible for reporting any discrepancies to DHS, or other process as determined by DHS.

13.4 Claims Processing

1. Describe your capability to process and pay provider claims as described in the RFP in compliance with State and Federal regulations.

Molina agrees, understands and will comply with the provisions of services specified in Attachment 1 – Scope of Work, Section 13.4 – Claims Processing, and ensures that it has the capacity to process and pay provider claims for services rendered to our members. Molina ensures that we will process and pay provider claims is compliance with subsection 13.4.3 – Compliance with State and Federal Claims Processing Regulations. Our claims processing system will also comply with the requirements related to claims forms as set forth in Iowa Admin. Code 441 Chapter 80.2, and all applicable state and federal regulations, including HIPAA regulations. Accordingly, Molina will require that all providers that submit claims have a national provider identifier (NPI) number in compliance with 45 CFR 162.410.

Claims Processing

Molina will ensure that all paper and electronic claims received are adjudicated in a timely and accurate manner using QNXT, its comprehensive claims payment/health information adjudication system. QNXT collects, analyzes, integrates and reports data and provides information on areas including service utilization and claim disputes and appeals. QNXT, Molina's claims processing system, integrates member demographic data, case management information, provider information, service provisions, claims submission and reimbursement, and has modules that collect, store and produce information for the purposes of financial, medical and operational management.

Organization-wide, Molina currently receives 91 percent of all claims electronically. Molina ensures that it will meet DHS program goals to receive and pay electronic and paper claims in a timely manner. The Molina claims processing and payment system is HIPAA compliant and will be modified, as necessary initially and on an ongoing basis, in accordance with DHS's rules and requirements.

Claims Adjudication Process

Molina's claims adjudication process for both paper and electronic submissions ensures claims that pass the validation processes of Molina's electronic data interchange system are loaded into its claims adjudication and processing system QNXT. All claims are processed in receipt date order. Processes are established to ensure a prompt and accurate turnaround meeting all regulatory compliance standards.

Claims are received at the corporate office either as a hardcopy via mail (very small volume), via centralized post office boxes in Long Beach, California, or through electronic submission, electronic data interchange. Electronic data interchange claims are received daily from clearinghouses that format electronic data into standard 837 I or P file formats and uploaded into the claims processing system. The claim is routed through a preprocessor and then through Molina Claims Gateway. An image of the claim is also generated and can be retrieved through a claim viewer.

As claims are loaded into QNXT, the system assigns each claim entered a unique claim reference number. The claim reference number is an eleven-digit number that contains the receipt date information in the form of two digits for the year, three digits for the Julian date and six digits indicating the claims submission type (i.e., Electronic Data Interchange, Future Vision, Web Portal or paper). The last five digits of the claim reference number are usually assigned in sequential order. For audit purposes, the system stores the username for the user that created the claim, the create date, the last user update and update date. The status of the claim is a key element in the inventory management process. As a result of

the pre-load process, which verifies the member ID, pay-to, rendering physician, and service location, a claim is either uploaded to QNXT or if it fails, it will be rejected to the Editor for correction.

The Claims Management team monitors inventory via the claims workflow application and assigns examiners to specific claims queues for processing. As an examiner processes a claim, the claim may take several courses. The claim status and system assigned edit denotes what course the claim has taken and at what stage of the life cycle the claim is in. This is monitored in real-time through the claims workflow application. The examiner may require assistance from other departments such as Provider Services, Configuration, Eligibility and Utilization Management to investigate a pended claim. If the exception noted requires assistance from another department, the examiner routes the claim to the appropriate queue assigned to the other department. These work queues are also utilized and worked by other departments such as Configuration and Utilization Management. Pended claims which are routed to other departments for processing are monitored in real-time through claims workflow reporting. The Claims Management team utilizes the claims workflow application to generate reports that provide the age of the claim and to ensure that other departments or the examiner are reviewing or processing those claims approaching internally established time frames.

2. Describe your plan to monitor claims adjudication accuracy.

In compliance with the provisions of Attachment 1 – Scope of Work, Section 13.4 – Claims Processing, subsection 13.4.1 – Claims Processing Capability, Molina will develop and implement policies and procedures to monitor claims adjudication accuracy. At the request of DHS, Molina will submit these policies and procedures to the State for review and approval.

Monitoring Process for Accurate and Timely Claims Adjudication

Molina's Claims Management team has processes and procedures in place to ensure that all claims are adjudicated in an accurate and timely manner. Molina utilizes a number of key reports and applications to monitor and manage the claims inventory effectively.

In addition to the claims workflow reports previously described, the Claims Management team utilizes various other reporting which provides information regarding claims statistics, history of a claim, etc. These reports are published via Microsoft SSIS/SSRS self-service model and offer the flexibility to denote parameters for specific date ranges, line of business, types of claims or a variety of other filters which creates the ability to have customized reports that will meet DHS business needs. Molina will develop and implement, or modify existing reports as necessary, to meet DHS requirements and reporting needs.

Molina uses multiple system availability and performance monitoring tools to monitor its systems 24 hours a day, 365 days a year. Molina has its own Network Operation Center and Network Operation Engineers who are alerted when system resources reach critical thresholds or experience problems. These alerts received are detailed messages providing critical detailed information about the issue and directing network administrators to the root cause of the problem, thus reducing resolution time. Molina will provide DHS staff information about the system events, status updates and resolutions on an hourly basis via e-mail and telephone.

Identification and Resolution of Deficiencies

Reports are used to identify deficiencies or issues with individual claims or across the claims processing and payment system. Molina's Claims Management team assesses deficiencies and develops a corrective action plan to research; resolve and report back to team leadership on the resolution of identified deficiencies. Additionally, a cross functional Provider Payment Initiative team has been formed to identify root causes and mitigate under/over payments. This team consists of individuals who have end-to-end work experience and will focus on identifying and implementing more efficient claims processes. This operational team will work closely with other functional teams such as the centralized Provider

Telephonic, and the Web Portal teams to understand the common payment inquiries and concerns expressed by the provider network.

Timeliness Standards
Molina will pay or deny ninety percent (90%) of all clean claims within fourteen (14) calendar days of receipt, ninety-nine point five percent (99.5%) of all clean claims within twenty-one (21) calendar days of receipt and one hundred percent (100%) of all claims within ninety (90) calendar days of receipt. Molina is proud of its timeliness achievements across all of our contracts; Molina's average turnaround time for clean claims is 99.7 percent within 30 days.

Development and Implementation of Intervention to Improve Claims Processing and Payment
Increasing the percentage of claims received electronically continues to be one of Molina's key initiatives to improve the claims processing and payment process. In all of its state health plans, Molina regularly evaluates its in-house tools (e.g. Web Portal) and systems (e.g. claims) to determine inefficiencies that can be resolved. For example, Molina's enhancement of its Web Portal to allow providers to submit claims directly through the Web Portal has proven particularly valuable to low volume providers and providers with limited resources to purchase electronic solutions. Molina also identified an opportunity to reduce the attachments required for claims adjudication, allowing more claims to be submitted electronically. Additionally, Molina Provider Services Representatives regularly reach out to its provider network to provide education on various methods of electronic submission and Web Portal resources. Through this education, Molina has been able to increase its rates of EDI adoption versus paper claim/encounter submissions across all Molina health plans.

Molina also conducts regular internal audits of its claims adjudication processes. This audit verifies that the claims process is meeting all performance requirements and standards. Key elements of the internal audit are verification of the accuracy of payments against provider contract terms and adherence to regulatory and Molina guidelines and policies. Additionally, the audit ensures that all reimbursement requirements are implemented as specified in the contract. This will be developed and implemented as part of Molina's internal audit function under the DHS contract as well as in accordance with DHS requirements.

Cost Avoidance/TPL Activities

Molina will process and coordinate claims utilizing state-provided eligibility data and data from other insurance coverage. QNXT supports full coordination of benefits (COB) functionality including Medicare as primary coverage. Molina contracts with Health Management Systems (HMS) to verify other insurance coverage of its members. This service also provides cost avoidance and recovery mechanism by providing current information captured on HMS's platform from various health plans. HMS verifies the member's eligibility monthly and adds data regarding other insurance coverage to each member's record, if identified. QNXT coordinates other health insurance at the claim line or at the claim header level, allowing for appropriate calculation of payment due for services rendered ensuring appropriate and accurate cost avoidance. For services where Molina is determined to be secondary, payment will be made in accordance with federal and state regulations allowing for payment up to the established allowable levels.

Molina pays covered services and makes reasonable efforts to recover payments for such services whenever it is determined that other health insurance was in effect at the time services were rendered. Recovered funds are posted in QNXT and applied against each applicable claim. Molina will bill the primary insurance carrier to alleviate provider abrasion and any billing issues for the provider of service. If Molina requests a refund from the provider of service and if the provider of service does not submit a refund, QNXT supports off-setting claims payments against monies to be recovered. Any individual recoupment in excess of $50,000 per provider will be submitted in advance to DHS for approval. QNXT serves as a key data repository for fraud and abuse and program integrity reviews providing investigators

with source information on what was paid, coding on claims, provider NPI, and diagnosis and procedures. It is fully integrated with Molina's program integrity strategy to ensure financial stewardship is effective.

3. Describe your provider claims submission process, including provider communications addressing the provider claims process.

Molina will comply with the provisions of services specified in Attachment 1 – Scope of Work, Section 13.4 – Claims Processing, subsection 13.4.1 – Claims Processing Capability, and ensures that it has the capacity to process and pay provider claims for services rendered to our members.

Molina can accept claims via three methods: clearinghouse, Web Portal and paper. Electronic Data Interchange (EDI) claims are received daily from clearinghouses and the web portal electronic HIPAA standard 837 I or P file formats and are uploaded into the claims processing system. The claim is routed through a preprocessor and then through Molina Claims Gateway. An image of the claim is also generated and can be retrieved through a claim viewer. Providers, provider groups, IPAs, MSOs, and vendors can also log in to the Web Portal to securely submit their claims/encounters using secured Socket Layer (SSL). Submissions are automatically logged and tracked through the website. Submitters can then view a log of all their submissions to Molina, including errors, through the site to enable resubmission of any failed submissions. Organization-wide, Molina currently receives 91 percent of all claims electronically. Following these actions, a pre-load process verifies the member ID, pay-to, rendering physician, and service location. The claim is then either uploaded to QNXT or, if that process fails, the claim is routed to a claim editor for correction.

Electronic Claims Processing

Molina encourages providers to submit claims electronically and receive electronic payments. Molina has entered into a partnership agreement with Emdeon to serve as its single source Electronic Data Interchange (EDI) clearinghouse for claims and encounter submissions to Molina. This partnership, referred to as "Managed Gateway Agreement" or MGA, is a single-vendor solution for Molina and helps manage its entire claim lifecycle, thereby simplifying processes for its vendors and contracted providers. Emdeon accepts all electronic claims submitted from any direct provider, practice management system vendor, clearinghouse, or any other third party on Molina's behalf. Emdeon's claim edits are applied consistently to 100% of inbound electronic claims. Emdeon also provides comprehensive claim tracking for both providers and payers' service representatives throughout the claim delivery cycle. Molina provider community benefits include:

- EDI Utilization – Emdeon has the ability to influence higher EDI utilization among Molina's provider community by helping provider identify and overcome barriers to EDI (Growth Program) adoption;
- resulting in greater savings to Molina in the form of reduced EDI "churn", often experienced when
- competing EDI vendors convince providers to switch clearinghouses;
- Improved auto-adjudication rates/few pended claims through consistent editing and pre-adjudication claim scrubbing; and
- Improved provider service with complete visibility and accountability in claim delivery.

Automatic Clearinghouse Support

Molina EDI Gateway is used to generate HIPAA 835 and EFT transactions. A BizTalk Orchestration calls specific stored procedures to retrieve the payment-related information from QNXT. This information is then used by BizTalk to map data to x12 Healthcare Claims Payment/Advice (835) with ACH flag and an EFT file is generated. An automated secure FTP system is used to submit this data in an encrypted format (PGP) to transmit to the bank.

Paper Claims Processing

Molina partners with Emdeon to implement and manage streamlined processing of paper claims; Molina also utilizes Emdeon as a single point of entry for all inbound paper-based claims and encounter processes.

On a daily basis, Emdeon performs scanning, conversion of information elements to structured data using Optical Character Recognition software, and imaging for document management purposes on all paper HCFA and UB claims/encounters it receives, including those with claim attachments. As part of this process, Emdeon performs a document preparation function and creates inventory control logs when claims are scanned using batch count verification with high level quality control processes. Emdeon then performs an exhaustive data validation and character recognition quality process. At the end of that process, claims are imaged and exported to a multi-page image file; concurrently claims data are exported to a data file. The data files are run through a final system quality check that must be approved by an Emdeon account manager. After that quality check is completed, Molina's IT department connects to Emdeon's secure FTP site to download the claims/encounters data and related image files. Molina performs a record count validation and verifies the Julian dates for the receipt date of claims. Once these validations are successfully completed, the files are processed through the Molina EDI Gateway process. The claim image files are unzipped into Molina's imaging database and a final validation is performed to ensure the images are viewable. Once all these files are loaded successfully, a notification that triggers the actual processing of the associated claims is issued to the Claims department.

4. Describe policies and procedures for monitoring and auditing provider claim submissions, including strategies for addressing provider noncompliance; include any internal checks and balances, edits or audits you will conduct to verify and improve the timeliness, accuracy, and completeness of data submitted by providers.

Molina will comply with the provisions of services specified in Attachment 1 – Scope of Work, Section 13.4 – Claims Processing, subsection 13.4.10 – Audit. We acknowledge and will comply with any random sample claims audit requested by DHS.

Molina conducts internal audits of our claims adjudication processes to ensure that all performance requirements and standards are being met. Key elements of the internal audit are verification of the accuracy of payments against provider contract terms and adherence to regulatory and Molina guidelines and policies. Additionally, the audit ensures that all reimbursement requirements are implemented as specified in the contract. This audit function currently exists, and is in compliance with DHS requirements.

Claims are audited daily by samples chosen using the Claims Audit Tool (CAT.NET), a third party application which allows for 30 filters to be used when pulling claim samples. Filters include billed amount, approved amount, service code, age of claim, examiner and allows auditors to pull random samples of claims for review. Sample claims are compared to the supporting documentation to ensure that the claim was properly processed. For each claim, the following minimum attributes are tested for accuracy; data entry (e.g., claims data correctly entered into the claims system as compared to the claims image), proper authorization, member eligibility, corroboration with contracted rate, duplicate payment has not occurred, denial reason appropriately applied, effect of modifier codes correctly applied, other insurance considered and proper coding including bundling/unbundling.

In addition to the daily audits, focal and process audits and testing of system enhancements are performed. Currently, Molina utilizes the services of Ernst & Young for regular internal control audits as well as its annual Sarbanes-Oxley Audit, which includes but is not limited to reviewing payment processing and the QNXT Claims Payment module. A comprehensive review of Molina's Claims Standard Operation Procedures is also conducted yearly.

The documented results of individual claim audits are stored in CAT.NET. Error tickets describing each error issued are distributed daily to the appropriate Claims management staff for review and corrective action. Financial dollar errors are tracked to ensure consistent and appropriate resolution within the designated timeframe. Automated weekly and monthly summary audit results are available. CAT.NET offers historical reporting which allows trending and trending of audit errors by type, error code, user, processing unit, timeframe etc. Reports are available on paid and denied claims, both audited and non-audited.

Testing is also performed by Molina's Claims Operations Projects and Initiatives team prior to implementation of complex contracts, contract changes and/or system enhancements or modifications.

Implementing Necessary Corrective Actions

Molina's Claims Operations department has deployed a Provider Payment Initiative team of highly experienced claims analysts to implement corrective actions resulting from an audit. The main goal of this team is to improve the satisfaction level of providers, health plans, employees and regulators to achieve operational excellence.

Specifically, this team is charged with:

- Identifying the root cause of provider payment errors to improve the overall throughput of claims payments;
- Improving financial quality (i.e., dollars and incidence) of claims payments;
- Identifying and implementing process efficiencies; and
- Improving overall customer satisfaction.

5. Describe your claims dispute procedures.

Molina will comply with the provisions of Attachment 1 – Scope of Work, Section 13.4 – Claims Processing, subsection 13.4.2 – Claims Disputes, and will develop, implement, and maintain written policies and procedures, subject to DHS review and approval, for registering and responding to claims disputes, including disputes for out-of-network providers. Molina's provider claims payment dispute system has the capability to report claims processing activities for both the purpose of analyzing appropriate payment and metrics such as timeliness of payment and accuracy.

Claims Dispute and Resolution Process

Molina's claims dispute and resolution process includes use of a variety of different mechanisms through which disputes can be submitted, defined protocols, ongoing provider interaction and communication, and tracking and reporting capabilities. The Provider Claims Dispute process is intended as a mechanism by which Providers may raise concerns with the manner in which claims are processed. Providers are given access to the provider Claims Dispute process to facilitate resolution of claims payment issues and concerns. If a claim has not been paid in full, has been denied, does not satisfy the Provider, or the Provider believes may have been processed in error, the Provider is able to file a Claims Dispute. Requests for a Provider Claims Dispute must be submitted in writing to the Provider Services Department via fax, surface mail or email. Each Provider Claims Dispute is logged into a tracking system.

The Provider Services Department works with the Provider to gather all needed information and investigates the claims related issue at hand, reviewing all aspects of the issue including, contract requirements, claims processing guidelines and other pertinent information submitted by the Provider. Depending on the Claims Dispute outcome, Provider Services either educate the Provider as to the rationale for the correct claim(s) processing or coordinate with the Claims Department to correct any errors and have the claim(s) re-processed within the appropriate time frames. Providers are notified in writing of the disposition of the Claims Dispute investigation within the contractually obligated time frame and the Claims Dispute resolution is recorded in the Provider Claims Dispute tracking system. The

Provider Services Department maintains tracking reports for root cause analysis to determine process improvement in claims configuration, claims examiner processing guidelines, claims reconsideration and dispute guidelines, and other departmental processes that affect claims payment. The submission and resolution of a Provider Claims Dispute does not prevent a Member from filing a Grievance or Appeal for the same issue.

Providers seeking a redetermination of a claim previously adjudicated must request such action within 30 calendar days of original remittance advice date. Additionally, the item(s) being resubmitted should be clearly marked as a redetermination and must include the following documentation:

- The item(s) should be clearly marked as a Claim Dispute/ Adjustment;
- Payment adjustment requests must be fully explained;
- The previous claim and remittance advice, any other documentation to support the adjustment and a copy of the Referral/Authorization form (if applicable) must accompany the adjustment request; and
- The claim number clearly marked on all supporting documents.

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

The Provider is notified of Molina's decision in writing within 60 calendar days of receipt of the Claims Dispute/Adjustment request. Providers may request a claim dispute/adjustment when the claim was incorrectly denied as a duplicate or due to claims examiner or data-entry error.

Grievance and Appeal data, including practitioner specific data, is reported quarterly to the Member Provider Service Committee and the Quality Improvement Committee. Grievance and Appeals reports are reviewed monthly by the Credentialing Coordinator for inclusion in the trending of ongoing sanctions, grievances and quality issues.

6. Describe proposed processes for collaborating with other program contracts to simplify claims submission and ease administrative burdens for providers.

Molina will comply with the provisions of services specified in Attachment 1 – Scope of Work, Section 13.4 – Claims Processing, subsection 13.4.5 – Coordination among Contractors, and will ease administrative burdens for providers by collaborating with other program contract to simplify claims submissions.

Molina is committed to utilizing advanced, reliable and user-friendly technology to minimize administrative burdens and simplify access to review information for its own staff as well as subcontracted and provider staff. Molina's strategic focus is on utilizing technology and automated solutions to alleviate administrative costs while enhancing information access and expediting the prior authorization process.

To simply the claims submission process, Molina uses a Web Portal to help reduce the administrative burden on providers. Some of the current functionality available includes:

- On-line claims entry, which assists providers that do not have full EDI submission abilities to submit claims electronically rather than on paper;
- Claim status information on submitted claims, which is available for both paper and electronic submissions;
- Secure messaging capabilities for transmission of PHI between providers and Molina.
- Real-time eligibility verification;

- On-line authorization request; and
- HEDIS missed service notifications for members paneled to the provider.

The Web Portal is currently being enhanced to improve services available to providers, and members will also have services available to make it easier for them to access information:

- Real-time automated authorization approvals, which will speed up response time for providers and reduce administrative staffing needs;
- Members and Providers will both have access to the member care plan for members in case management;
- Members will be able to change their PCP and demographic information through the portal rather than needing to talk to customer service;
- Members can request a new ID card and print a temporary card to use while the new card is being mailed;
- Members will be able to see their own HEDIS missed services for their health conditions, along with links to health education and wellness incentive programs;
- Members in case management will be able to use the system for secure communication with their case manager rather than needing to call in to customer service;
- Members will be able to see their prescription drug history and laboratory results; and
- Members will be able to print out a personal health record.

If members or providers either do not have online access or prefer not to use this option, Molina's customer service systems are also designed to reduce the burden for them to receive the information they need:

- Molina currently has in place an Interactive Voice Response (IVR) system that uses voice recognition and touch tones to either help route the member or provider to the proper customer service representative queue or provide some services automatically;
- Simple activities, such as ID card requests (for members) or eligibility verification (for providers) can be done automatically by the system;
- More complex activities can be routed with the various voice prompts into a queue in order to speak with customer service representatives that can best resolve the issue;
- Molina's IVR system is currently in the process of a redesign to help route callers to the proper queue with fewer steps and prompts; and
- Molina is also working on an improved Customer Relations Management system that will provide better integration of the information from web inquiries, IVR inquiries, and customer service calls so that information will not need to be repeated.

Molina has implemented member-centric telemedicine programs that focus on providing positive health outcomes to members. Telemedicine programs can help to reduce provider and member administrative burdens by:

- Reducing the need for care coordination between multiple practitioners since a broader range of care can be provided by the member's PCP when supported by the specialty consultation available through the program;
- Reducing or eliminating the need for a member to travel to a different city for specialty care; and
- Maintaining and strengthening the PCP-member relationship because the member interacts with their PCP more often rather than having to establish new provider relationships with specialty practitioners.

Commitment to Enhancing Productivity

As part of its commitment, Molina has taken the following steps to enhance productivity, to expand access and to ease information exchange for all parties.

- Maximize usage of the internet for publishing, distributing and exchanging information.
  - The Internet has simplified many everyday tasks, becoming an integral part of day-to-day operations. Molina utilizes the capability and benefits of internet convenience to providers for a number of business purposes involving its partners, including verifying recipient eligibility; verifying PCP information; obtaining PCP rosters; submitting provider reconsideration requests; submitting prior authorization requests (information about diagnosis and procedure codes is also readily available); checking prior authorization status and approvals/denials; downloading forms; and changing provider mailing address and telephone number. Molina offers these online services free of charge to all contracted providers.
  - The Molina website is updated daily with new information and tools for providers, such as links to CPT and ICD coding, prior authorization forms, and provider related data such as disease management education material.
  - Web Portal, Molina's web-based and HIPAA secure site, offers real-time information 24 hours a day, 7 days a week.
  - Molina Provider Services staff is available to train providers to use Molina's Web Portal. Web Portal instructions are outlined in the Provider Manual.
- QNXT, the platform utilized by Molina, is a multi-level medical management system that includes information/data on the recipient, provider, authorization, call tracking, eligibility, and conditions. This type of platform allows Utilization Management to access all available recipient data from all systems rather than incurring long call-times while navigating several platforms.
- UMK2, a Molina developed, innovative electronic fax platform, is fully integrated into Molina's medical management system, QNXT. This high level of technology allows Molina's Prior Authorization department to receive a faxed request, examine clinically relevant documentation submitted, apply utilization criteria, enter notations into QNXT, build the prior authorization for upload to DHS claims system for claim payment and return the authorization back to the provider in one efficient process.
- Care Review staff have all systems available to answer and process telephone requests in an efficient and timely manner to assist providers.

7. Propose ideas for handling Medicare crossover claims which reduce the administrative burden on providers.

In accordance with the provisions of services specified in Attachment 1 – Scope of Work, Section 13.4 – Claims Processing, subsection 13.4.5, Molina will ease the administrative burdens for providers by handling Medicare crossover claims. Molina's core information processing system, QNXT, accepts and adjudicates Medicare or crossover claims in compliance with all federal and state requirements. QNXT allows the adjudication of these claims and stores the Medicare allowed and paid amounts as well as the Medicaid allowed and paid amounts including claim adjustment reason codes. When QNXT identifies members as having coverage other than Medicaid, the system alerts during claim adjudication that an external enrollment segment exists.

8. Describe processes for notifying providers of a member's financial participation or cost sharing requirements.

Molina will comply with the provisions specified in Attachment 1 – Scope of Work, Section 13.4 – Claims Processing, subsection 13.4.8 – Member Financial Participation and Cost Sharing. As appropriate, Molina will bill members identified by the state for their portion of financial participation. Molina understands that it is responsible for notifying providers of a member's financial participation or cost sharing requirement. Molina provides detailed information regarding a member's financial participation and cost-sharing requirements in our Explanation of Benefits (EOB), which is mailed to providers.

9. Describe processes for providing monthly prospective reimbursement to providers of IDPH funded services.

Molina acknowledges and will comply with the provisions of services as specified in Attachment 1 – Scope of Work, Section 13.4 – Claims Processing, subsection 13.4.9 – IDPH Prospective Reimbursements. Accordingly, Molina will provide prospective reimbursement to providers of Iowa Department of Public Health (IDPH) services.

Providers of IDPH funded services are critical components of the health care safety net and thus ensuring their cash flow is of vital importance. Molina proposes to implement a prospective reimbursement system that incorporates settlement to the state's expenditure target periodically; the specific terms of this system will be negotiated with DHS.

In its other medical assistance health plan accounts, Molina has already demonstrated its ability to design and implement unique reimbursement arrangements that fit the circumstances of those accounts. For instance, in New Mexico, Molina has implemented the following special reimbursement provisions:

- Both contracted and non-contracted FQHCs and RHCs are paid a minimum of Prospective Payment System (PPS) or alternative payment methodology in compliance with Section 1905 (a)(C) of the 1902 Social Security Act.
- Molina and First Choice Community Health (FCCH) have executed an agreement for FCCH's management of complex chronic patients, for which they will receive a PMPM supplemental payment for each member who participates.
- In addition, special payments are made for presenting cases of selected Molina members to the University of New Mexico's Project ECHO team of specialists. Project ECHO has received national attention given its leveraging of telemedicine assets to develop the capacity to safely and effectively treat chronic, common, and complex diseases in rural and underserved communities.
- Finally, New Mexico has implemented a Medicaid Health Homes initiative; under that program Molina is making per-member-per-month health home payments.

Because of QNXT's flexibility and ease of configuration, Molina is able to support a wide variety of reimbursement arrangements.

13.5 Encounter Claims Submission

1. Describe your policies and procedures for supporting the encounter data reporting process, including:

Molina agrees, understands and will comply with the provisions of Medicaid services as specified in Attachment I – Scope of Work, Section 13.5 – Encounter Claim Submission, and will have policies and procedures in place to support encounter claims submissions to support the Iowa High Quality Healthcare Initiative. Molina ensures that we will strictly adhere to the standards defined by DHS for items such as the file structure and content definitions. Molina acknowledges that DHS will have the right to make revisions to these standards, as applicable.

In compliance with the provisions specified in section 13.5.3 – Encounter Claims Policies, Molina's initial draft plan to meet the encounter data reporting requirements of the Iowa High Quality Healthcare Initiative is provided below. Molina will provide an official draft plan within 30 days of Contract execution. Accordingly, Molina will submit to DHS a final work plan, incorporating all changes requested by DHS, within 60 days of the official submission of the plan. We will resubmit the work plan annually that addresses our strategy for monitoring and improving encounter claims submissions.

Molina has engineered and implemented an encounter data management methodology and technology solution that it is currently employing with great success in all of its Medicaid Managed Care and Medicaid/Medicare duals accounts.

a. A workflow of your encounter data submission process proposed, beginning with the delivery of services by the provider to the submission of encounter data to the State. If you will subcontract with multiple vendors or provider organizations for claims processing management, workflows should incorporate all such vendors, including vendor's names and the approximate volume of claims per vendor identified.

Molina uses various combinations of network technologies to provide secure and reliable access to its data resources. Molina has developed and implemented the following electronic healthcare transactions covered under HIPAA:

- Claims/Encounter Data – ASC 837 Professional, Institutional and Dental claims;
- Eligibility – ASC 270/271 Eligibility Inquiry and Response and ASC 834 Benefit enrollment and maintenance transaction;
- Referral Certificate and Authorization – ASC 278 health care services request for review and response;
- Claim Status – ASC 276/277 Healthcare claim status request and response;
- Payment and Remittance Advice – ASC 835 Health care claim payment/advice;
- Functional acknowledgements – ASC 997's, 999's, 824's and TA1 transaction sets; and
- Encounter Status - ASC 276/277 Healthcare encounter status request and response to vendors who have the ability to accept for encounter files.

Molina has experience in receiving and transmitting HIPAA compliant 834 eligibility files and receiving and transmitting HIPAA compliant 837 encounter files to state agencies, vendors, providers and other HIPAA trading partners with which it has a Business Associate Agreement (BAA). CMS requires that Medicare encounter data be submitted in one of two ways: one way is through a Risk Adjustment Processing System file format (RAPS) for Part A and Part B services; the other method is through a Prescription Drug Event (PDE) file format for Part D services. Molina is capable of submitting Medicare Encounter Data to Iowa in a HIPAA compliant format.

Data Exchange

Electronic Data Interchange (EDI) Claims

Molina Healthcare has a partnership agreement with Emdeon to serve as its single source Electronic Data Interchange (EDI) clearinghouse for claims and encounter submissions to Molina. The partnership, referred to as Managed Gateway Agreement, is a single-vendor solution for Molina and helps manage its entire claim life cycle, thereby simplifying processes for its vendors and contracted providers. Emdeon will accept all electronic claims submitted from any direct provider, practice management system vendor, clearinghouse, or any other third party on Molina's behalf. Emdeon's claim edits will be applied consistently to 100% of inbound electronic claims. Emdeon will also provide comprehensive claim tracking for both providers and payers' service representatives throughout the claim delivery cycle. Molina provider community benefits include:

- Electronic Data Interchange Utilization – Emdeon has the ability to influence higher Electronic Data Interchange utilization among Molina's provider community by helping them identify and overcome barriers to Electronic Data Interchange (Growth Program) adoption, resulting in greater savings to Molina in the form of reduced Electronic Data Interchange "churn", often experienced when competing Electronic Data Interchange vendors convince providers to switch clearinghouses;
- Improved auto-adjudication rates/few pended claims through consistent editing and pre-adjudication claim scrubbing; and
- Improved provider service with complete visibility and accountability in claim delivery.

Molina's long and deep experience in managing Medicaid and Medicare membership ensures that Molina staff has extensive understanding of encounters processing and management. Encounters processes have distinctive owners on Molina business side supported by commensurate IT functions. Molina has achieved almost 100% accuracy in processing submissions across its business lines/states.

Molina has extensive experience in submitting Encounter Data to government agencies (state and CMS). Molina currently offers Medicaid and Medicare services in the following (CA, FL, IL, MI, NM, OH, the Commonwealth of PR, SC, TX, UT, WA, WI, MAPD, MMP and Market Place) and is responsible for submitting Encounter Data to the appropriate government agencies adhering to the encounter submission and processing guidelines as outlined by each state's Medicaid/Medicare contract. For Molina Healthcare Encounter Data submission, Molina follows national industry standards and state companion guides to support HIPAA X12N Medical (837P), Institutional (837I) and Dental (837D) formats, and other proprietary formats, National Council for Prescription Drug Programs (NCPDP) formats. Molina submits timely, accurate, complete and finalized Fee-for-Service (FFS) claims, Capitated encounters and Pharmacy encounters to the state agencies

Molina has implemented quality and completeness checks throughout the claims/encounter submission process to ensure that encounter submissions are complete and meet required standards. Molina works closely with its providers to ensure that encounter data received is complete and meets Molina quality standards, valid code sets, HIPAA compliance, etc. Molina is consistently validating the encounter data, performing analysis, such as benchmarking, to ensure volume of encounters received and submitted.

Encounter files are first validated to ensure they are HIPAA compliant. Invalid HIPAA files are rejected back to the provider for correction. Once the encounter file passes the HIPAA validation, the encounter data is reviewed to assure the file content meets HIPAA and Molina standards. All encounters failing any of the inbound edits are denied back to the provider for correction. Before encounters are submitted to the state for processing, they are run through another series of internal outbound edits to assure data is complete and meets state encounter data edit requirements. Any encounters failing the internal edits are pended for manual review until the error(s) is/are resolved, after which it will be submitted to the state agency for processing.

Molina maintains an internal workflow system to monitor and report on all, multiple or any one encounter throughout the entire life cycle of the encounter – from claims payment through submission to the state. This workflow can pinpoint where the error resides if indicated based upon validation edits established within the Molina encounter or claims payment processes. Additionally, numerous reports are used to verify, trend and track the encounter for reporting key performance indicators, daily, weekly, monthly, quarterly and annually, which allows Molina to reconcile submitted and rejected encounters at multiple levels.

Molina works closely with its providers and subcontractors to ensure they are in compliance with Encounter Data submission requirements. This includes training, technical assistance and other activities to support providers and subcontractors to ensure compliance with the HIPAA 837 format. Molina also partners with a primary claims clearing house, Emdeon, to identify opportunities to assist providers to use electronic claims submission and improve the quality of claims submitted. Contractually, Molina providers who are not sub-capitated are required to submit all services provided to members via the claims submission process. Regardless of the capitation model, sub-capitated providers will be required to submit Encounter Data. Providers may qualify for pay-for-performance rewards for submitting timely and accurate data. Providers are subject to potential financial penalties for failure to submit timely and accurate data.

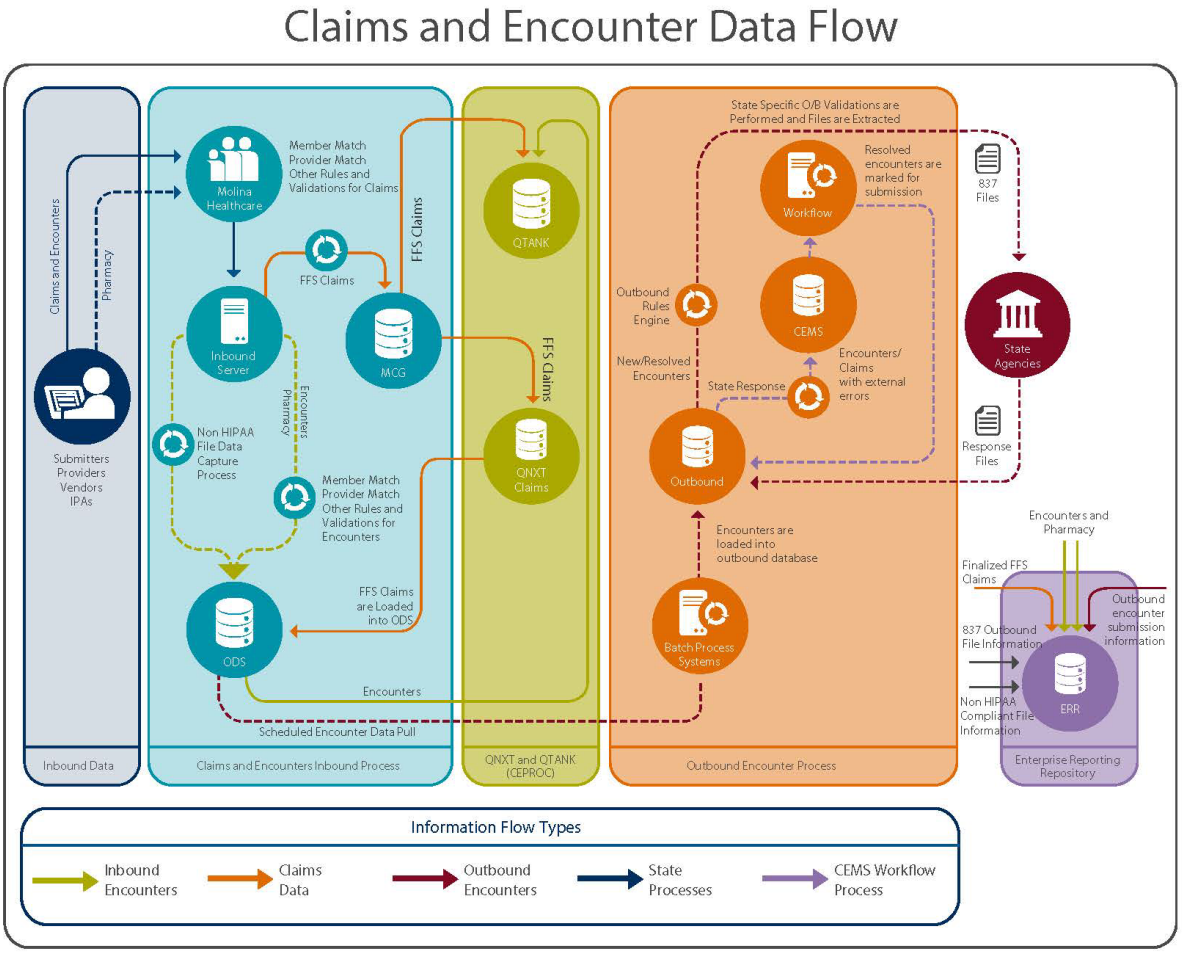
Encounter Data submitted is a vital component of the provider relationship with Molina as completeness and quality impacts the accuracy and validity of most metrics and thus the ability of the plan to identify best practices and provider issues; therefore, meaningful discussions with providers are based on the premise that performance reported reflects actual performance. Molina holds regular joint operations meetings with sub-capitated providers and large volume fee-for-service providers. At these meetings, claims and/or encounter status and issues are a standing agenda item to ensure providers are focused on achieving maximum compliance rates.

Molina's joint operations work dovetails with its internal processes. In order to ensure Molina is compliant with Iowa standards, Molina will establish an Encounters team led by the Plan President. This is a business practice utilized in other state Molina health plans to review all incoming and outgoing Encounter Data and implement corrective action plans as required. Molina recognizes that Encounter Data is a critical component of demonstrating rendered services to DHS so the agency can accurately evaluate state programs and Molina's performance, especially against quality metrics. Molina's systems and processes generate Encounter Data for all covered services and any additional services that may be offered. Molina manages all Encounter Data processing internally and will establish quality measures to ensure accuracy, timeliness and completeness of Encounter Data submissions to the State.

Encounter Processes

Molina's robust state-of-the-art technologies ensure a comprehensive business process supports the quality of encounter submissions. The process caters to various sources of encounters and is agile enough to address provider-specific nuances. Exhibit 13.5.1.a-1 provides a detailed workflow of Molina's claims and encounter data submission process.

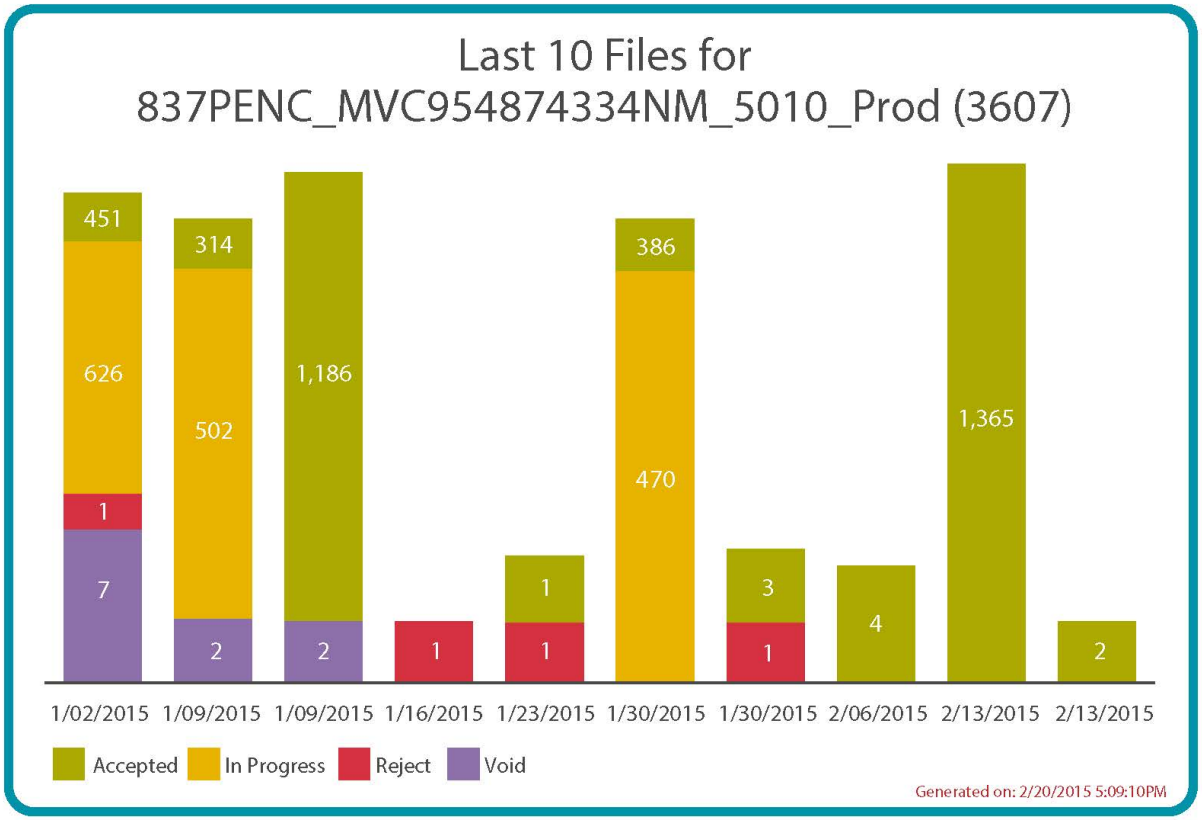
Exhibit 13.5.1.a-1 Claims/Encounters Process Flow



Molina's encounter processes include:

- Inbound Claims/Encounter Processing Completeness Checks – Molina has implemented quality and completeness checks throughout the claims/encounter process to ensure that encounter submissions meet state required standards. These measures include: Acceptance and verification of encounter data via Molina's Web Portal – Providers, provider groups, IPAs, MSOs and vendors can log in to the Web Portal website to submit their encounter files through secured socket layer (SSL). Submissions are automatically logged and tracked through the website. Users can then view a log of all their submissions, including errors, through the site to enable resubmission of any failed submissions. Exhibit 13.5.1.a-2 is a sample dashboard displayed on the Web Portal. The dashboard gives the provider submission summary. There are numerous such reports which help providers track their submissions online.

Exhibit 13.5.1.a-2 Sample Dashboard on the Web Portal



- Acceptance and verification of encounter data via Paper (e.g., scanning/imaging) – All paper HCFA encounters, HCFA and UB claims, including those with claim attachments, are picked-up on a daily basis by Molina's scanning and imaging vendor, Future Vision, to be scanned, Optical Character Recognition (OCR), and imaged. Future Vision performs a document preparation process; inventory control logs are created. The claims are scanned using batch count verification and high-level quality control processes within 24-48 hours of claims receipt. These files are sent daily to Molina to load in our Operational Data Storage database (ODS) for processing.
- Enforcement of timely submission of encounter data from providers and subcontractors.
- Timely processing of claims and encounters, as well as diligent enforcement of system edits to ensure state data requirements are met.
- Internal monitoring of claims/encounter inventory including inventory totals, claims aging, and staff productivity.

Encounter Submissions to the State and Reconciliation Process

Molina has ability to select and submit encounter data as frequently as necessary in order to comply with State's encounter submission requirements and processing needs. All encounters undergo a thorough validation before the building of the State-required data formats. Submission of duplicate encounters is eliminated by virtue of the selection logic that controls the process of preparing encounters for submission. The process to create the encounter file includes a complete validation of encounters and claims data against state specific edits to ensure data is accurate and complete. All submitted claims/encounters are logged to the system for future tracking purposes. Molina's encounter process also

includes the identification of adjustments and voids. Therefore, Molina has the ability for reporting of voids and adjustments in its encounter files to the State or in a separate file, if necessary.

State-adjudicated encounters reported from the state in the response file(s) are reconciled against originally submitted encounters, logged during the reconciliation process, and will be resubmitted with the correction, if necessary. The process also includes retrospective data analysis performed using CEMS system (Claims Encounter Management System – Detailed of CEMS provided below) and is distributed to all internal stakeholders to support continued improvement of the encounter process. Any errors flagged by the pre-submission verification process are reviewed by a business encounter workgroup that meets on regular basis to identify and coordinate resolution as well as prepare the encounters for resubmission to the state. This group is charged with evaluation of retrospective data and coordination across departments to address submission errors/rejections and ensure correction and resubmission and also initiates and manages projects to coordinate any remediation efforts required to support the encounter resubmission process.

Finally, in line with the Molina's encounter function, there will be a dedicated Molina team that will reach out directly to providers to ensure compliance of complete encounter submissions to Iowa.

Claims Encounter Management System (CEMS)

Molina's Claims Encounter Management System, a custom-developed web-based application, offers a 360-degree view of claims and encounters to Molina's staff, allowing data to be collected from all systems beginning at the gateway entry (i.e. raw 837 files) through submission to Iowa. The Claims Encounter Management System utilizes Silver Light technology, which offers a variety of reports and metrics to provide enterprise-wide trends across claims and encounter data that are processed within different stages and environments. It also provides a detailed life cycle of a claim or an encounter, empowering users to know exactly how a claim/encounter progressed across the different Molina data sources. As part of the life cycle within the Claims Encounter Management System, Molina staff can view a rejected encounter down to the claim detail level. Encounters pended and not submitted by Molina based upon Molina's validation edits or State-rejected encounters can be reviewed within CEMS workflow to determine where the error occurred and why. Remediation is immediate, as the Claims Encounter Management System contains the encounter rejection reason(s), allowing Molina to review and resolve the issue accordingly and resubmits data in a timely manner to the State.

Exhibit 13.5.1.a-3 Claims Encounter Management System
Claims File Life Cycle Flow Chart

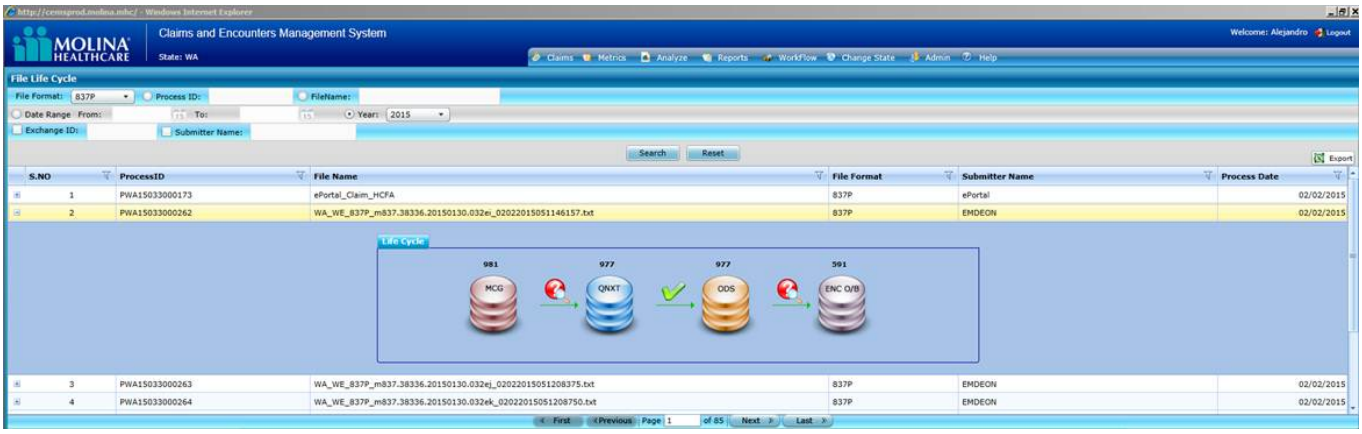
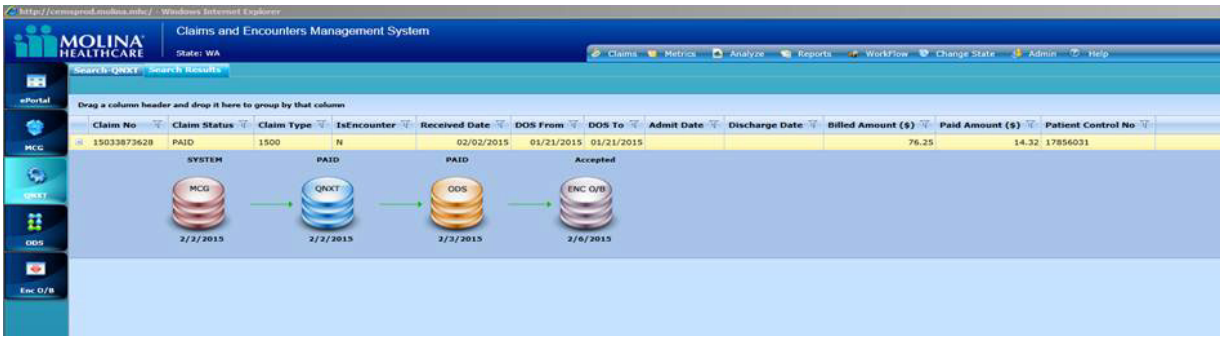


Exhibit 13.5.1.a-4 Claims Encounter Management System
Individual Claims File Life Cycle Flow Chart



Encounter Reports

Molina has developed a number of custom reports for encounters (aka, dashboard reports) for review by Molina's senior management. These encounter dashboard reports (depicted below) are also shared with Molina's partner agencies and detail the status of encounter submissions and submission errors. Sample reports currently available include (see exhibits for corresponding graphs):

- Encounter Trending – Submitter Last 10 Submissions – identifies number of encounters accepted, rejected or identified as duplicates by submission file.
- Submitter Encounter Summary Report – shows encounter errors (code, description and count) for each submission
- Encounter Top 5 Errors – Shows categories and counts of top 5 errors.
- Encounter Inbound and Outbound Key Performance Indicator Reports – Generates as needed either daily, weekly, monthly, quarterly, annually, etc.
- Encounter Inbound Volume by State and Submitter – Provides encounter volumes by state, submitter and file type, weekly, monthly, quarterly, and annually, etc.

Exhibit 13.5.1.a-5 Status of the Submitted Encounters

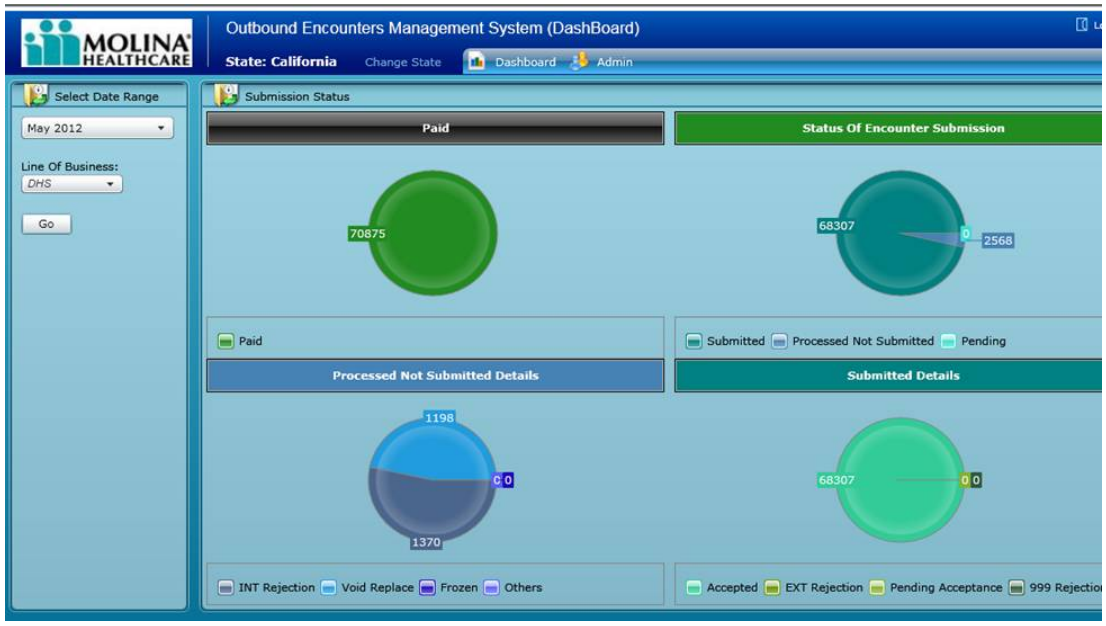
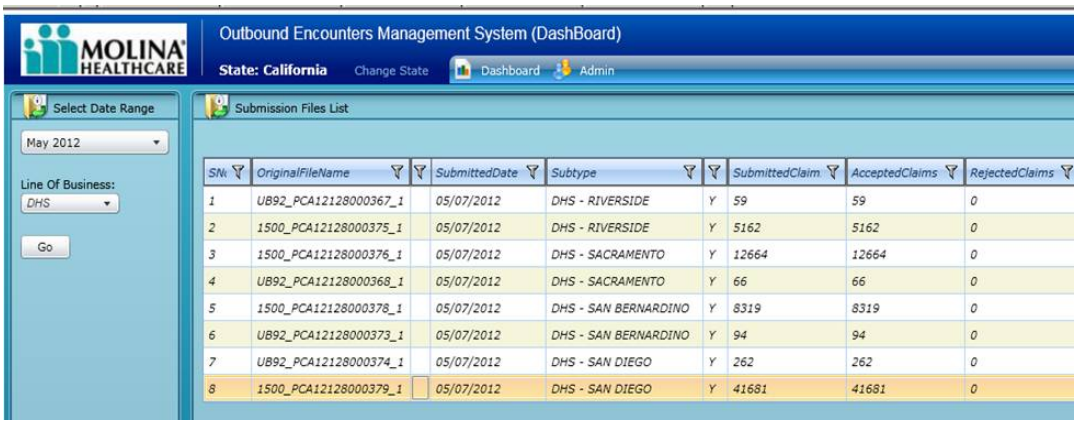


Exhibit 13.5.1.a-6 Encounter File Submission Report



SN	OriginalFileName	SubmittedDate	Subtype		SubmittedClaim	AcceptedClaims	RejectedClaims
1	UB92_PCA12128000367_1	05/07/2012	DHS - RIVERSIDE	Y	59	59	0
2	1500_PCA12128000375_1	05/07/2012	DHS - RIVERSIDE	Y	5162	5162	0
3	1500_PCA12128000376_1	05/07/2012	DHS - SACRAMENTO	Y	12664	12664	0
4	UB92_PCA12128000368_1	05/07/2012	DHS - SACRAMENTO	Y	66	66	0
5	1500_PCA12128000378_1	05/07/2012	DHS - SAN BERNARDINO	Y	8319	8319	0
6	UB92_PCA12128000373_1	05/07/2012	DHS - SAN BERNARDINO	Y	94	94	0
7	UB92_PCA12128000374_1	05/07/2012	DHS - SAN DIEGO	Y	262	262	0
8	1500_PCA12128000379_1	05/07/2012	DHS - SAN DIEGO	Y	41681	41681	0

Exhibit 13.5.1.a-7 Encounter File Submission Trends

Encounter File Submission Trends

State	Frequency	Line of Business	Submission Period	# of Encounters Extracted	Internal Rejected	Submitted Encounter	State Rejected	Success %	Internal Rejected %
CA	Monthly	DHS	Jan '12	158,839	6,856	143,660	445	99.69%	4.32%
CA	Monthly	DHS	Feb '12	87,924	1,270	86,552	158	99.82%	1.44%
CA	Monthly	DHS	Mar '12	76,228	1,399	74,683	113	99.85%	1.84%
CA	Monthly	DHS	Apr '12	78,879	2,500	76,379	168	99.78%	3.17%
CA	Monthly	DHS	May '12	70,887	1,370	68,543	0	100.00%	1.93%

b. Your operational plan to transmit encounter data to the State, indicating any internal checks and balances, edits or audits you will use to verify and improve the timeliness, completeness and accuracy of encounter data submitted to the State.

Molina is responsible for submitting encounter data to the appropriate government agencies in all of its Medicaid and Medicare accounts; in doing so Molina adheres to the encounter submission and processing guidelines outlined in each contract. Molina's encounter data submission processes follow national industry standards and state companion guides to support HIPAA X12N (4010 and/or 5010) Medical (837P), Institutional (837I) and Dental (837D) formats, National Council for Prescription Drug Programs (NCPDP) formats and proprietary formats as deemed applicable. Molina submits timely, accurate, and complete finalized FFS claims and capitated encounters.

For managing the flow, generation and submission of encounter data, Molina uses Claims Encounter Management System (CEMS), a custom-developed web-based application that offers a 360-degree view of claims and encounters to Molina's staff and allows encounter data to be collected from all systems at a common gateway entry (i.e., raw 837 files) and processed through submission. CEMS also records a detailed life cycle of a claim or encounter, empowering users to know exactly how a claim/encounter progressed across the different Molina data sources. As part of the life cycle within CEMS, Molina staff can view a rejected encounter down to the claim detail level. Encounters pended and not submitted by Molina based upon Molina's validation edits or State-rejected encounters can be reviewed within CEMS to determine where and why an error occurred; remediation can occur in near real-time.

Molina conducts quality and completeness checks throughout the encounter submission process to ensure that encounter submissions are complete and meet required standards. Before encounters are submitted for processing, they are run through a series of internal outbound edits to ensure data is complete and meets the encounter data edit requirements that apply to a particular contract. Any encounters failing the internal edits go through a correction process until the error(s) are resolved.

Inbound Claims/Encounter Processing Completeness Checks

Molina has implemented quality and completeness checks throughout the claims/encounter process to ensure that encounter submissions meet state required standards. These measures include:

- Acceptance and verification of encounter data via Molina's Web Portal – Providers, provider groups, IPAs, MSOs and vendors can log in to the Web Portal website to submit their encounter files through secured socket layer (SSL). Submissions are automatically logged and tracked through the website. Users can then view a log of all their submissions, including errors, through the site to enable resubmission of any failed submissions. The dashboard gives the provider submission summary. There are numerous such reports which help providers track their submissions online.
- Acceptance and verification of encounter data via Paper (e.g., scanning/imaging) – All paper HCFA encounters, HCFA and UB claims, including those with claim attachments, are picked-up on a daily basis by Molina's scanning and imaging vendor, Future Vision, to be scanned, Optical Character Recognition (OCR), and imaged. Future Vision performs a document preparation process; inventory control logs are created. The claims are scanned using batch count verification and high-level quality control processes within 24-48 hours of claims receipt. These files are sent daily to Molina to load to QNXT system for processing.
- Enforcement of timely submission of encounter data from providers and subcontractors.
- Timely processing of claims and encounters, as well as diligent enforcement of system edits to ensure state data requirements are met.
- Internal monitoring of claims/encounter inventory including inventory totals, claims aging, and staff productivity.

Encounter Submissions to the State and Reconciliation Process

Molina has ability to select and submit encounter data as frequently as necessary in order to comply with State's encounter submission requirements and processing needs. All encounters undergo a thorough validation before the building of the State-required data formats. Submission of duplicate encounters is eliminated by virtue of the selection logic that controls the process of preparing encounters for submission. The process to create the encounter file includes a complete validation of encounters and claims data against state specific edits to ensure data is accurate and complete. All submitted claims/encounters are logged to the system for future tracking purposes. Molina's encounter process also includes the identification of adjustments and voids. Therefore, Molina has the ability for reporting of voids and adjustments in its encounter files to the state or in a separate file, if necessary.

State-adjudicated encounters reported from the state in the response file(s) are reconciled against originally submitted encounters, logged during the reconciliation process, and will be resubmitted with the correction, if necessary. The process also includes retrospective data analysis performed using CEMS system and is distributed to all internal stakeholders to support continued improvement of the encounter process. Any errors flagged by the pre-submission verification process are reviewed by a business encounter workgroup that meets on regular basis to identify and coordinate resolution as well as prepare the encounters for resubmission to the state. This group is charged with evaluation of retrospective data and coordination across departments to address submission errors/rejections and ensure correction and resubmission and also initiates and manages projects to coordinate any remediation efforts required to support the encounter resubmission process.

Finally, in line with the Molina's encounter function, there will be a dedicated Molina team in the local Iowa service area that will reach out directly to providers to ensure compliance of complete encounter submissions to the State of Iowa.

2. Describe your experience and outcomes in submitting encounter data in other states.

Molina's long and deep experience in managing Medicaid and Medicare membership ensures that Molina staff has extensive understanding of encounters processing and management. Encounters processes have distinctive owners on Molina business side supported by commensurate IT functions. Molina has achieved almost 100% accuracy in processing submissions across its business lines/states.

Molina has extensive experience in submitting Encounter Data to government agencies (state and CMS). Molina currently offers Medicaid and Medicare services in 11 states (CA, FL, IL, MI, NM, OH, SC, TX, UT, WA, and WI) and the Commonwealth of Puerto Rico, and is responsible for submitting Encounter Data to the appropriate government agencies adhering to the encounter submission and processing guidelines as outlined by each state's Medicaid/Medicare contract. Molina follows national industry standards and state companion guides to support HIPAA X12N Medical (837P), Institutional (837I) and Dental (837D) formats, and other proprietary formats, National Council for Prescription Drug Programs (NCPDP) formats. Molina submits timely, accurate, complete and finalized Fee-for-Service (FFS) claims, Capitated encounters and Pharmacy encounters to the state agencies.

No major issues were encountered during testing and implementation in any of Molina Healthcare, Inc.'s existing states' encounter submissions. If issues are identified through the testing phase, they are historically resolved by working very closely with the state or any third party regulatory agency. A thorough testing plan is developed to ensure Molina meets all the state requirements, and testing with the state is conducted to validate state edits, etc. This facilitates the tracking and trending of any issues during the testing phase. Meetings are scheduled with the state as needed to discuss issues identified and to determine next steps for resolving these issues.

13.6 TPL Processing

1. Describe your plans for coordinating benefits in order to maximize cost avoidance through the utilization of third-party coverage.

Molina agrees, understands and will comply with the provisions of Medicaid services as specified in Attachment 1 – Scope of Work, Section 13.6 Third Party Liability (TPL) Processing. In compliance with subsection 13.6.1 – TPL Responsibility, and will develop and implement detailed processes and procedures, subject to DHS review and approval, for the coordination of benefits and recovery of TPL. Molina will make every reasonable effort to determine the liability of third parties to pay for services rendered to members enrolled in the Iowa High Quality Healthcare Initiative. Molina acknowledges and understands the provisions of subsection 13.6.2 – Cost Avoidance, and has processes and procedures in place to ensure that Medicaid is always the payer of last resort for applicable members. Molina acknowledges and will follow all actives laid out in the Iowa Department of Human Services, Medicaid TPL Action Plan, revised December 23, 2011.

Molina processes and coordinates claims utilizing State-provided eligibility data and data from their insurance coverage. QNXT, Molina's core administration system, supports full coordination of benefits functionality including Medicare as primary coverage and serves as the authoritative source of member eligibility and enrollment data including other potential sources of insurance coverage.

Molina contracts with Health Management Systems to verify other insurance coverage of its members. This service also provides cost avoidance and recovery mechanism by providing current information

captured on Health Management System platform. Health Management Systems verifies the member's eligibility monthly, and when identified, adds data regarding other insurance coverage to each member's record. QNXT coordinates other health insurance at the claim line or at the claim header level, allowing for appropriate calculation of payment due for services rendered ensuring appropriate and accurate cost avoidance. Additionally, Molina utilizes First Recovery Group to assist in the review and determination of Third Party Recovery (TPR) cases associated with accidents/trauma. Refunds received by First Recovery Group are forwarded to Molina for refund posting into QNXT.

For services where Molina is determined to be secondary, payment will be made in accordance with federal and state law allowing for payment up to the established allowable levels. Molina pays covered services and makes reasonable efforts to recover payments for such services whenever it is determined that other health insurance was in effect at the time services were rendered. Recovered funds are posted in QNXT and applied against each applicable claim. Molina will bill the primary insurance carrier to alleviate provider abrasion and any billing issues for the provider of service. If Molina requests a refund from the provider of service and if the provider of service does not submit a refund, QNXT supports off-setting claims payments against monies to be recovered.

2. Describe your process for identifying, collecting, and reporting third-party liability coverage.

Molina has detailed processes and procedures in place to identify, maintain and collect third party liabilities, in compliance with the provisions of Medicaid services specified in Attachment 1 – Scope of Work, Section 13.6 – Third Party Liability (TPL) Processing. We exert every reasonable effort to determine the legal liability of third parties to pay for services rendered to members and to cost avoid and/or recover liability from the third party. To achieve this, Molina has efficient systems and processes in place that use a cost avoidance method to pay claims and that greatly enhances Molina's ability to successfully capture third party resources, as appropriate. These systems and processes work to identify, determine and coordinate benefits with other payers; identify opportunities for and obtain recoveries of amounts due from other health insurance coverage sources; and track and monitor Molina's activities in these areas.

Identification, Maintenance, and Collection of Third-Party Liabilities

Molina has processes in place to identify, maintain and collect third party liabilities related to subrogation and/or tort. Third Party Liabilities are identified via several methods, including the following:

- From ICD-9 codes mined from the claims data fed to the First Recovery Group;
- When a call is received from a provider, member or attorney indicating an accident related insurance payment has occurred;
- Direct referral from Molina Utilization Management Team; and
- When a refund is received from an attorney or liability carrier.

Molina currently utilizes First Recovery Group for the identification and recovery of third party claims via the review and determination of third-party cases associated with accidents, trauma, etc. The recovery process at First Recovery Group is initiated via either Molina's utilization management staff submitting a direct referral, or via Molina sending a monthly electronic file of claims paid in the previous month to First Recovery Group's secure FTP. For the monthly file, during processing, the claims are scrubbed by First Recovery Group's data mining system using proprietary algorithms to review all levels of ICD-9 codes, CPT codes, and E-codes within an episode of care. This system identifies cases that are possible recovery opportunities and a questionnaire is sent to the members requesting additional information about the case. Members are given the option to respond to these questionnaires by mail using postage pre-paid envelopes, or by calling First Recovery Group's toll-free number to discuss the case with First Recovery Group member services staff. Based on the information provided, a decision is made to pursue the case for recovery or dismiss it as non-recoverable. The recovery staff at First Recovery Group receives any

cases that have been determined to be recoverable. First Recovery Group will then handle the case through conclusion. All subrogation/tort monies are collected by First Recovery Group are submitted to Molina for deposit and for uploading to QNXT and Molina's recovery application, Recovery.Net.

Maintenance and Follow up for Outstanding Liabilities

First Recovery Group uses a proprietary operating system designed for the purpose of identifying accident related claims and subrogation opportunities. Files are tracked in an automated file management tool. The system provides an automated follow-up application that triggers an alert to a First Recovery Group in-house attorney indicating that the collection was made timely or is still outstanding. If still outstanding, detailed procedures are followed to contact the third party to reaffirm expectations for the recovery to be remitted. Upon settlement, the system is updated with reminders to verify that the funds are received on the agreed upon date. If the funds are not received, the third party is then contacted to establish cause and the system is updated. First Recovery Group's attorneys develop a direct relationship with the insurance carrier and/or law firm and seek to recover the maximum amount allowed on behalf of Molina.

Litigation to Recover Funds from Third Parties

For cases where litigation is required, Molina's legal department works in collaboration with First Recovery Group, Molina's subrogation business partner, to recover funds that should have been paid by another party. First Recovery Group provides in-house attorneys and state-specific expertise.

3. Describe your process to identify members with third party coverage who may be appropriate for enrollment in the Health Insurance Premium Payment (HIPP) program.

In compliance with the provisions of Medicaid services specified in Attachment 1 – Scope of Work, Section 13.6 Third Party Liability (TPL) Processing, subsection 13.6.5, Molina will identify members with third party coverage who may be appropriate for enrollment in the Health Insurance Premium Payment (HIPP) program. Once identified, Molina will provide information to DHS regarding individuals who are potentially HIPP eligible within the timeframe and in the manner determined by DHS. Molina acknowledges and understands that DHS is maintains full and final authority for determining HIPP eligibility.

Molina contracts with Health Management Systems (HMS) to provide the collection of Health Insurance Information to Molina. Below describes the process used by HMS.

- HMS receives eligibility information from various Health Plans.
- HMS incorporates health insurance information into its National Eligibility Database (NEDB) and delivers verified policy information to Molina between 30- 45 days of Medicaid Eligibility receipt. Verified TPL eligibility data is maintained and updated in HMS's NEDB.
- HMS maintains a wide range of health insurance information, including demographic data on recipients and policyholders and policy-specific data such as policy numbers, group numbers, coverage types, and eligibility periods.

13.7 Health Information Technology

1. Describe your proposed healthcare information technology (HIT) and data sharing initiatives.

Molina ensures that it will comply with the provisions of services as Specified in Attachment 1 – Scope of Work, Section 13.7 Health Information Technology, and currently has the health information technology infrastructure and capacity to support the data sharing requirements for the High Quality Healthcare Initiative.

Molina is aware of and commends Iowa in its health information technology (HIT) and data sharing initiatives. As part of our participation in the High Quality Healthcare Initiative, Molina will fully support the goals in Iowa for effective health information data sharing initiative. We will actively participate as part of the Iowa Health Information Network (IHIN) with the goals of enabling providers to access vital patient health information and to achieve better care health care outcomes.

Molina believes an efficient healthcare information exchange system that assists medical providers to access and better understand a patient's full medical history, leads to higher quality of care and an overall reduction in health disparities.

Molina assists network providers to advance their health information HIT capabilities by providing access to its claims, authorization and eligibility data electronically through its Web Portal. Molina strives to ease the administrative burden of providers and encourages them to utilize Molina's Web Portal and Interactive Voice Response (IVR) services. The Web Portal allows all providers anytime online access to member eligibility, assigned PCPs, authorization status and guidelines, claims status information and provider training materials. Providers may also determine member eligibility through Molina's IVR system without direct contact with a Molina staff member. Since Molina contracts directly with behavioral health providers and does not use a third-party behavioral health vendor, all of the technologies available to Molina's medical and ancillary providers are also available to behavioral health providers.

By leveraging Molina's Clinical CareAdvance and QNXT technology platform, Molina will aggregate medical, behavioral and prescription encounter data for members to determine the most appropriate plan of care. As part of Molina's care coordination model, this information is included in the Care Plan developed for at-risk members and delivered to PCPs to facilitate collaboration with delivering optimal care to the member. In addition, leveraging Molina MIS technology to improve overall quality of care, Molina will establish the following Pay for Performance incentive with providers to improve quality outcomes, contain administrative costs and reduce the potential for medical and data errors:

Exhibit 13.7.1-1 Provider Pay-for-Performance Incentive

Goal Increase data accuracy while decreasing medical errors and administrative costs.		Incentive
PCP Measures	PCP office has EMR capabilities in place and actively in use. PCP submits at least 97% of claims and/or encounters electronically. PCP uses e-prescribing for at least 50% of all Molina prescriptions.	For providers with a minimum of 50 assigned members, reimbursement rates will be enhanced for providers who meet thresholds of electronic office components: EMR, Electronic Claims, e-prescribing.

2. Describe how you propose to interface with the Iowa Health Information Exchange.

In accordance with the provisions specified Attachment 1 – Scope of Work, Section 13.7 – Health Information Technology, Molina will participate in state sponsored Health Information Exchange (HIE) sites (e.g., IHIN), and will work with the IHIN once it becomes fully operational. Molina acknowledges and understands that DHS reserves the right to require participation in future initiatives, and will comply with this provision.

Molina brings more than 30 years of experience, state-of-the-art technologies and valuable partnerships to support electronic submission and exchange of health information data with its providers, vendor partners and Medicaid state and Medicare agencies.

Molina will work with the state to help achieve HIE objectives that allow widespread adoption and meaningful use of electronic health records. Molina understands that providers face significant challenges managing multiple systems and applications in a multi-payer environment and Molina technology framework has been developed to enable single sign-on of Molina's network providers to access its secure and robust self-service Web Portal. Web Portal is Molina's provider website that supports member and provider transactions via the Internet. Web Portal is built on industry standards and highly scalable architecture with a framework that supports security standards such as SAML2.0, WSFed, and facilitates exchange of authentication tokens in a secure and reliable manner. The design of Web Portal is flexible and can support variations across HIE partners.

Data Processing Flow and Interfaces

Molina's state-of-the-art Management Information System, managing information for all Molina subsidiary health plans nation-wide, enables efficient start-up activities that accommodate industry standard HIPAA compliant interfaces as well as state specific and newly established interfaces. The Management Information Services staff offers extensive experience to manage transitions and maintain electronic interfaces with other contractors, providers, and the state as demonstrated with each contract implementation between Molina and DHS.

See Exhibit 13.7.2-1 Data Processing Flowchart and Interfaces Diagram provides a high-level progression of inbound and outbound data flows for data and process flows for all key business processing functions as well as the interaction with MIS applications and subsystems. These major functions include Membership, Provider/Service Coordination and Encounter/Claims. The following are the highlights of each function:

Membership

- Process and load HIPAA-compliant standard 834 enrollment; tracking members covered services in the QNXT system. The Membership function processes electronic data transmission, which adds, deletes or modifies membership records with accurate begin and end dates.
- QNXT provides a single source for eligibility updates/status;
- Updated eligibility to Web Portal and Interactive Voice Response (IVR) system within 24 hours;
- Partnerships with various clearinghouses including Emdeon for receipt of data from providers; and
- HIPAA compliant Electronic Data Interchange (EDI) for clearinghouse and direct EDI and Web Portal data submissions.

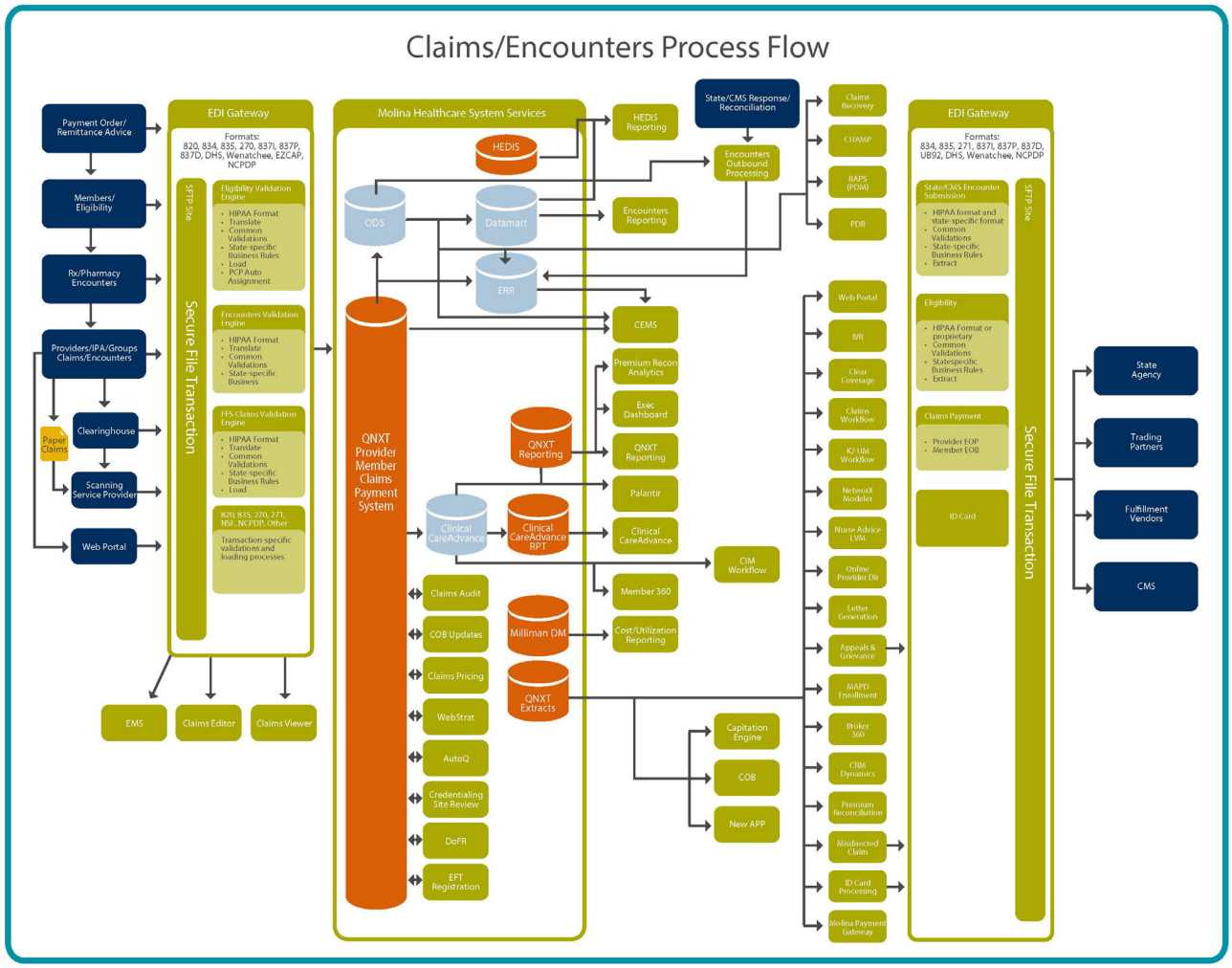
Provider

- Provider data submissions and reference are provided through Emdeon/Empower, IVR, and the Web Portal in addition to the formulary and other references, and provider specific reporting;
- Provider Credentialing through Visual Cactus System, Laserfiche, National Provider Data Bank (NPDB), and the Council for Affordable Quality Healthcare (CAQH);
- UM/K2 Prior Authorization System for prior authorization and referral management, including integration to QNXT for authorization claims matching and processing, as well as paperless processing of inbound fax requests;
- Molina is working on an initiative to give providers the ability to submit prior authorization request electronically and receive immediate, real-time responses (approvals or denials) to their requests utilizing McKesson's ClearCoverage, a web-based decision tool used as the point of care, available in Q1 2015; and
- QNXT exports data feeds to Care Advance for identification and referral of eligible members for care management, service coordination and disease management programs.

Encounter/Claims

- Variety of methods for claims submission including clearinghouse, Web Portal (as per 8.1.20.3 providing a no-cost alternative to bill without the use of a clearinghouse), and via paper;
- Solid claims and Encounter Processing from data load (via BizTalk) including QNXT;
- Integration of QNXT with other claim focused systems to enhance claim processing accuracy including K2 Claim Workflow, Claim Viewer, QC Audit Pro, Claim Editor, HMS for coordination of benefits, HCI (fraud and abuse evaluation), and WebStrat to support advanced DRG pricing; and
- Encounter tracking and reporting through the Operational Data Store.

Exhibit 13.7.2-1 Data Processing Flowchart and Interfaces Diagram



Information and Communications Technology Infrastructure (Hardware and Software)

Molina's Information Systems hardware and software infrastructure is capable of performing all required Information Technology functions to support DHS requirements for the High Quality Healthcare Initiative. Molina has invested in the latest technologies and most reliable support information systems to provide timely, accurate information and services to State and Federal government agencies, and its members and providers. These information systems technologies include:

- Voice Over Internet Protocol (VoIP) telephony systems (Cisco Systems);
- Interactive Voice Response (IVR) including provider and member self-service;
- RecoverPoint Disaster Recovery technology that enables a 30-minute recovery of core systems to its data hot site;
- Symantec's NetBackup Technology for fully automated remote backup and off-site storage;
- Virtual Machine server technology with sophisticated server clustering technology; and
- State-of-the-art Data Center and Network Operations Center that provides 24/7/365 support for all systems and network infrastructure; industry standard safeguards include physical security measures such as card access systems, locked storage to secure equipment, 24/7 surveillance.

Molina employs a robust hardware and data storage environment to house its systems. Specific Hardware Server and Data Storage systems include:

- EMC Clarion Series Storage Area Network (SAN) – Provides a fully redundant, highly available storage system with no single points of failure and features global hot spares, redundant power and cooling, online RAID Group expansion, and data path parity checking throughout the array.
- EMC Symmetrix vMAX – A high-end storage array to support the highest performing SSD disks and high speed fiber channel interfaces.
- Cisco UCS blade technology – Highly optimized, scalable, fault tolerant, and efficient, Molina uses the Cisco UCS series servers to support:
  - Email services; domain controllers (network/user authentication);
  - File/print services; FaxServer (RightFax) application;
  - Stand-alone SQL database servers; and
  - BizTalk, Terminal Services.
- Quantum Scalar i500 LTO-4 Tape Library – Molina deploys the industry leading Quantum Scalar i500 Tape Libraries to back up all corporate-wide information including SQL databases, cubes, files, Exchange mails and claims imaging.

On top of its operating systems, hardware, storage and software, Molina maintains a wide variety of management tools and utilities including:

- Altiris, an integrated IT lifecycle management suite of products that allows seamless management for desktops, notebooks, handhelds and servers;
- Autosys, a job scheduling tool;
- Citrix, an application virtualization solution for providing any user with secure access to client/server applications from anywhere, using any device or connection;
- Symantec Netbackup software to schedule and perform daily backups;
- System Center Operations Manager solution to manage the IT infrastructure environment and lowering the cost of operations;
- IronPort's secure email server enables Molina to automatically secure online communications with its providers and partners;
- Moveit DMZ a secure managed file transfer system optimized for mission critical encrypted file and data transfers with trading partners; and
- HP Quality Center (QC 10.0), a software test management tool used for tracking progress on testing and defect tracking.

Electronic Health Records
Recognizing the value of electronic health records (EHRs) to the care and service of its members, Molina tracks and monitors those contracted providers that are not utilizing EHRs. Molina will include EHR information in its provider database, which is reportable on demand. This will allow Molina's Provider Representatives to pull reports of providers without EHRs that they can use to do targeted provider training and education on the value of EHRs and how to obtain funding and support to implement an EHR their practice. Molina's training will assist providers in understanding the benefits of EHRs as the platform to improve communication between the patient and provider; empower the patient to be more involved in healthcare choices; improve quality and safety by a reduction in errors and promote cost-containment through improved coordination.

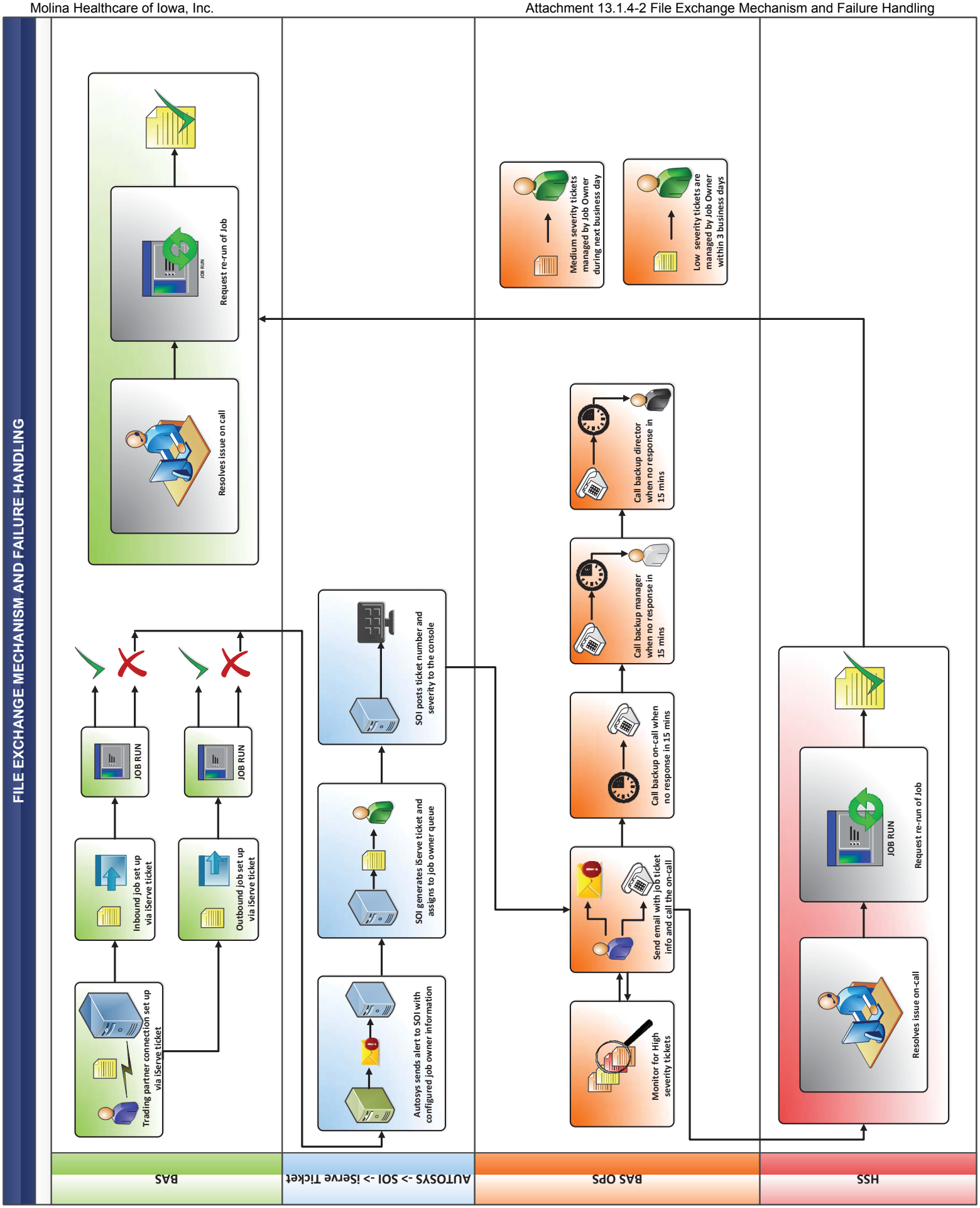
Molina understands the many benefits and challenges of implementing EHRs. All Molina primary care clinics use GE Centricity EHR and Practice Mamanegemnt System with built in PHR functionality. The integrated EHR captures all clinical encounters and results , billing and auditing functions, and referral information. Molina has worked directly with the vendor to put in place a robust training curriculum to ensure all employees (providers, nurses, front office) are fully trained in data entry and reporting, HIE, and maximizing the use of this valuable tool. Molina accepts medical records retrieved from EHRs, securely and in compliance with HIPAA and privacy standards and captures the data from a provider's EHR after Molina has secured the necessary security agreements. Molina currently routes the data into its standard data repository for mining for quality metrics (such as missed HEDIS services, and chronic disease risks).

Personal Health Records
Molina will provide members with access to electronic versions of their personal health records (PHRs). PHRs grant patients access to a wide range of health information sources, best medical practices and health knowledge. Molina's Member Web Portal will provide PHR capabilities for its members including, but not limited to: access to service history, medication history, lab results, allergy information, service request/authorizations and status; and access to their care plan. Members will also have the ability to download and/or print a record of this information.

3.Describe HIT initiatives you have implemented in other states.

Molina is actively engaged with several Medicaid state agencies to develop and integrate HIE capabilities. This will allow Molina to share/receive real time members' clinical information with/from the state agency. These initiatives allow for the timely availability of patient's data and help improve care coordination and management of member care. The HIE program is already implemented in the State of Washington and will being implemented in Michigan in 2015, as state agencies will be ready to partner with Molina to implement HIE capabilities.

Molina has also implemented HIE internally. Molina's state-of-the-art, scalable HIE platform allows for a seamless, single pane view of various member and related provider information. The platform provides a unique view of the member's history and related care coordination and management activities, including information regarding enrollment, eligibility information, calls, HEDIS information, Electronic Health Records, provider information, encounters, claims, care plans, lab data and pharmacy data. This view will allow Molina's Case Managers to derive better planning, tracking and decisions. This HIE has been rolled out in all states where Molina has plans.


FILE EXCHANGE MECHANISM AND FAILURE HANDLING
BAS
AUTOSYS -> SOI -> iServe Ticket
BAS OPS
HSS
Trading partner connection set up via iServe ticket
Inbound job set up via iServe ticket
Outbound job set up via iServe ticket
JOB RUN
JOB RUN
Autosys sends alert to SOI with configured job owner information
SOI generates iServe ticket and assigns to job owner queue
SOI posts ticket number and severity to the console
Monitor for High severity tickets
Send email with job ticket info and call the on-call
Call backup on-call when no response in 15 mins
Call backup manager when no response in 15 mins
Call backup director when no response in 15 mins
Medium severity tickets managed by Job Owner during next business day
Low severity tickets are managed by Job Owner within 3 business days
Resolves issue on-call
JOB RUN
Request re-run of Job
Resolves issue on call
JOB RUN
Request re-run of Job

MIT Enterprise Problem Management Procedure

Service Management

Version 1.0

Created October 29, 2014

Revised March 24, 2015

Document Control

Revision History

Date	Version	Description	Author
01/29/2015	1.0	Final version of the Procedure document for Enterprise Problem Management	Dinesh Muthuraj

Approval

Date	Version	Approver
01/29/2015	1.0	Royce D'Souza

Document Classification: Molina Internal

Refer to Information Services Policy and Procedure, *IS 72.00, Data Classification*, for additional information and required handling procedures.

Privacy and Security Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule and the American Recovery and Reinvestment Act (ARRA) of 2009 requires that covered entities protect the privacy and security of individually identifiable health information.

Protected health information (PHI) includes demographic information and other health information and confidential information, whether verbal, written, or electronic, created, received, or maintained by Molina Healthcare about members and patients. It is health care data plus identifying information that would allow the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

Copyright © 2014 Molina Healthcare, Inc.

Table of Contents

1. Purpose of the Document 4
2. Introduction 4
3. Goal 5
4. Objective 5
5. Roles involved in Problem Management 6
6. Problem Management Process Flow 9
7. Activities, Procedures and Responsibilities 10
7.1. Data Analysis Procedure 10
7.2. Problem Creation Procedure 12
7.3. Validation & Prioritization Procedure 13
7.4. Investigation Procedure 17
7.5. Error Control Procedure 19
7.6. Problem Closure Procedure 24
8. States and Transitions 27

1. Purpose of the Document

This document defines the Molina Information Technology (MIT) Enterprise Problem Management Procedure. The document details the key steps taken during the life-cycle of a Problem, from identification of a potential problem, through classification, investigation, resolution (i.e. Implementation of agreed corrective action) and closure.

2. Introduction

The MIT Enterprise Problem Management Procedure provides a consistent method for everyone to follow when working to resolve severe or recurring issues impacting services provided by MIT.

This procedure should be followed by:

- MIT personnel responsible for analysis and remediation of root cause of Problems
- MIT personnel involved in the operation and management of the Problem process

3. Goal

The goal of the MIT Enterprise Problem Management Process is to minimize the adverse impact to the business, due to Incidents and Problems in the services IT provides.

4. Objective

The primary objectives of the MIT Enterprise Problem Management Process are to:

- Prevent recurring incidents
- Minimize the impact of Problems
- Manage Problems within an agreed timeframe

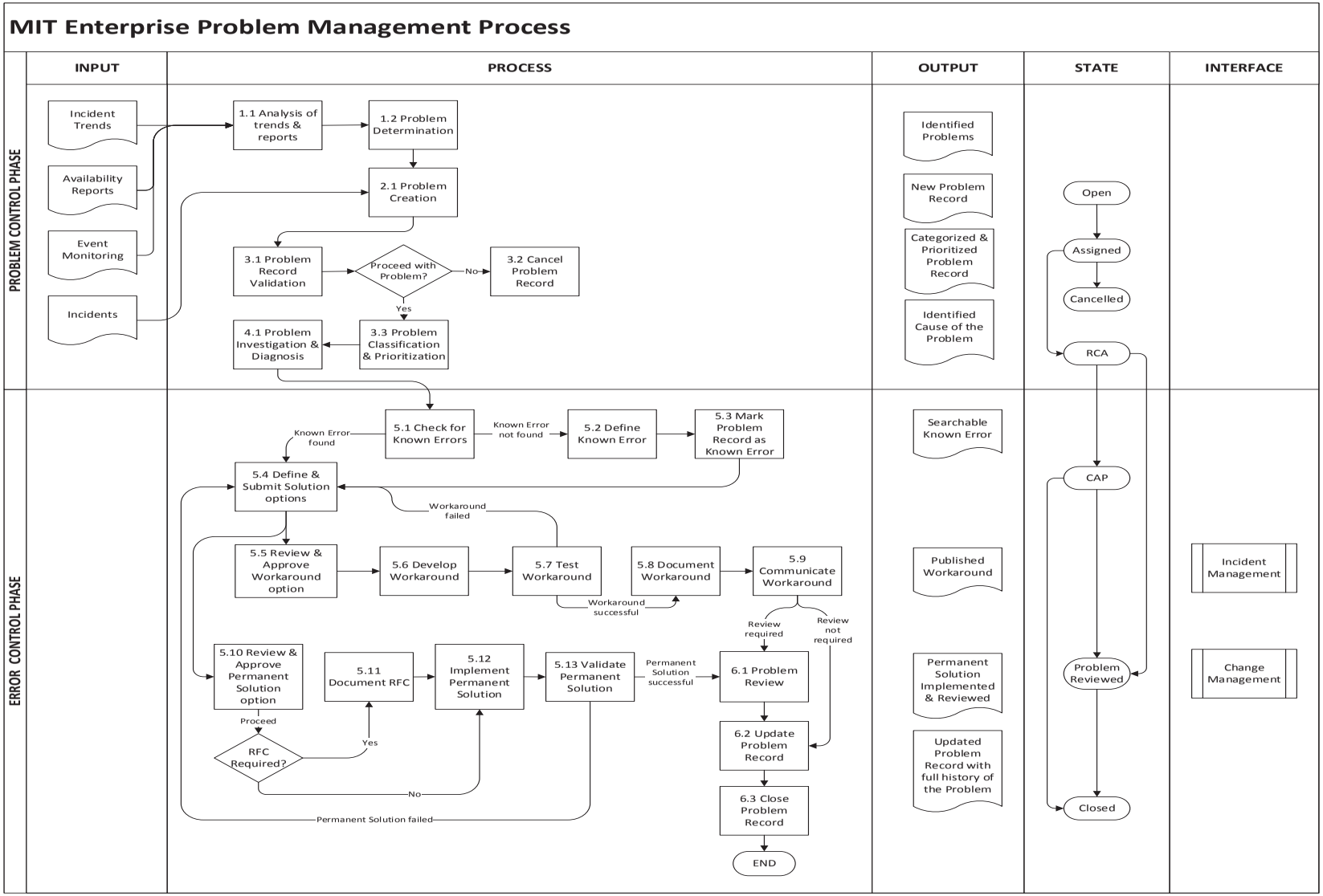
5. Roles involved in Problem Management

Role	Responsibilities
Enterprise Problem Manager	• Establishes Problem Management Policy, Process and Procedures. • Works closely with the Enterprise Incident Manager (Incident Management Process Owner). • Socialize the Problem Management Process and Procedures to various functional teams. • Receives Major Incident notification from Incident Management. • Analyzes Availability Reports, Incident Trends, Event Monitoring Reports, and identifies the symptoms (Proactive Problem Management). • Conducts periodical meetings with the Functional Problem Managers and other appropriate staff to review the trend (Proactive Problem Management). • Determines potential Problems, creates new Problem records and assigns to the Functional Problem Manager. • If a Problem Record has been created as a result of proactive Problem Management trending analysis, links the related Incident Records in the Problem Record. • Confirms that Problem Management will engage with incidents as necessary. • Classifies and Prioritizes the Problem Records. • Assign the appropriate Functional Problem Manager who will respond to the Problem tickets. • Define and track KPIs. • Tracks all the Problems that are active and ensure appropriate completion of activities. • Participates in the root cause analysis sessions. • Forms a steering committee and conducts RCA review sessions to provide approval for the findings and solution. • Tracks the implementation of the Request for Change (RFC) and receive information on the outcome via the Change and Release Management process. • Conducts Problem Reviews as needed. • Reviews Problem Management process periodically and applies Lessons Learned to the process as necessary. • When all necessary updates have been made to the Problem Record, reviews for accuracy and then closes the Problem Record. • Submits periodic reports to the Management.
Functional Problem Manager	• Manages the entire lifecycle of the Problem Management activities per established policy and process. • Receives request from Enterprise Problem Manager to partake in Problem Management response to the Major Incident.

	• Gathers the data collected to date by Incident Management. • Analyzes the data collected from various sources relating to the Major Incident. • Analyzes historical data to see whether a new Problem Record needs to be created or whether an existing Problem Record needs to be updated or reopened and updated. • Undertakes any necessary actions to create a Problem Record. • Analyzes Availability Reports, Incident Trends, Event Monitoring Reports, and identifies the symptoms (Proactive Problem Management). • Documents and presents proposed Resolution options which include risks, costs, schedule, and effort to fix to decision authority. • Requests functional management and ensure resources are assigned who can participate in the Problem Management activities. • Assigns the Problem Records to an appropriate Support Team. • Undertakes an investigation into the Problem using documented techniques mentioned in the Policy and Process. • Using the root cause analysis data, completes the Problem diagnosis and documents results in the Problem Record. • Verifies whether there is already a Known Error and matching Workaround that relates to this Problem type. • Takes the results of the root cause analysis and documents the Known Error. • Discusses the root cause analysis and Known Error. • Discusses options for resolving the Known Error with Support Team and other relevant stakeholders. • Documents options for resolution (Workarounds and Permanent Solution). • Submits it to the Steering Committee for review and approval of the findings and proposed resolution. • Ensures the Workaround is created, validated and documented that allows users to bypass or mitigate the Known Error. • Gains Approval for the Workaround. • Communicates the Workaround. • Confirms with users that the Workaround is working. • Generates a Request for Change (RFC) intended to permanently resolve the Problem/Known Error. • Submits the RFC through the Change Management process. • Supports the Problem Review process. • Makes necessary updates to the Problem Record as needed. • Provide periodical Reports and Management information to Enterprise Problem Manager.
Enterprise Problem	• Responsible for creating the Enterprise Problem Management Process

Architect	and Procedures. • Works closely with the Enterprise Problem Manager. • Involves in socializing the Problem Management Process and Procedures to various functional teams. • Updates the Enterprise Problem Management process and procedures annually based on the inputs from SMO and various functional members. • Involves in analyzing the Availability Reports, Incident Trends, Event Monitoring Reports, and identifying the symptoms (Proactive Problem Management). • Involves in the RCA sessions and contributes to finding the root cause.
Support Team	• Provides factual data and technical support to the Functional Problem Manager throughout the Problem Management lifecycle. • Assists Enterprise Problem Manager and/or Functional Problem Manager in an investigation of the Problem using documented techniques. • Creates a Workaround that allows users to bypass or mitigate the Known Error. • Tests the Workaround. • Documents the Workaround. • Provides Permanent Solution options and data to arrive at the Cost Benefit for each option. • Document the Permanent Solution proposal. • Support all activities of the approved Workaround and Permanent Solution.
Incident Manager	• Accountable to the Incident Management Process. • Responsible for monitoring and managing the overall operation of the Incident Management process, and implementing changes and improvements to the process.
Change Manager	• Observes the implementation of the Request for Change and receives information on the outcome.
End User	• Decides whether the implemented Change has successfully resolved the Problem/Known Error.

6. Problem Management Process Flow



7. Activities, Procedures and Responsibilities

7.1. Data Analysis Procedure

The purpose of this procedure is to *proactively* identify problems to reduce the occurrence of repeating incidents and first time incidents.

Activities	Enterprise Problem Manager	Functional Problem Manager	Support Team	Incident Managers	Change Manager	Network Operations Center
1. Data Analysis						
1.1 Analysis of trends & reports	A/R	R	S	I	S	C
1.2 Problem Determination	A/R	R	I	I	I	I

Inputs	1. Incident Trends 2. Availability Reports 3. Event Monitoring
Entry Criteria	1. Planned proactive Problem Management trending analysis activity. 2. Suspecting a problem in a CI based on the recent events. 3. Infrastructure related incidents that are not critical by recurring.

Activity	Responsible Role	Action
1.1 Analysis of trends & reports	Enterprise Problem Manager, Functional Problem Manager	Analyze the information from incident trends, Availability reports, Event Monitoring to narrow down specific group of data to identify the problem. Consider the following when analyzing the trends: 1. Number of similar or recurring incidents. 2. Increased number of incidents in a specific tower or CI. 3. Number of incidents in a specific Data Center / V-Block etc. Once analyzed, produce reports that may contain the following details: 1. Trend analysis of the incidents by status. 2. Specify the pattern changes.

		3. Provide reasons for problem indication. 4. Provide recommendation if a problem should be opened or not.
1.2 Problem Determination	Enterprise Problem Manager, Functional Problem Manager	Determine if the identified troublesome records in the report be considered to open a Problem ticket. Consider the following to determine a problem: 1. Increase in Incidents for a particular issue that is not already identified as a Problem or Known Issue. 2. Impact due to multiple incidents that were not already captured as a Problem, but needs investigation to prevent similar occurrences. 3. Possibility of a Permanent Solution by performing a root cause analysis and arriving at a solution. 4. Possibility of the issue that may occur again for which an analysis and solution may provide a Permanent Solution and prevent a future outage.

Outputs	Detected Problems		
Exit Criteria	Problem Management team engaged.		
Risks	1. Analysis not performed.	Impact: This could increase the major incidents.	Mitigation: Schedule and analyze trends periodically. This could uncover Problems that could be eliminated proactively.
	2. Inadequate analysis.	Impact: Failure to identify problems and take the necessary corrective action.	Mitigation: Identify and formally document procedures that can be used for properly analyzing the data to uncover Problems.

7.2. Problem Creation Procedure

The purpose of this procedure is to detail the steps necessary to complete the Problem Discovery and Logging process. This is considered as a *reactive* in Problem Management.

Activities	Enterprise Problem Manager	Functional Problem Manager	Support Team	Incident Managers	Change Manager	Network Operations Center
2. Problem Creation						
2.1 Problem Creation	A/R	R	C	I	I	R

Inputs	1. Detected Problems. 2. Major Incidents. 3. Known Error info from Release Management.
Entry Criteria	4. Trend Analysis completed by the Problem Management team. 5. Major Incident notification received by the Problem Management team.

Activity	Responsible Role	Action
2.1 Problem Creation	Enterprise Problem Manager, Functional Problem Manager, NOC	Undertakes any necessary actions to create a Problem Record in iServe. If the source of the problem is a major incident, then a problem record can be created from the major incident. In this case the Problem will be created by the Network Operations Center (NOC) and the problem will be assigned to the Enterprise Problem Manager. If the source is analyzed data of trends and reports, then a new problem records can be created from the Problem module by the Enterprise Problem Manager/Functional Problem Manager. The type of information that may be captured includes: 1. Problem Number, Date and time stamps when the problem was opened. 2. Opened by (Name of the Problem initiator). 3. State (for new problems the default state with be Open). 4. Assigned to (Person primarily responsible for working this Problem). 5. Problem category. 6. Problem Priority. 7. Short description of the Problem.

		8. Description (Detailed description of the Problem). 9. Links to Incidents: a. If the Problem was created through an Incident record, a link to the Incident will already be associated to the Problem record. b. If a Problem Record has been created as a result of analyzing the trends and reports (proactive Problem Management), link the associated Incident Records to the new Problem that was created. If it is a repeat Problem, an existing Problem Record can be updated, or an existing closed Problem Record may need to be reopened depending on the nature of the Problem and the length of time since it last occurred.

Outputs	1. New Problem record created through a major incident record. 2. An existing Problem record updated and the major incident record linked to the Problem record. 3. New Problem record created independently and all related incident records linked to it.		
Exit Criteria	New Problem record created or an existing Problem record updated.		
Risks	1. Inadequate analysis of existing Problem Records.	Impact: This could increase the utilization of resources for similar problems (duplicating effort). Multiple root causes for similar Problems will be performed.	Mitigation: Follow the process and analyze the existing Problems for all the requests before creating a new Problem record.

7.3. Validation & Prioritization Procedure

The purpose of this procedure is to categorize and prioritize the Problem. Priority level dictates the importance of the problem and the urgency to address it.

Activities	Enterprise Problem Manager	Functional Problem Manager	Support Team	Incident Managers	Change Manager	Network Operations Center
3. Validation & Prioritization						
3.1 Problem Record Validation	A/R	S				
3.2 Cancel Problem Record	A/R	S				I
3.1 Problem Classification & Prioritization	A/R	S	C	C		I

Inputs	1. New Problem record. 2. Updated Problem record.
Entry Criteria	A Problem Record has been created or updated.

Activity	Responsible Role	Action
3.1. Problem Record Validation	Enterprise Problem Manager	Enterprise Problem Manager assesses the newly created problem record for its validity to be considered as a Problem. Once the assessment is complete, if the record is considered valid, it will be assigned to the appropriate Functional Problem Manager for further action. If the record is considered not valid, proceed to procedure **3.2**.
3.2. Cancel Problem Record	Enterprise Problem Manager	If the record is considered not valid, the record will be cancelled with proper justification. iServe will notify the NOC.
3.3 Problem Classification & Prioritization	Enterprise Problem Manager	Classification: If the Problem is created through a major incident, the Problem shall also be classified with the same CI(s) as of the incident. Otherwise the Problem Management will decide on the CI(s) after analyzing the historical data of similar problems/incidents. Prioritization: Using established criteria a Priority shall be attached to the Problem Record. Following criteria may be considered for identifying the priority. Revenue affected. Service levels impacted. Contractual requirements affected. Locations impacted. Number of users impacted etc.

Outputs	Categorized and Prioritized Problem Record.		
Exit Criteria	Problem is categorized and prioritized.		
Risks	1. Incorrect Categorization.	Impact: Inaccurate attempts at root cause analysis.	Mitigation: If the Problem record is generated through a major Incident, then use the same categorization from the Incident. If the Problem records

			were created as a result of proactive data analysis, then determine the category from the analyzed data.
	2. Incorrect Prioritization.	Impact: Inappropriate level of attention and resources applied to the Problem. This may at times lead to escalation to the executive management.	Mitigation: Use the Prioritization chart to determine the correct priority of the Problem.

Priority Determination

The priority given to a problem that will determine how quickly it is scheduled for resolution will be set depending upon a combination of the related incidents' severity and impact.

The table below provides the guidelines for determining the priority based on Urgency and Impact.

Problem Priority			Urgency		
			Low	Medium	High
			• No Revenue affected. • Degraded Service but still processing. • Available Workaround can be utilized efficiently to restore service. • Contractual requirements not affected.	• Revenue may be affected, but not significantly. • Services intermittently available or non-critical services unavailable. • Available Workaround can be utilized but partially effective or not efficient. • Contractual requirements may be breached.	• Revenue affected significantly. • Services not available or critical functionality of services unavailable. • No Workaround available. • Contractual requirements breached.
Impact	Low	• More than one customer, but less than an entire department, clinic, office or building.	Low	Low	High
	Medium	• One or more entire departments, clinics, offices or buildings, but less than an entire state.	Medium	Medium	High
	High	• One or more entire states. • Entire company.	Medium	High	Critical

7.4. Investigation Procedure

The purpose of this procedure is to detail the steps necessary to complete the problem investigation and diagnosis process.

Activities	Enterprise Problem Manager	Functional Problem Manager	Support Team	Incident Managers	Change Manager	Network Operations Center
4. Investigation						
4.1 Problem Investigation & Diagnosis	A	R	R	I		S

Inputs	1. Incident data. 2. Categorized and Prioritized Problem record.
Entry Criteria	Categorized and Prioritized Problem record.

Activity	Responsible Role	Action
4.1 Problem Investigation & Diagnosis	Functional Problem Manager, Support Team	Perform the following to identify the root cause, workarounds, and potential solutions. 1. Identify the team as necessary. 2. Document findings and store evidence into the Problem record. 3. Determine if a Problem can be associated with an existing Known Error. Possibilities shall include: a. Root Cause and CI are known. b. Possibility of a recurrence. 4. If root cause is unknown, utilize the problem analysis techniques such as Kepner-Tregoe (primary technique), Ishikawa diagrams (supporting technique). Refer to Root Cause Analysis Techniques for more details. 5. Determine Root Cause(s) and record the details. 6. Assess the problem and recommend action to resolve problem. **NOTE:** Following are the timelines for submitting the initial findings of Root Cause Analysis (RCA): Priority: Critical — Submit initial findings of RCA within: 05 Business Days from the date of assignment

			High	10 Business Days from the date of assignment
			Medium	15 Business Days from the date of assignment
			Low	25 Business Days from the date of assignment

Outputs	Appraised situation, updated Problem record with the exact cause of the Problem.		
Exit Criteria	Identified Root Cause and Known Error.		
Risks	1. Delay in analyzing the Root Cause.	Impact: Core team may forget the actual cause of the Problem. This would lead to inefficient analysis of the cause. Also they may be impact in reporting the metrics to the management.	Mitigation: Initiate the Root Cause and submit the initial findings within the stipulated time specified in the above section. This would provide some documentation to refer to even if there is a delay in identifying the actual Root Cause due to other priorities.
	2. Incorrect diagnosis captured.	Impact: Problem not understood correctly which leads to incorrect diagnosis. This would lead to incorrect resolution attempts and ultimately not identifying the correct Permanent Solution.	Mitigation: Entire RCA team should work on understanding the Problem and arriving at a clear Problem statement. This can be achieved by using the Ishikawa diagrams and/or by brainstorming. Use the findings from the Ishikawa diagrams and Kepner-Tregoe technique to determine the actual cause of the Problem.

7.5. Error Control Procedure

A temporary solution that helps in reducing or eliminating the impact of an Incident or a Problem for which a full resolution is not yet available.

When a Workaround is identified, the Problem Record still remains open and the details of the Workaround are recorded in the Problem Record (and the Known Error Database) and communicated to Service Desk personnel.

A Known Error record must be created and saved in the Known Error Database once diagnosis is complete. This is so that further occurrences of Incidents and/or Problems can be more easily identified and linked together, and so that necessary actions can quickly be undertaken.

Activities	Enterprise Problem Manager	Functional Problem Manager	Support Team	Incident Managers	Change Manager	Network Operations Center
5. Error Control						
5.1 Check for Known Errors	A/R	R	S	C		
5.2 Define Known Error	A	R	S			
5.3 Mark Problem Record as Known Error	A	R	I	I	I	
5.4 Define & Submit Solution options	C/I	A/R	R			
5.5 Review & Approve Workaround option	A/R	S	C	I	I	
5.6 Develop Workaround	A	R	S			
5.7 Test Workaround	A	R	S			
5.8 Document Workaround	A	R	S			
5.9 Communicate Workaround	A	R	I	I	C/I	
5.10 Review & Approve Permanent Solution option	A/R	S	C	I	I	
5.11 Document Request for Change (RFC)	A	R	S	I	C	
5.12 Implement Permanent Solution	I	A	R	I	C	
5.13 Validate Permanent Solution	I	A	R			

Inputs	1. Documented Root Cause information. 2. Updated Problem Record.
Entry Criteria	A Problem Record with root cause analysis undertaken and Diagnosis completed.

Activity	Responsible Role	Action
5.1. Check for Known Error	Functional Problem Manager, Enterprise Problem Manager	1. Verifies whether there is already a Known Error and matching Workaround in the system that relates to this Problem. 2. Reports findings to Enterprise Problem Manager. 3. If a Known Error and matching Workaround exist, a decision should be made about whether this Workaround should be employed to resolve the associated Incident(s) at this time. a. If no Known Error is in place, proceed to procedure **5.2.** b. If Known Error is in place, proceed to procedure **5.4.** c. If Workaround in place is approved for use with this Problem, communicate this to necessary parties (Service Desk etc.) and proceed to procedure **5.4.**
5.2. Create Known Error	Functional Problem Manager	Using the results of the root cause analysis, document the Known Error in the Problem Record.
5.3. Mark Problem Record as Known Error	Functional Problem Manager	Mark the Known Error checkbox and save the Problem Record. This will list the Problem in the Known Error list.
5.4 Define & Submit Solution options	Functional Problem Manager, Support Team	Problem Management's most important objective is to find out the unknown cause and arrive at a Workaround to temporarily fix the problem and a Permanent Solution (or otherwise called as the permanent fix) for the identified problem. Following steps may be performed with the relevant stakeholders to define and submit the Solution proposal: 1. Document the code/process/procedure modifications. 2. Document the estimates (cost, schedule, and effort) for fixing. 3. Document possible new procurements such as new software, upgrades, new infrastructure etc. and document the facts. 4. Perform and document cost benefit analysis. 5. Document contingency planning details. 6. Document alternate options for the Solution. 7. Create a presentation that would have the above details in a clear concise way and submit it to all the reviewers before the meeting. 8. Schedule a meeting for reviewing and finalizing an option. 9. If the proposal has only Workaround option(s), then proceed to procedure **5.5**. 10. If the proposal has only Permanent Solution options, then proceed to

		procedure **5.10.** 11. If the proposal has both Workaround and Permanent Solution options, then the priority is given for the Workaround. If a Workaround option is identified and if finding a permanent solution takes time, then submit the Workaround option first to the reviewers for their review and approval.
5.5 Review & Approve Workaround option	Enterprise Problem Manager	Enterprise Problem Manager leads the Review and Approval meeting for the Workaround proposal. EPM shall invite all the relevant stakeholders for the meeting to review and finalize on an option to go with. Following steps may be performed during the review meeting: 1. Functional Problem Manager shall present the Workaround options that would include the pros and cons of all the options and also would provide a recommended option. 2. The review team may decide on an option to proceed with and provides approval.
5.6. Develop Workaround	Functional Problem Manager	After the Review meeting, the Support team works on developing the Workaround. Functional Problem Manager involves and keeps track of this activity and takes it to completion. In this activity, Support team does the following activities. 1. Determine if Workaround exists for the known error. 2. If not, develop a Workaround if possible and record in the Known Error record. 3. If a Workaround exists, determine suitability of workaround using a detailed analysis by consulting with the support team. If the Workaround is not suitable for the current Problem, develop a Workaround if possible.
5.7. Test Workaround	Functional Problem Manager	1. Test the Workaround in one of the test environments to ensure it works. This step should be performed before the Workaround can be communicated to the Incident Management team. 2. Once the Workaround testing is successful, proceed to procedure **5.8**. 3. If the Workaround fails, proceed to procedure **5.4.**
5.8. Document Workaround	Functional Problem Manager, Support Team	1. If the Workaround tested is successful, document the Workaround that allows users to bypass or mitigate the Known Error in the Problem form with the following details: a. Symptoms – specify the subjective evidence that indicates a problem. b. Step to create a Workaround – specify the steps which if the team follows will resolve the issue temporarily or permanently. c. Expected outcome – specify the expected output by following the steps. d. Impact/Influence on related services – specify if the above Workaround may impact other services or create deviations.

		2. Once the Workaround is documented, proceed to procedure **5.9.**
5.9. Communicate Workaround	Functional Problem Manager	Once the Workaround is identified and documented, it should be communicated to the Incident Management team for them to inform to the necessary parties and close the incident. 1. To communicate the Workaround, click on the Communicate Workaround link in the Problem form. This will send the notifications to all the relevant stakeholders of the linked Incidents and to the Incident Management. 2. Confirm with users that the Workaround is working.
5.10. Review & Approve Permanent Solution option	Enterprise Problem Manager	Enterprise Problem Manager leads the Review and Approval meeting for the Permanent Solution proposals. EPM shall invite all the relevant stakeholders for the meeting to review and finalize on an option to go with. Following steps may be performed during the review meeting: 1. Functional Problem Manager shall present the proposals that would include the pros and cons of all the options and also would provide a recommended option. 2. Functional Problem Manager shall present the cost benefit analysis in detail. 3. If a Workaround is already identified, review team compares the Permanent Solution with Workaround and see if the Permanent Solution provides additional value if implemented. 4. Finally, the review team may decide on an option to proceed with and provides approval. 5. If decided to proceed with an option of the Permanent Solution, EPM discusses with the Functional Problem Manager and Support Team to check if a Request for Change (RFC) is required. If an RFC is required, proceed to procedure **5.11**. If an RFC is not required, then proceed to procedure **5.12**.
5.11. Document Request for Change (RFC)	Functional Problem Manager	1. Generates a Request for Change (RFC) intended to permanently resolve the Problem/Known Error. 2. Submits the RFC through the Change Management process.
5.12. Implement Permanent Solution	Support Team	1. If the Permanent Solution is decided to be executed as a project, PMO process kick in as the project may require approval from Project Oversight Committee. Functional Problem Manager tracks the project periodically. 2. If the Permanent Solution is decided to be executed as a change, the support team quickly gets into the design discussion mode for implementing the Permanent Solution. If there are changes to the design envisioned, an architect shall be involved in the design discussions. 3. The fix is then tested locally to ensure it works prior to including the change in production.
5.13. Validate Permanent	Support Team	1. Check if the implemented solution has resolved the issue. 2. Decide whether the implemented Change has successfully resolved the

Solution		Problem/Known Error by consulting with the end user. 3. If the implemented solution successfully resolved the Problem/Known Error, ensure any necessary communications are undertaken. Proceed to procedure **6.1**. 4. If the implemented solution failed to resolve the Problem/Known Error, and if it needs further research, ensure the Workaround (if identified) will remain in effect and communicate to the stakeholders accordingly. Proceed to procedure **5.4.**

Outputs	1. Updated Problem Record. 2. Known Error documented. 3. Work around documented. 4. Request for Change.		
Exit Criteria	1. Workaround identified. 2. RFC generated to Change Management, if change leading to permanent resolution can be identified.		
Risks	1. An existing Workaround not recognized and utilized.	Impact: Duplication of effort in investigating and identifying a Workaround. Unnecessary extended outages.	Mitigation: If there is an existing Known Error, a Workaround may most probably exist. Check for the existing Workaround before starting to investigate. A Workaround may also exist without a Known Error. Check the system for the documented Workaround.
	2. Problems not linked to the Known Error.	Impact: Newly reported Problems are investigated independently leading to wasted time and resources and potentially extended outages.	Mitigation: Check for existing Known Error in the system that can be associated with the given Problem. If so, then link the Problem with the existing Known Error. This will avoid any additional effort for investigating the Problem.
	3. No Permanent Solution documented.	Impact: The Problem may remain, leading to extended or repeated outages, until a Permanent Solution is implemented.	Mitigation: In some cases a Workaround may be considered a Permanent Solution that may resolve the Problem permanently. If the Workaround is only a short term fix, the team should figure out an option to

			fix the problem permanently and seek approval to implement it by presenting the impact of the Problem and the resolution option(s).
	4. Planned resolution fails.	Impact: Problem/Known Error will be ongoing. Another attempt at resolution will need to be undertaken. Extended outages will result.	Mitigation: A review process is established and followed to ensure all the Workaround/Permanent Solution is properly validated before implementing.

7.6. Problem Closure Procedure

For the Problems that are marked for review, a Problem review must be held soon after implementing the solution. The Problem Review is an opportunity to examine:

- Things that were done correctly.
- Things that were done incorrectly.
- Things that can be improved in the future.

Review may not be required for minor problems; however this can be decided on a case by case basis.

Activities	Enterprise Problem Manager	Functional Problem Manager	Support Team	Incident Managers	Change Manager	Network Operations Center
6. Problem Closure						
6.1 Problem Review	A/R	S	C	C	C	C
6.2 Update Problem Record	A	R	C			
6.3 Close Problem Record	A/R	S	I	I		I

Inputs	1. Incident Data. 2. Problem Data. 3. Known Error data. 4. Workaround data.

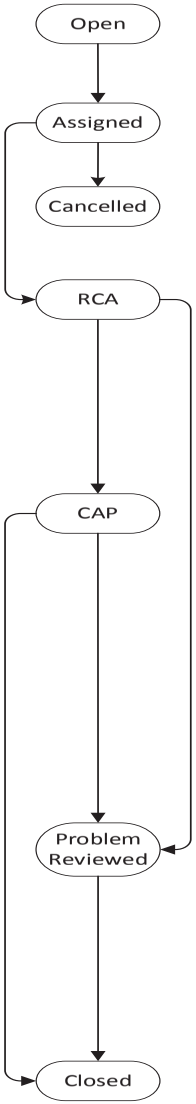
	5. Root Cause Analysis. 6. Resolution options. 7. Request(s) For Change.
Entry Criteria	Implemented RFC in support of permanently resolving a Known Error; or Implemented Workaround (without an RFC).

Activity	Responsible Role	Action
6.1. Problem Review	Enterprise Problem Manager	Enterprise Problem Management team schedules and invites the appropriate stakeholders for the meeting. Following information may be reviewed during the review session: 1. Known Error data. 2. Workaround data. 3. Root Cause Analysis information. 4. Permanent Solution & its effectiveness. 5. Request(s) For Change. Following will be discussed upon reviewing the above data: 1. What did we do right? 2. What did we do wrong? 3. What do we do differently next time? Takes away Lessons Learned from the meeting which could include: 1. Process improvement recommendations. 2. Action Items to the support teams/process teams.
6.2. Update Problem Record	Functional Problem Manager	1. Make necessary updates to the Problem Record, Workaround, and Known Error.
6.3. Close Problem Record	Enterprise Problem Manager	1. When all necessary updates have been made to the Problem Record, reviews for accuracy and then closes the Problem Record. 2. Problem Manager applies Lessons Learned to the Problem Management process as necessary. 3. In case of proactive Problem Management, closing a Problem record will automatically close the dependent Incidents.

Outputs	1. Lessons Learned.

	2. Updated & Closed Problem Record. 3. Closed Incident Record(s).		
Exit Criteria	Closed Problem and Incident Record(s).		
Risks	1. Problem Review not held.	Impact: Problem Review (otherwise called the Postmortem) if not performed, we lose the opportunity to understand what can be improved. This may be the process, skill, procedure etc.	Mitigation: Create criteria to identify what problems need to go through Problem Review. Following this criteria will ensure we address gaps in the process, skills etc.
	2. Problem Record not updated.	Impact: By not maintaining the full history of the Problem, reporting cannot have full justification, action items may be lost, and potential for process improvement may also be lost.	Mitigation: Create rules in iServe to ensure the appropriate fields in the Problem Record are populated. At important status transition, configure iServe to send notification to Problem Manager who can review the Problem records for its thoroughness. Problem Manager may follow up with the assignee to fill in the missing information.
	3. Problem Record not closed.	Impact: The Problem may be ongoing and may require additional work to close. May show up in reports for escalation if there is no proper justification.	Mitigation: There may be a good justification for not closing the Problem such as other prioritized Problem activities or waiting for dependent upgrades/installation etc. These justifications may need to be properly documented such that the delayed Problem closure may not lead to escalation. Also the Problem closure delays may need to be communicated to the relevant stakeholders for their awareness.

8. States and Transitions

States	Transitions
	**Open:** New Problem that was created through an incident or directly through Problem module and waiting for action. **Assigned:** All Problems are assigned initially to the Enterprise Problem Manager (EPM). EPM assesses the Problem record for its validity. If the record is considered valid, then the EPM prioritize the Problem Record and assigns it to the Functional Problem Manager. **Cancelled:** EPM assesses the Problem record for its validity. If the record is considered not valid, then the EPM will provide proper justification and cancels the Problem record. **RCA:** Root Cause Analysis (RCA) is performed at this stage to identify the actual cause of the Problem. The support team works in coordination with the Functional Problem Manager (FPM) to arrive at the initial findings of the RCA. They submit the initial findings to the EPM. The findings will be reviewed by the steering committee. Based on the approval, the support team will continue with their detailed RCA. RCA will be submitted to the EPM who leads the steering committee meeting. Steering committee reviews the RCA and provides approval to proceed. After the root cause has been identified and approved, FPM marks the Problem Record as Known Error. **CAP:** The team may decide to go with identified Workaround and Permanent Solution or any one of the options. The team documents the options in detail and submits it to the EPM. EPM schedules a meeting and invites appropriate stakeholders to review CAP. During the meeting the committee may decide and approve all options or either one. The support team starts work on the approved options. If both the options (Workaround and Permanent Solution) are approved, the support team works on the Workaround first and FPM ensures the Workaround in place. FPM communicates the Workaround to all affected parties and updates the Problem Record. In parallel, Support team works on the permanent solution. If the permanent solution requires a change, FPM ensures that the Request for Change (RFC) is raised. Once the permanent solution is implemented, FPM updates the Problem Record. **Problem Reviewed:** EPM determines the Problems that are eligible for Problem Review and schedules the review sessions. If only the Workaround is documented without a permanent solution, and if a review is required, then the Workaround is reviewed and all necessary info is updated in the Problem Record. If a permanent solution is implemented and successful, a Problem Review is conducted to review the fix, discuss what went right, what went wrong, what practices can be carried forward, what can be improved, action items for improvements etc. **Closed:** When all necessary updates have been made, EPM closes the Problem Record.

Healthcare Systems & Services

Release Management

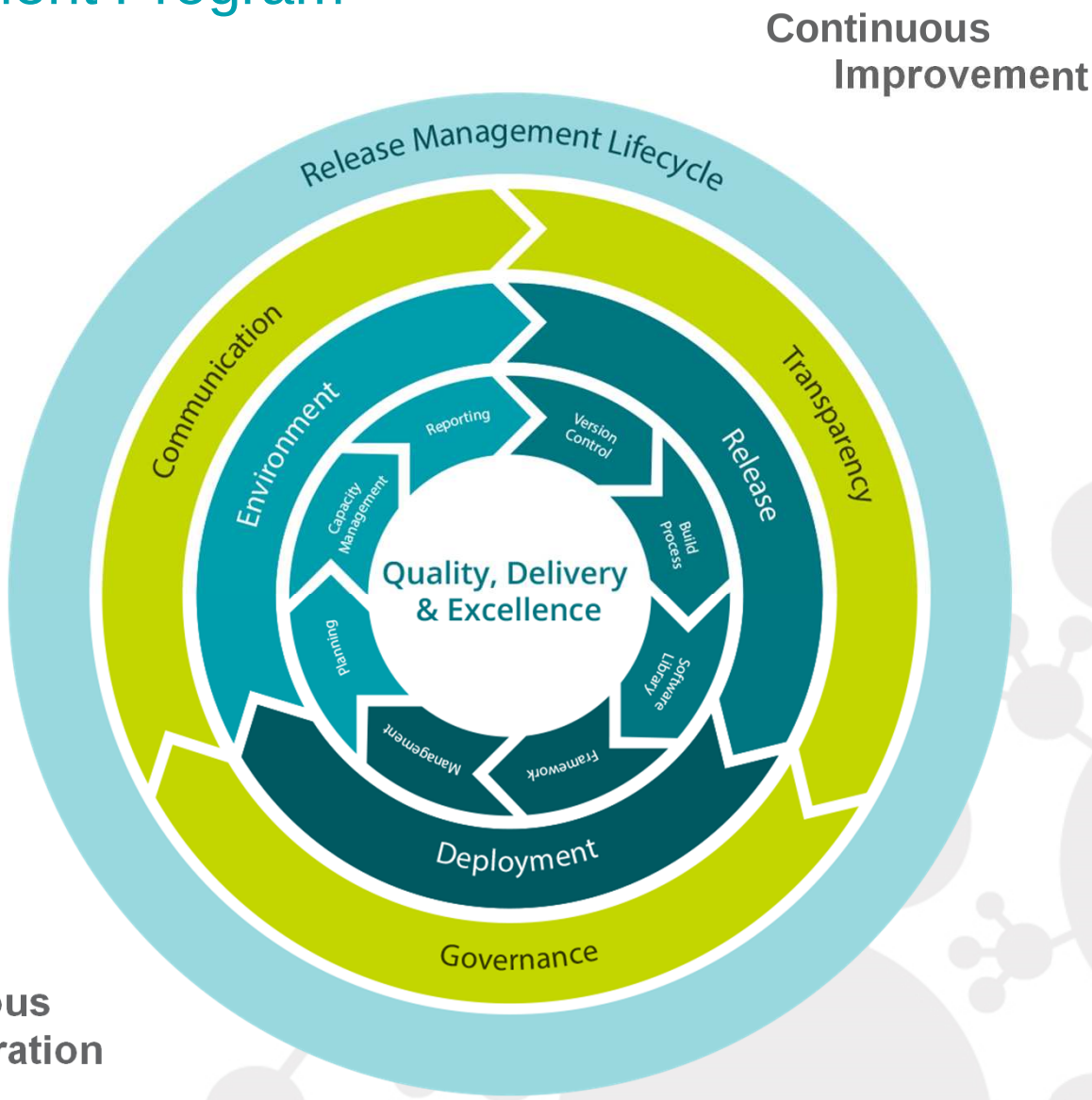
& Process Improvement

MOLINA HEALTHCARE
Your Extended Family.

03/30/2015

Release Management Program

The purpose of the program is to establish and adopt a process which will structure, organize, govern and control each teams development portfolio and lifecycle.



MOLINA HEALTHCARE
Your Extended Family.

Our Mission

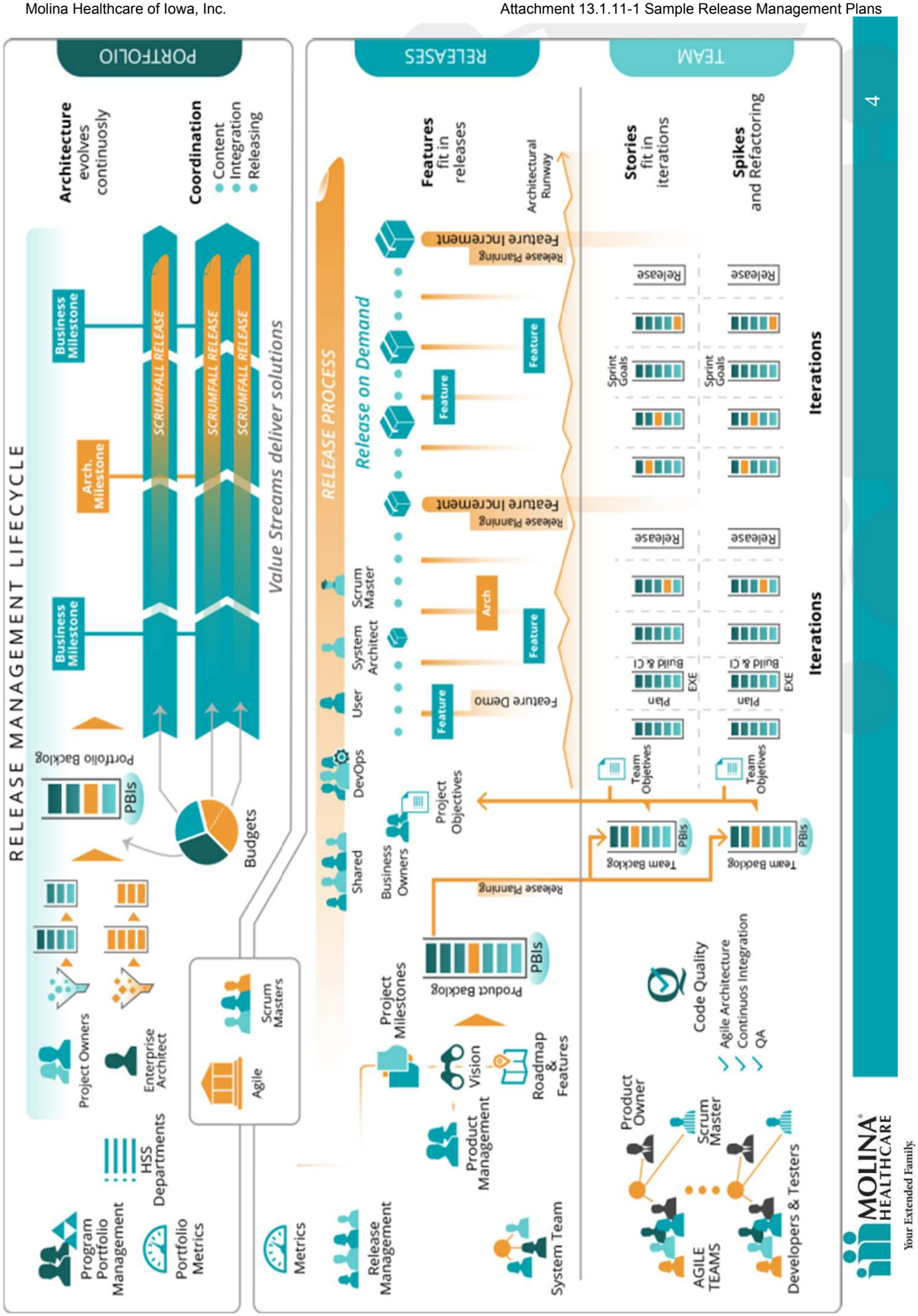
Development :

- Reduce manual processes
- Multi-team work coordination and packaging specific release(s)
- Practice Continuous (or near-continuous) Integration
- Manage different work types (new development and support)
- Integrated QA process
- Quality checks (Governance)
- Reduce rework/downtime
- Have reporting on resources (capacity planning)

Business Support :

- Communication
- Release scheduling
- Have visibility into work status
- Reduce business disruption/impact
- Improve delivery quality
- Improve customer satisfaction
- Release Financial Tracking and Costing

MOLINA HEALTHCARE
Your Extended Family.

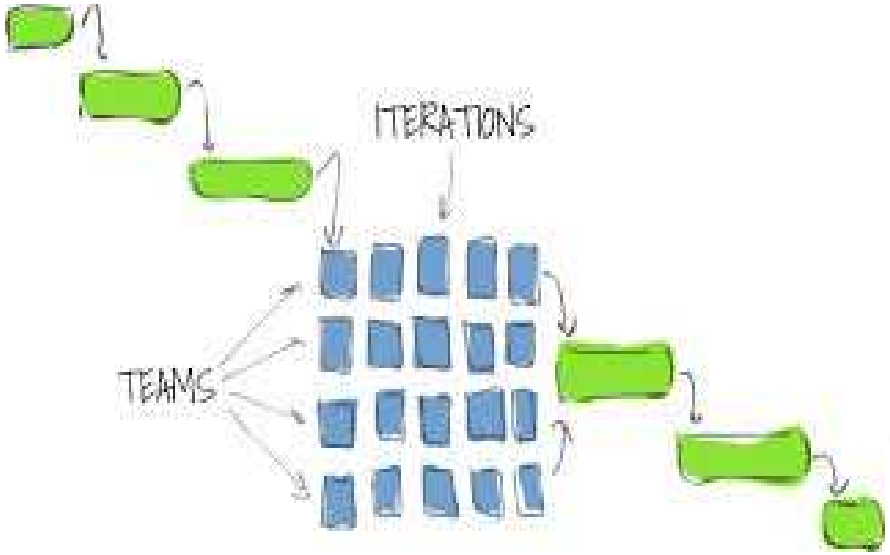


MOLINA HEALTHCARE
Your Extended Family.

Introducing Scrum Fall

Water-Scrum-fall is a hybrid approach to application lifecycle management that combines a project management methodology of waterfall and the development methodology of Scrum.

- Today, a development team that uses a waterfall approach regards the development process for a software product as one large project. At the end of the project, the team releases working software to an operations team for installation and maintenance. Typically, the business owner (also called the product owner) only sees the finished product.
- In contrast, a development team that uses Scrum, would approach the same development project as a series of very small projects called sprints. Working software is released periodically in an iterative manner until the entire software product is complete. Allowing for a quicker time to market for our customers.



MOLINA HEALTHCARE
Your Extended Family.

Application Lifecycle Management – Enterprise Software Development

- Team first
- Transparency
- Collaboration
- Integration

Collaborative Development

- Focus on development team productivity
- Enables distributed development
- Flexible support for development processes
- Manage change in the application life cycle

Source Code Management

- Workspaces
- Snapshots
- Baselines
- Change sets
- Suspend changes
- Component
- Streams
- SVN bridge
- Bridges and connectors

Work Items Management

- Iteration planning
- Attachments
- Audit trails
- Customize workflow
- Bridges and connectors

Build Management

- Define builds
- Continuous integration
- Remote build server
- Bridges

Team Health

- Transparent development
- Team centralization
- RSS/Atom Feeds
- Improved Communication
- Process enforcement and customization
- Dashboards
- Reports
- Role-based permissions

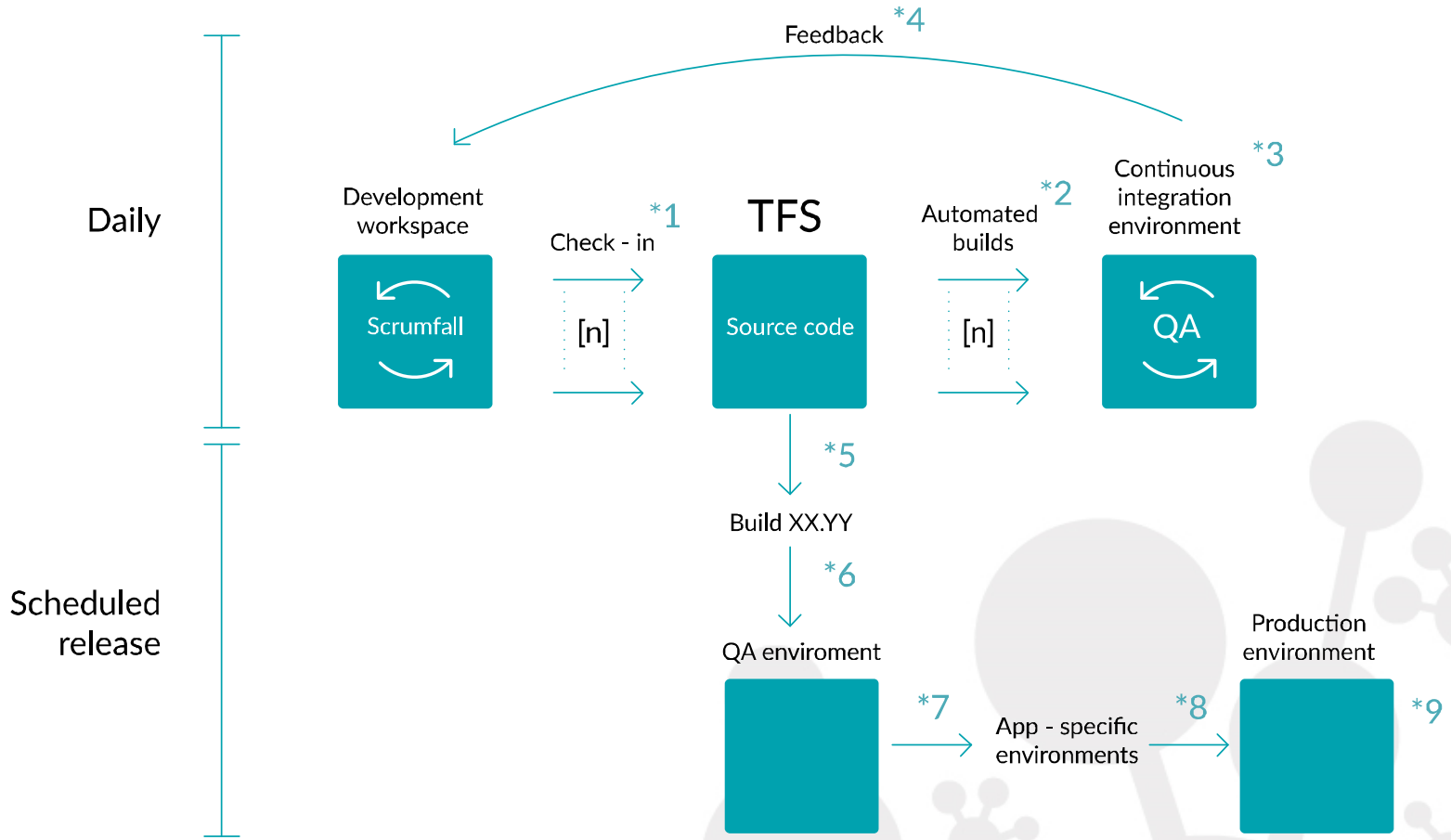
- Web-based UI
- Knows application domain
- Talks business language

Team Collaboration

- View iteration plans and validate deliverable time lines
- Create, update, query, and view dispositions of development tasks
- Overview of the resource utilization
- View personalized dashboards

MOLINA HEALTHCARE
Your Extended Family.

Revised Functional and Process Workflow Diagram



Molina Healthcare has an unparalleled capability to develop, produce and deliver standard and as-needed program reports that meet state and federal contractual requirements in an efficient, accurate and timely manner.

SECTION 14 – PERFORMANCE TARGETS AND REPORTING REQUIREMENTS

Please explain how you propose to execute Section 14 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Molina understands, agrees and will comply with all Performance Targets and Reporting Requirements set forth in accordance with Section 14 of Attachment 1—Scope of Work.

1. Describe your plan to provide the reports described in the RFP, in the format required, and using templates that may be specified in the Reporting Manual and updated from time to time.

Molina has the systems and resources in place to generate the required reports in Sections 14.1 through 14.11 of Attachment 1 – Scope of Work, as well as any additional ad hoc reports needed by DHS. Molina's Report Generation subsystem, integrated within the QNXT claims administration system is capable of supporting many reporting requirements for a wide range of areas, including but not limited to grievances and appeals, claims payment, utilization management, care coordination, member services, membership, encounters, provider, and premium data. Molina has an array of other tools, applications, and databases that supplement what is available from QNXT and enhance Molina's ability to extract data and produce reports for submission to DHS as well as for support of internal operations.

Molina has experience in developing various reports of size and scope and is prepared to produce data and reports as required in subject areas of, but not limited to:

- Financial Reports (e.g., Medical Loss Ratio);
- Member Services Reports (e.g., Completion of Comprehensive Health Risk Assessment, Care Plan Development, CAHPS surveys, PCP Assignment);
- Provider Network Reports (e.g., GeoAccess and Credentialing);
- Quality Management Reports;
- LTSS Reports (e.g., Nursing Facilities Admission Rates);
- Utilization Reporting (e.g., Prior Authorization Turn Around Time Compliance); and
- Claims Reports (e.g., Clean Claims Turnaround Time Compliance).

See Attachment 14.1-1 Sample Turnaround Time and Assessment Dashboard Reports and Attachment 10.2.5-1 Quality Improvement Draft Work Plan. Molina will also develop reports as required by DHS to address other areas such as:

- Quality of Life Reports;
- CMS Reports; and
- IDPH Reporting to support additional reporting requirements (e.g., the Substance Abuse Prevention and Treatment Block Grant).

The Report Generation subsystem supports reporting to enable plan management and DHS to make intelligent decisions regarding Molina health plan activity. The Report Generation subsystem is used to

simplify and enhance the cataloging, viewing and printing of reports, forms and letters by business users for operational, administrative, and regulatory reporting. Reports can include a summary table that presents data over time including monthly, quarterly and/or year-to-date summaries as directed by DHS.

Molina's Corporate IT Team also maintains an internal data repository, which contains all Molina data for claims, encounters, members, providers, pharmacy, lab, and risk adjustments. Reports are extracted using SQL queries, SQL query library, SQL Server Reporting Services (SSRS), and claims payment system reporting. All data is housed on a server that is accessible 24 hours a day/7 days of week by both the Molina Healthcare of Iowa Healthcare Analytics Team and analytic teams that support and collaborate with the Iowa team and reside in Molina corporate office including IT Actuarial, Office of Healthcare Value and Medical Informatics, Claims and Encounters, and Provider Network Strategy. Many pre-built operational and analytics reports are available through the SQL Server Reporting Services (SSRS) and the Business Intelligence (BI) environment. Reports can often be programmed to automatically be sent to an FTP site or e-mail address. Direct delivery to DHS from the system may not be appropriate in all cases when additional analysis is required as part of the report submission, but direct delivery to internal users for review and analysis helps to enhance timeliness and accuracy because fewer people have to be involved in the process.

Molina understands that various reports as identified by DHS require certification by an Authorized Certifier. This worked well with Molina and DHS because the reports that required certification were primarily financial in nature. In the event that DHS expands the scope of reports that require certification, Molina will work closely with DHS to determine if the list of Authorized Certifiers should be extended to include Molina leadership in other functional areas. When a report is due, an Authorized Certifier will review the accuracy of language, analysis, and data in each report and complete a signed attestation for the report. The attestation will include a certification, based on best knowledge, information, and belief, as to the accuracy, completeness and truthfulness of the data in the report. Molina's Contract Manager will include a signed attestation along with other required report elements each time the report is submitted.

2. Describe additional data/reports you are capable of providing that can help the State evaluate the success of the program.

Molina's database will be used for DHS reporting requirements on a monthly basis, and the reporting tools are scalable for reporting on a variety of timelines. The reporting tools also include ad hoc capabilities for producing reports based on a wide range of data elements, including but not limited to member, provider, initiation codes, and resolution codes. Molina offers DHS the following reports that will meet the reporting requirements in accordance with Section 14 Performance Targets and Reporting Requirements of Attachment 1 – Scope of Work.

Claims Payment Reports

Molina's QNXT claims payment module has the capability to report claims processing activities for both the purpose of analyzing medical costs as well as for the purpose of looking at production metrics such as claims inventory, timeliness, and accuracy.

The QNXT system contains a vast volume of claims detail information across all service areas that are available for reporting at both the detail and summary levels. The multiple tools available for accessing data in these systems provides Molina with the flexibility to produce customized reports that support management of costs and utilization and can also provide DHS with both routine and ad hoc reports for decision making in the assessment of historical activities and determination of future program direction. Molina also works with MedInsight, a Milliman product, which receives extracts of data and groups it into Health Cost Guidelines (HCG) Groupers – classification of claims service categories. The HCG Groupers helps Molina track claim costs by hospital, surgical, medical, and other categories as well as,

adjust costs to specific situations. The MedInsight system also has modules for prospective risk scoring that can be used both for targeting care management and for cost planning purposes.

In addition to many of the standard claims processing Key Performance Indicator metrics (receipts, processing, inventory, turnaround times) available in reports that can be run by users from self-service reporting tools, Molina uses a Claims Workflow application to help manage the flow of claims through the system and route claims to the proper teams for problem resolution. The use of a system with automated routing functionality helps to reduce claims turnaround times and having specific queues for routing of issues helps to improve accuracy. These different tools help support the reporting of claims processing activities to DHS.

Claims processed by Molina subcontractors as encounters can also be integrated into QNXT for reporting and analysis in combination with claims processed internally by Molina. The Claims Encounter Management System (CEMS) works to manage the workflow and track the lifecycle of both internal and external encounters similar to the manner in which the Claims Workflow application helps to track and route claims for processing and issue resolution. These systems are used in concert for the extraction and submission of encounters from Molina to DHS as well as for tracking of the accuracy rates for files accepted by DHS and tracking of resubmissions of denied encounters where appropriate. These processes provide the information and tools for reporting encounters data to DHS at the summary level.

Utilization Management Reports
The integrated structure of the QNXT administration system positions Molina to be able to document, monitor, and report utilization activities from both authorization and claims based data. Authorization data lends itself more to real time tracking and management of care for services that are a focus of the annual UM Work plan and Evaluation while claims based data can provided tracking for costs and utilization of services regardless of whether they require prior authorization.

Both the Authorizations and Claims modules allow for reporting of under and over utilization broken down by a wide variety of categories, including but not limited to inpatient, outpatient, physician, radiology, long-term care, behavioral health, member demographics, and provider demographics. The reporting of these different categories is done for internal purposes in order to properly manage the care and utilization of the Molina membership. Molina will also provide this information to DHS in required formats and can adapt and expand the external reports to DHS and according to future DHS need.

Care Coordination Reports
Molina's Clinical CareAdvance System is a web-based integrated platform for performing Care Management and Disease Management. It enables a member-centric view for clinical users by aggregating data from a variety of sources such as predictive modeling risk scores, claims, pharmacy, and lab. Currently a nightly data feed from QNXT to Clinical CareAdvance is in place which integrates membership and claims data from QNXT to CCA. Molina is in the process of upgrading Clinical CareAdvance (to version 5.0) to be the single system platform supporting all of Molina's member care-related activities and functions, including Care Management, Disease Management and Utilization Management that will interface with QNXT directly rather than just on a nightly feed. The information on services and interventions with members is fully reportable by CCA at detailed and summary levels. CCA will be key in tracking the member-to-coordinator staffing levels, success rates for reaching members for care management and risk assessment, and the timeliness of care management activities (provided both internally and externally). Reporting tools are available internally for operational management and are customizable to provide similar information to DHS in required templates and for ad hoc reports.

Member Services Reports
Molina's Member Enrollment/Eligibility Module collects, processes, and maintains current and historical information on members, including all demographic information and eligibility spans within multiple programs. The system also has a Call Tracking Module that stores and tracks calls from members and

providers to provide reporting capabilities for the full range of inquiries. In addition to tracking information on the calls, the system provides operational capabilities to initiate member actions directly from the call, including the ability to change the member's PCP, send the member a new ID card and other member materials, or provide information to the member about recommended preventive services to improve healthcare quality. Because of the integration of the Call Tracking Module with the rest of QNXT, the call information can be integrated with Eligibility information. This allows reporting to be possible at summary levels depending on member or provider demographics.

Since the system is used to initiate these actions, tracking and reporting of mailing volume and timelines for the Member Materials report can be system generated. Molina uses information from Call Tracking and from the Cisco Unified Intelligence Center (CUIC) software integrated with the call center phone system to track call performance metrics for both internal operational performance management as well as for external reporting to DHS. The CUIC planning capabilities help to ensure that Molina not only can report to DHS on metrics such as call volume (received and answered), abandonment rates, answered within 30 seconds, and summaries by call topic, and the system can be used to plan workforce needs around vacations and holidays to ensure that the standards for these metrics are continually met.

Ad-hoc Reports

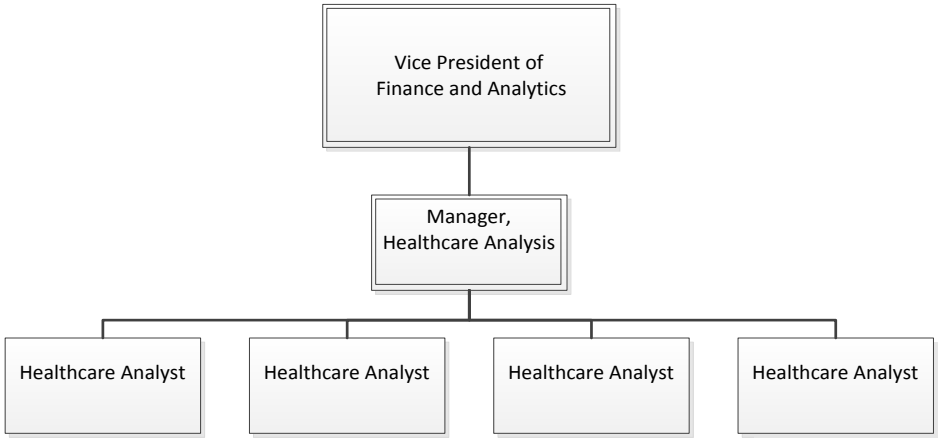
Molina has the personnel and infrastructure in place and is prepared for submission of ad-hoc reports as required by DHS. Molina's ad-hoc capabilities include report generation using data from QNXT claims processing system, Data Mart, and other core systems which include financial, enrollment/eligibility, provider, encounter/claims processing and utilization management data sources. Molina tailors its processes to meet the requirements of ad-hoc reporting requests by adapting and/or streamlining documentation, development, and testing processes in order to accurately meet DHS's needs with varying turn-around times. The complexity of the request and the urgency of DHS's needs determine the extent of design and testing for each report. Molina works internally with the subject matter experts (those with the business knowledge) and the Healthcare Analytics team to define the specifications and produce the reports. Often with simple requests that have precise specifications from DHS the Healthcare Analytics team can translate the request into reporting logic, test results and produce the ad-hoc report without requiring the step of consulting with subject matter experts. At the point of report design, the Healthcare Analytics team and the subject matter experts can also determine whether a new report should be developed or if existing tools or reports could be adapted in order to meet DHS's need for both content and turnaround time. Molina has the capability to generate reports in various formats including Microsoft Excel, Microsoft Access, Microsoft Word, character separated values, data interchange format, fixed length ASCII, Adobe PDF, HTML, XML, Rich-Text Format, and other formats as needed. All reports can be generated as hard copy or in an electronic format.

3. Describe your internal operational structure that will support the compilation of the performance data and reporting processes of the programs, including:

a. The qualifications and experience of the staff responsible for the production and delivery of performance data to the State.

Molina deploys a dedicated team of staff across local and corporate levels to support data collection, reporting, analysis, and problem solving and process improvement activities. The Iowa IT/Healthcare Reporting and Analytics Team will include the Vice President of Finance and Analytics, Manager of Healthcare Analytics, and four Healthcare Data Analysts. That team is supported by and works in conjunction with the IT Team from Molina's corporate offices. The Molina Corporate IT Reporting and Operations Team consists of an Associate Vice President for Healthcare Systems; Director of Operations and Maintenance; two IT Managers; and 19 Programmer/Systems Analysts.

Exhibit 14.3.a-1 Molina Healthcare of Iowa's IT/Healthcare Reporting and Analytics Team



Additional reporting and analytic teams that support and collaborate with the Iowa team and reside in Molina corporate offices include Actuarial, Office of Healthcare Value and Medical Informatics, Claims and Encounters, and Provider Network Strategy. Together these teams represent eight vice presidents, two associate vice presidents, eight directors, six managers, and 34 analysts. Included among them is the Director of Data Governance who works across the enterprise to support data collection and integrity. Collectively, Molina's corporate and local Iowa Healthcare and Analytics Team will offer data analytics expertise and experience, access to nationwide best practices, resources for developing tools and reports and capacity for larger scale projects. In other states, Molina's combined local and corporate reporting teams have provided invaluable leadership to states, working collaboratively with MCOs to improve the content and levels of comparative reporting across MCOs.

The Molina Analyst Forum is a mechanism for health plan and corporate analytic staff to share technical and business expertise, reports and analyses, and best practices enterprise wide. Similarly, the Finance and Analytics Management Committee, consisting of the plan Vice Presidents of Finance and Analytics and corporate analytics leadership, meets regularly to discuss emerging trends, solve problems, share best practices, and find support. Together these groups meet to identify problems, find solutions, and improve processes.

b. The process for internal review and validation of data prior to submission to the State.

Accuracy in reporting is greatly enhanced by strong planning and design processes. Clear reporting specifications can also enhance the potential for automation to help reduce the impact of potential human error in report production. Internally, Molina establishes reporting specifications through the collaboration between subject matter experts who own the reports and the Healthcare Analytics team who will implement the specifications to produce the reports. In cases where the specifications are simple, the report owner and the Healthcare Analytics team can work together similar to an ad hoc request to document the specifications, translate the specifications into reporting logic, and test the results before putting the final output into production status. When the reporting specifications are more complex, a Business Requirement Document (BRD) process is used to ascertain the range of system and programming resources that will be needed to develop the report. The BRD process is most often used when subject matter experts from multiple departments will need to have input. This multi-disciplinary input helps to ensure that the report is designed from a full business oversight rather than only being designed from a singular viewpoint. The BRD is used throughout the process to maintain documentation of design, specification, testing, validation, and version control.

Once the initial design and implementation of reports is complete, production of system generated reports is followed by a rigorous process of review and analysis prior to finalization and submission to DHS. First and second level reviews occur within the functional areas for which the reports are generated. First and second level reviewers are cross checking the data integrity, noting process improvement opportunities, and completing analyses regarding the meaning, applicability, and trends of the information being presented. A dedicated contract manager oversees the process of report submission in order to promote timely and accurate submission of reports. This dedicated staff member conducts a final quality check for compliance with all reporting requirements and may return reports to functional leads for final corrections prior to submission to DHS. The contract manager provides report feedback from all sources internally and externally in order to establish an ongoing quality improvement process in reporting requirements. There is further oversight of the process and specific report integrity conducted in a reporting committee at Molina that meets on a monthly basis. The oversight committee is comprised of senior leaders and all functional leads including Healthcare Analytics. A standing agenda item includes the internal scorecard that Molina utilizes to monitor ongoing compliance with all reporting requirements.

Timeliness is assured by a combination of automated report scheduling and coordinated lead time planning. Whether a report is pre-scheduled to run automatically or initiated by a report generator, the timing of the runs are scheduled several days in advance of the due date of the report. Standard timelines are applied that allow for the owner of the report to review the report for completeness and accuracy. The report analysis is performed by the report owner at this time and any required attestations are also signed. Time is also built into the schedule for the contract manager to review the reports for compliance with required templates and overall quality before the report is ultimately submitted to DHS.

4. Please provide any available Medicaid HEDIS scores in states in which you operate.

All eligible Molina health plans collect, calculate and report HEDIS measures to NCQA. Molina has implemented innovative programs for Asthma, comprehensive Diabetes care and other key HEDIS measures that have delivered consistently positive health outcomes for its members nationwide. HEDIS staff at the corporate office oversees the administrative data collection and reporting aspects of the HEDIS process, as well as other key metrics. Cutting edge NCQA-certified HEDIS software from Inovalon ensures the validity and quality of results. Molina employs a dedicated HEDIS Manager who will oversee medical records data collection in Iowa in cooperation with DHS; this Manager is responsible for the analysis and follow-up on results. Molina's HEDIS process is audited by a NCQA certified auditor.

Exhibit 14.4-1 HEDIS Results - 2012-2014

HEDIS Measures	2012 Rate	2013 Rate	2014 Rate	NCQA QC 2013 Medicaid Avg.	Molina State
Follow-Up After Hospitalization for Mental Illness – 7 day	55.71%	30.54%	51.53%	43.83%	OH
Follow-Up After Hospitalization for Mental Illness – 30 day	72.91%	43.86%	73.93%	63.75%	OH
Well-Child Visits in the First 15 Months of Life - 6+ Visits	62.41%	62.41%	64.46%	63.60%	TX
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	69.76%	73.51%	74.01%	72.00%	FL
Adolescent Well-Care Visits	54.97%	56.22%	64.12%	49.69%	TX

HEDIS Measures	2012 Rate	2013 Rate	2014 Rate	NCQA QC 2013 Medicaid Avg.	Molina State
Weight Assessment and Counselling for Children – BMI Percentile	39.51%	36.20%	56.73%	51.78%	FL
Weight Assessment and Counselling for Children – Nutrition Counselling	57.62%	56.95%	60.49%	55.01%	FL
Weight Assessment and Counselling for Children – Physical Activity Counselling	44.81%	41.94%	50.99%	44.23%	FL
Prenatal and Postpartum Care – Timeliness of Prenatal Care	86.50%	89.17%	89.17%	82.93%	NM
Comprehensive Diabetes Care – A1c Testing	81.46%	84.33%	83.66%	82.98%	CA
Comprehensive Diabetes Care – Eye Exam	47.46%	56.66%	65.27%	53.17%	MI
Comprehensive Diabetes Care – Nephropathy Screening	73.01%	76.38%	82.78%	78.38%	FL
Controlling High Blood Pressure	63.49%	64.86%	64.86%	56.36%	MI
Breast Cancer Screening	53.75%	55.61%	61.07%	51.82%	MI
Adult BMI Assessment	45.25%	63.58%	73.95%	67.63%	FL

*Significance is based on a z-test for differences in rates; an alpha value of 0.05 and a one-sided test of improvement.

5. Provide a copy of your most recent external quality review report for the Medicaid contract that had the largest number of enrollees as of the RFP release date.

As of May 2015, Molina Healthcare of California has the largest number of members out of Molina's 11 state health plans. See Attachment 14.5-1 Molina Healthcare of California EQRO Report, which can be found behind Tab 6.

MOLINA HEALTHCARE
OHCV - Medical Informatics

Prior Auths & Elective InPatient Turn Around Time

Data As Of: 04/14/2015

Reporting Period: Last 1 Month: 201503
Plan Name: MI
Procedure Category: ALL, Behavioral Health, Cardiac Rehab, Chiropractic Services, Cosmetic Recons, Dental, Dialysis, DME, Expermnt, Investigtn, Genetic Counsl, Home Health, Home Healthcare, Home Infusion, Incontinence Products, LTAC/Rehab, Mental Health, Neuropsycho & Psycho, NICU, Nutritional Supplmnt, OB-Newborn, OB/GYN, Office Surgical, Office Visit, OP Hosptl, Ambul, Surg Cntr, Outpatient Hospice & Palliative Care, Outpatient Surgical, Pain Management, Pregnancy & Delivery, Skilled Nursing, Sleep Studies, Therapy, Transplant, Transportation, Unlisted CPT & Misc Codes

Methodology Procedure Code

			Non-Urgent				Urgent				Retro Review				Total			
Plan	LOB Group	LOB	Average TAT Dy--Hr	Compliant Counts	Auth Counts	Percentage Compliance	Average TAT Dy--Hr	Compliant Counts	Auth Counts	Percentage Compliance	Average TAT Dy--Hr	Compliant Counts	Auth Counts	Percentage Compliance	Average TAT Dy--Hr	Compliant Counts	Auth Counts	PercentageCompl
Last 1 Month: 201503					*Category = ALL*													
MI			**2D----**	**3,362**	**3,885**	**86.5%**	**19H**	**681**	**838**	**81.2%**	**3D----2H**	**21**	**44**	**47.3%**	**2D----6H**	**4,052**	**4,742**	**85.4%**
		CHIP	1D----	29	29	100.0%	10H	5	6	83.3%	0H	0	0	0.0%	1D----	34	35	97.1%
	MarketPlace	MP	1D----	11	12	91.6%	1D----6H	2	3	66.6%	0H	0	0	0.0%	1D----	13	15	86.6%
	Medicaid	_ALL	2D----	2,554	2,979	85.7%	21H	585	730	80.1%	2D----3H	3	6	50.0%	2D----5H	3,142	3,715	84.5%
		ABD	2D----8H	864	999	86.4%	21H	162	208	77.8%	10D----22H	1	1	100.0%	2D----2H	1,027	1,208	85.0%
		ABD Dual	2D----7H	23	28	82.1%	1D----2H	1	1	100.0%	0H	0	0	0.0%	2D----6H	24	29	82.7%
		ABD Kids	2D----	161	198	81.3%	13H	46	60	76.6%	0H	0	0	0.0%	1D----	207	258	80.2%
		EXPANS	2D----	852	995	85.6%	21H	202	258	78.2%	5H	1	4	25.0%	2D----6H	1,055	1,257	83.9%
		TANF	2D----	654	759	86.1%	23H	174	203	85.7%	1D----2H	1	1	100.0%	2D----8H	829	963	86.0%
	Medicare	MEDI	2D----	768	864	88.8%	9H	89	99	89.8%	3D----12H	6	13	46.1%	2D----	863	976	88.4%
	Medicare	MMOP	0H	0	1	0.0%	0H	0	0	0.0%	0H	0	0	0.0%	0H	0	1	0.0%
Last 1 Month: 201503					*Category = Behavioral Health*													
MI			**19H**	**44**	**45**	**97.7%**	**4H**	**2**	**2**	**100.0%**	**0H**	**0**	**6**	**0.0%**	**18H**	**46**	**49**	**93.8%**
	MarketPlace	MP	3H	2	2	100.0%	0H	0	0	0.0%	0H	0	0	0.0%	3H	2	2	100.0%
	Medicaid	_ALL	13H	24	24	100.0%	5H	1	1	100.0%	0H	0	2	0.0%	12H	25	27	92.5%
		ABD	10H	2	2	100.0%	0H	0	0	0.0%	0H	0	0	0.0%	10H	2	2	100.0%
		ABD Kids	3H	1	1	100.0%	5H	1	1	100.0%	0H	0	0	0.0%	4H	2	2	100.0%
		EXPANS	11H	6	6	100.0%	0H	0	0	0.0%	0H	0	2	0.0%	8H	6	8	75.0%
		TANF	15H	15	15	100.0%	0H	0	0	0.0%	0H	0	0	0.0%	15H	15	15	100.0%
	Medicare	MEDI	1D----5H	18	19	94.7%	4H	1	1	100.0%	0H	0	0	0.0%	1D----3H	19	20	95.0%

SAMPLE

MOLINA HEALTHCARE
OHCV - Medical Informatics

Initial Assessment/Care Plan Dashboard

Data As Of: 04/09/2015

Reporting Period **201502 - 201504**
Plan Name: **CA**
LOB: **MMP**
Requirements: **CMS**
Assessment Category: **THRA, TCNA, FCNA**

Methodology

	CA		
	Assessed by Enrollment Month		
	Feb 15	Mar 15	Apr 15
Assessed Week Ending			
Feb 06, 2015	113		
Feb 13, 2015	146		
Feb 20, 2015	67		
Feb 27, 2015	40		
Mar 06, 2015	35	120	
Mar 13, 2015	30	171	
Mar 20, 2015	29	80	
Mar 27, 2015	15	40	
Apr 03, 2015	22	16	33
Apr 10, 2015	13	11	48

SAMPLE

MOLINA HEALTHCARE
OHCV - Medical Informatics

Initial Assessment/Care Plan Dashboard

Data As Of: 04/09/2015

Reporting Period **201502 - 201504**
Plan Name: **CA**
LOB: **MMP**
Requirements: **CMS**
Assessment Category: **THRA, TCNA, FCNA**

		Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	YTD
ENROLLED at Least 90 Days ALL Members															
Assessed Within 30 Days		15	394	161	376	413	401	311	260	419	973	280	364	81	1698
Assessed Within 60 Days		21	537	205	502	528	502	376	325	531	1640	390	387	81	2498
Assessed Within 90 Days		22	678	279	636	660	581	418	383	618	2456	412	387	81	3336
Enrolled at Least 90 Days in Reported Months		33	2156	837	1925	1901	1546	1115	1018	1402	6038	1232	1201	410	8881
90 Day Assessment Rate - Adjusted		85%	76%	74%	73%	86%	88%	90%	79%	82%	85%	36%	35%	21%	61%
90 Day Assessment Rate - Unadjusted		67%	31%	33%	33%	35%	38%	37%	38%	44%	41%	33%	32%	20%	38%
Mbrs Declined Within 90 Days		5	195	72	159	209	193	144	84	157	477	96	106	20	699
Mbrs Unable to Locate 3 Attempts Within 90 Days		2	1068	386	900	922	694	504	449	488	2671	0	0	0	2671
Mbrs not yet Assessed in 90 Days		4	215	100	230	110	78	49	102	139	434	724	708	309	2175
Care Plans Within 90 Days for Members Assessed	Care Plans if Assessed	19	495	240	498	510	460	337	315	514	1835	335	349	70	2589
	Assessed Within 90 Days	22	678	279	636	660	581	418	383	618	2456	412	387	81	3336
	Care Plan Completion Rate	86%	73%	86%	78%	77%	79%	81%	82%	83%	75%	81%	90%	86%	78%
Care Plans Within 90 Days for All Members	Total Care Plans	19	499	241	513	541	474	364	324	534	1928	355	369	73	2725
	Enrolled >= 90 Days in Reported Months	33	2156	837	1925	1901	1546	1115	1018	1402	6038	1232	1201	410	8881
	Care Plan Rate	58%	23%	29%	27%	28%	31%	33%	32%	38%	32%	29%	31%	18%	31%

SAMPLE

MOLINA HEALTHCARE
OHCV - Medical Informatics

Initial Assessment/Care Plan Dashboard

Data As Of: 04/09/2015

Reporting Period **201502 - 201504**
Plan Name: **CA**
LOB: **MMP**
Requirements: **CMS**
Assessment Category: **THRA, TCNA, FCNA**

	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	YTD
ENROLLED at Least 90 Days HIGH RISK Members														
Assessed Within 30 Days	2	59	16	34	35	32	24	18	24	114	14	23	2	153
Assessed Within 45 Days	2	63	17	45	44	35	26	21	27	135	17	24	2	178
Assessed Within 90 Days	2	75	23	53	51	40	29	27	33	161	19	24	2	206
Enrolled at Least 90 Days in Reported Months	2	133	35	79	81	54	53	40	57	252	39	44	23	358
90 Day Assessment Rate - Adjusted	100%	93%	92%	93%	91%	91%	94%	96%	92%	92%	51%	60%	10%	75%
90 Day Assessment Rate - Unadjusted	100%	56%	66%	67%	63%	74%	55%	68%	58%	64%	49%	55%	9%	58%
Mbrs Declined Within 90 days	0	21	3	10	7	6	9	3	10	25	2	4	2	33
Mbrs Unable to Locate 3 Attempts Within 90 Days	0	31	7	12	18	4	13	9	11	52	0	0	0	52
Mbrs not yet Assessed in 90 Days	0	6	2	4	5	4	2	1	3	14	18	16	19	67
ENROLLED at Least 90 Days LOW RISK Members														
Assessed Within 30 Days	13	335	145	342	378	369	287	242	395	859	266	341	79	1545
Assessed Within 60 Days	19	471	186	454	480	464	348	302	502	1498	371	363	79	2311
Assessed Within 90 Days	20	603	256	583	609	541	389	356	585	2295	393	363	79	3130
Enrolled at Least 90 Days in Reported Months	31	2023	802	1846	1820	1492	1062	978	1345	5786	1193	1157	387	8523
90 Day Assessment Rate - Adjusted	83%	74%	72%	72%	85%	88%	89%	78%	81%	85%	36%	34%	21%	60%
90 Day Assessment Rate - Unadjusted	65%	30%	32%	32%	33%	36%	37%	36%	43%	40%	33%	31%	20%	37%
Mbrs Declined Within 90 Days	5	174	69	149	202	187	135	81	147	452	94	102	18	666
Mbrs Unable to Locate 3 Attempts Within 90 Days	2	1037	379	888	904	690	491	440	477	2619	0	0	0	2619
Mbrs not yet Assessed in 90 Days	4	209	98	226	105	74	47	101	136	420	706	692	290	2108

Molina is committed to partnering with the state in the event of termination and will assist the Department, as requested, to ensure a smooth transition to the newly contracted Supplier.

SECTION 15 – TERMINATION

Please explain how you propose to execute Section 15 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Molina understands, agrees and will comply with all Termination requirements set forth in accordance with Section 15 of Attachment 1—Scope of Work.

1. Describe your plan to complete the duties outlined in Section 15 in the event of contract termination or expiration.

Molina will work with DHS to develop a robust Transition Plan within 60 days of contract execution to meet the contract Termination requirements as described in Section 15 Contractor's Termination Duties of Attachment 1 – Scope of Work.

In the event a Transition Plan needs to be executed, Molina will work closely with designated DHS representatives, providers, as well as DHS- and Molina subcontractors to ensure and mitigate any disruption of services to members during this transition phase. In addition to providing any and all necessary data files, and books and records, Molina will prioritize and safeguard the members' data elements and records by adhering to its detailed, compliant Personal Health Information (PHI) and HIPAA guidelines to protect the members' information. Molina will divide the Transition Plan into three distinct phases.

The Transition Plan will primarily be Molina's responsibility to execute and ensure the Transition Plan is implemented and carried out. Molina will work closely and coordinate with its corporate Information Technology (IT) department to assist and prepare the information for data transfer. The Plan President will be the accountable person within Molina for the Transition Plan. However, the Plan President may delegate the authority and oversight to a member of Molina's Senior Leadership Team (SLT) to be the executive point person (e.g., Vice President of Government Contracts). To support a successful transition, Molina will create a multi-disciplinary team that includes representation from health plan operations, health services, network management IT and compliance to ensure a Subject Matter Expert (SME) for all the critical areas that are impacted when the Transition Plan is executed. The Plan President or his designee will manage the relationship with DHS and/or the successor contractor. The Transition Plan will not be considered completed until the Plan President has signed off on the Transition Plan.

2. Provide a general end-of-contract transition plan which addresses the key components outlined in Section 15.

The first phase of the Transition Plan will be development of the Work Plan to execute a successful transition of data transfer to DHS or a successor contractor. This phase will also include a series of initial conference calls and/or meetings to outline the objectives and goals of Transition Plan to ensure the Work Plan meets the expectations of DHS and/or the successor contractor.

The Transition Plan will be a shared document to be viewed by all affected parties. In addition to the overall goal of protecting member, provider and state information, Molina will also address the following safeguards as it constructs the Transition Plan, including, but not limited to:

- **Confidentiality** – preserving authorized restriction on information access and disclosure, including means for protecting personal privacy and proprietary information;
- **Integrity** – guarding against improper information modification or destruction, and includes ensuring information nonrepudiation and authenticity; and
- **Availability** – ensuring timely and reliable access to and use of information.

The Transition Plan will contain a Work Plan, which is a detailed project/task list along with measurable milestones to evaluate Molina's successful progress toward a smooth transition and data transfer. The Work Plan will also facilitate the opportunity to address any gaps in data exchanges and complete the checklist to ensure all items in the project/task list are addressed. Within phase one, Molina along with DHS representatives will categorize the data files and elements to be transferred into the following three data classifications:

- **Confidential Data/Information** – Sensitive data that must be protected from unauthorized disclosure or public release based on state or federal law or other constitutional, statutory, judicial or legal agreements. Examples may include (but not limited to): Personally Identifiable Information, Medical Records, Copyrights, Patents and Trade Secrets.
- **Health Plan Sensitive Data** – Sensitive data that may be subject to disclosure or release and that requires some level of protection. Examples include (but not limited to): Operational information, Personnel Records, Information Security Procedures, Internal Communications.
- **Public Information** – Information intended or required for public release.

Once the Transition Plan is developed, the second phase will commence, emphasizing on implementing the Transition Plan. During this second phase, Molina, along with DHS and/or its contractor, will begin executing the Transition Plan, which will include the exchange of member data and demographic information, members' authorization information and claims history, enrollment files and other files for the purpose of generating ID cards, development of member and provider communications, member rosters by provider, and if necessary, in addition to sharing of Molina's network of providers to ensure continuity of care for the members. This phase will also include, at a minimum, weekly conference calls with the key parties at Molina, DHS and/or successor contractors to ensure the implementation phase is progressing as planned.

After the second phase is completed to the satisfaction of DHS, it will trigger the third and final phase of the Transition Plan, focusing on post data transfer. This phase will ensure the checklist items have been developed in phase one and executed during the second phase to ensure they are completed and signed off by Molina and DHS. During this final phase, Molina will continue to provide minimal customer service support for transitioning members to assist them with issues they may encounter during the change to ensure continuity of care and minimal disruption of service, as well as alleviate any administrative burdens to the provider community during the turnover. Additionally, Molina will submit periodic reports to DHS detailing Molina's progress in completing its obligations of the contract.

3.2.5 Information to Include Behind Tab 4: Bidder's Background

The bidder shall provide the information set forth in this section regarding its experience and background.

3.2.5.1 Experience.

The bidder shall provide the following information regarding the organization's experience:

3.2.5.1.1 Level of technical experience in providing the types of services sought by the RFP.

Molina has the level of technical experience to deliver the high quality healthcare services sought by the Department of Health Services (DHS) for the Iowa High Quality Healthcare Initiative, Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (hawk-i) programs.

For more than 30 years, Molina Healthcare, Inc. has partnered with government clients similar to the Department of Health Services (DHS) to provide a high quality Medicaid healthcare delivery system that improves health outcomes, access to preventive care, manage chronic diseases, and achieve cost management goals while preserving member access, choice, safety and independence. Molina is a publically traded, multi-state healthcare organization focused exclusively on Medicaid, Medicare, the Children's Health Insurance Program (CHIP), and other government-sponsored healthcare programs for low income families and individuals. As one of the nation's largest Hispanic-owned businesses, Molina has been a Fortune 500 company since 2012. Reflecting the company's rapid growth, Molina improved to #393 on the Fortune 500 list for 2014.

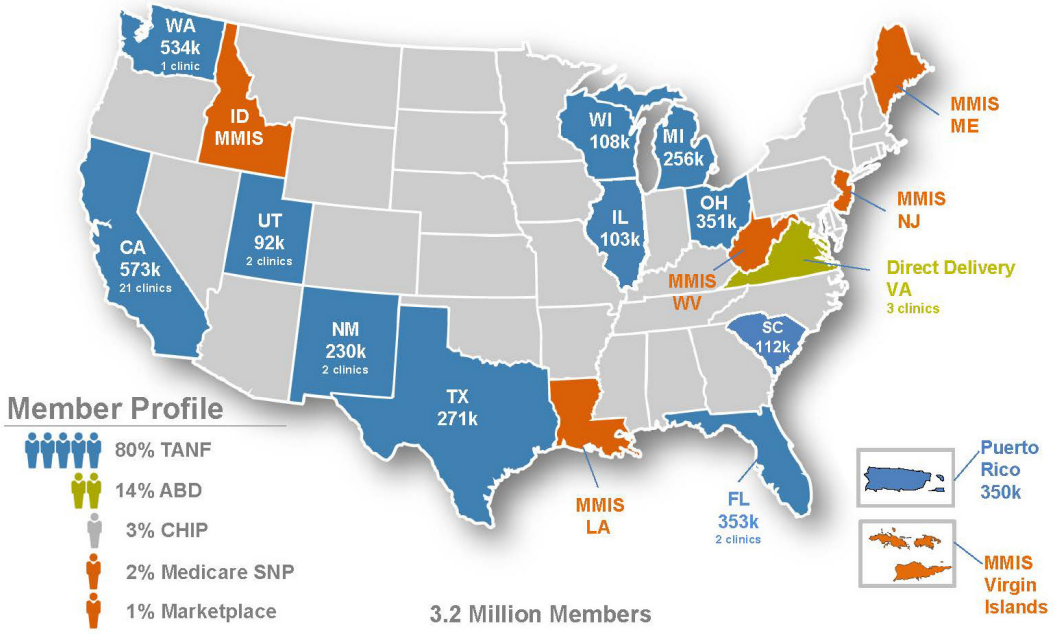
Molina operates licensed health plans in California, Florida, Illinois, Michigan, New Mexico, Ohio, South Carolina, Texas, Utah, Washington and Wisconsin and the Commonwealth of Puerto Rico. In aggregate, our 12 health plans serve nearly 3.2 million Medicaid, Medicare and Marketplace members, which consist of TANF, Aged, Blind or Disabled (ABD) and/or Long-term Care (LTC) members; CHIP members; Medicare Advantage Special Needs Plan (SNP) members; and Marketplace members. Molina is also participating in Medicare-Medicaid Plan (Dual Eligible) demonstrations in five states, the most of any MCO in the nation, and is serving more than 80,000 Dual Eligible members. Nationally reported data indicates that Molina currently has the second largest enrollment of Dual Eligible individuals amongst managed care organizations nationwide.

Molina has achieved National Committee for Quality Assurance (NCQA) accreditation for nine of its 12 health plans (California, Florida, Michigan, New Mexico, Texas, Ohio, Utah, Washington and Wisconsin). These NCQA accredited health plans are ranked in the top 100 nationwide by the NCQA.

The health plans most recently added to the Molina family located in Illinois, South Carolina and the Commonwealth of Puerto Rico are not yet accredited, however, accreditation will be pursued as soon as possible.

Molina also owns and/or operates 31 direct delivery primary care clinics serving more than 125,000 patients in California, Florida, New Mexico, Utah, Virginia and Washington, providing deeper insight and understanding of the care delivery challenges faced by providers and members than any other health plan. Through these clinics, Molina collectively provides some 162,000 annual primary care visits.

Molina Healthcare, Inc. Markets Nationwide



Moreover, Molina provides business processing and information technology administrative services to Medicaid agencies through its subsidiary, Molina Medicaid Solutions, which holds Medicaid Management Information Systems (MMIS) fiscal agent contracts in five states as well as a contract to provide drug rebate administration services for the Florida Medicaid Pharmacy program. The combined services of all Molina's fiscal agent contracts (excluding the Florida Medicaid Pharmacy Program) touch approximately 3.8 million Medicaid beneficiaries and 325,000 providers, making Molina one of the nation's largest Medicaid vendors.

Molina's operations nationwide are guided by core managed care principles that support a careful balance of providing positive member outcomes with cost-effective quality care. These principles include:

- Maintaining direct oversight responsibilities for delivery of services;
- Improving quality of care through increased continuity of care;
- Ensuring appropriate care settings through provision of private physician office care in lieu of time consuming, costly Emergency Room care;
- Ensuring appropriate use of Home and Community Based Services (HCBS) to avoid or reduce nursing facility usage and encourage independence;
- Utilizing recognized performance metrics, such as Healthcare Effectiveness Data and Information Set (HEDIS) to optimize the quality of care and personal health outcomes; and
- Investing in process improvements that ensure coordinated and integrated care for every member.

Molina's expertise is derived from deep experience in delivering covered benefits, including physical health, behavioral health and long-term services and supports (LTSS) in a highly coordinated manner. Molina operates programs that feature person-centered care coordination across health services and community support systems; medical home initiatives; highly regarded disease management programs. These programs have demonstrated success in managing funding streams across a wide variety of sources, the ability to cover the spectrum of medical and behavioral diagnoses with provider networks that are contoured specifically to member needs; and the technologies requisite for managing all of these programs while providing governmental clients with demonstrated proof of cost effectiveness and quality

enhancements for both Medicaid and Medicare.

Molina's experience with Medicaid-Medicare dual eligibles include Molina Healthcare of California, Illnois, Michigan, Ohio, South Carolina, Texas, which have been selected to participate in the dual eligibles demonstration projects. The dual eligibles demonstration project's goal is to better address the needs of dual eligible beneficiaries by having one entity coordinate care for the total needs of each person – including long-term care, behavioral health, social supports, and medical care. The Molina Healthcare of Washington plan provides long term care services under this structure through the Washington Medicaid Integration Partnership (WMIP) program. The WMIP Program is a managed care pilot program providing benefits for long-term care services, medical, mental health and chemical dependency treatment services. Molina Healthcare of Washington has served as the sole managed care plan for this pilot project since its inception in January 2005. With this demonstrated structure in place, Molina Healthcare of Iowa would be able to accommodate the requirements and perform under the Iowa High Quality Healthcare Initiative Contract within expected time frames.

This experience uniquely qualifies Molina to partner with DHS to modernize the Medicaid program for its Medicaid and CHIP enrollees while leveraging the strength and success of current DHS initiatives for the Iowa Medicaid, Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (hawk-i) programs.

3.2.5.1.2 Reserved

This page reserved for Section 3.2.5.1.2 per RFP Amendment 2.

3.2.5.1.3 Reserved

This page reserved for Section 3.2.5.1.3 per RFP Amendment 2.

3.2.5.1.4 Letters of reference from three (3) of the bidder's previous clients knowledgeable of the bidder's performance in providing services similar to those sought in this RFP, including a contact person, telephone number, and electronic mail address for each reference. It is preferred that letters of reference are provided for services that were procured in a competitive environment.

Molina has provided three (3) letters of reference; refer to:

Attachment 3.2.5.1.4-1 letter of reference
Attachment 3.2.5.1.4-2 letter of reference
Attachment 3.2.5.1.4-3 letter of reference

3.2.5.1.5 Description of experience managing subcontractors, if the bidder proposes to use subcontractors.

Molina has extensive experience managing its subcontractors and has policies and procedures in place to audit and monitor subcontractors data, data submission, and performance, to comply with Contract requirements. For all subcontractors, Molina is accountable and retains responsibility to perform ongoing oversight.

Oversight of subcontractors is conducted by Molina's Delegation Oversight Committee, which includes staff members from the local health plan departments who are involved in the daily management of subcontractors, or who are responsible for monitoring delegated activities, such as performance and compliance with Contract requirements.

The Delegation Oversight Committee meets on an ongoing basis to monitor performance of subcontractors, including periodic formal reviews, at least quarterly. Molina will continually monitor subcontractor metrics and performance in order to recognize high quality performance, identify opportunities for improvement, and where deficient and areas of improvement are identified, implement corrective action up to termination as necessary/warranted. Molina will provide to DHS findings of all subcontractor performance monitoring and reviews upon request and will notify DHS any time a subcontractor is placed on corrective action.

Molina ensure that any subcontractors or vendors it manages are contractually bound to ensure the seamless integration of services in compliance with DHS requirements, including:

- Clear communication and training;
- Recurring joint operations meetings between Molina and subcontractors/vendors; and
- Mandatory corrective action procedures to address deficiencies within defined time periods.

3.2.5.2 Personnel.

The bidder shall provide the following information regarding personnel:

3.2.5.2.1 Tables of Organization.

Illustrate the lines of authority in two tables:

- ***One showing overall operations***
- ***One showing staff who will provide services under the RFP***

Exhibit 3.2.5.2.1-1 and Exhibit 3.2.5.2.1-2 tables of organization below that illustrate lines of authority in two tables showing overall operations and staff to provide administration of services to members.

Exhibit 3.2.5.2.1-1 – Molina Healthcare of Iowa, Inc. Operations

Molina Healthcare of Iowa, Inc. Operations	
Operations and Functions	**Reports to:**
Contract Administrator/CEO/COO (President)	Regional Director
Medical Director (Chief Medical Officer)	President
Chief Financial Officer (CFO) (Vice President, Finance and Analytics)	President
Compliance Officer	President
Pharmacy Director / Coordinator	Medical Director
Grievance & Appeals Manager	Member Services Manager
Quality Management Manager (Director, Quality Improvement)	Medical Director
Utilization Management Manager	Care Coordination Manager (Vice President, Health Care Services)
Behavioral Health Manager	Care Coordination Manager (Vice President, Health Care Services)
Member Services Manager	President
Provider Services Manager	President
Information Systems Manager	President
Claims Administrator	President
Care Coordination Manager (Vice President, Health Care Services)	President
Program Integrity Manager (AVP, Special Investigation Unit)	President
Long Term Care Manager	Care Coordination Manager (Vice President, Health Care Services)

Exhibit 3.2.5.2.1-2 – Molina Healthcare of Iowa, Inc. Officers and Directors

Molina Healthcare of Iowa, Inc. Officers and Directors	
Name	**Title**
Paul Muench	Interim President
Bery Engebretsen, M.D.	Interim Chief Medical Officer (CMO)

3.2.5.2.2 Names and Credentials of Key Corporate Personnel.

- ***Include the names and credentials of the owners and executives of your organization and, if applicable, their roles on this project.***
- ***Include names of the current board of directors, or names of all partners, as applicable.***
- ***See Attachment 1: Scope of Work Section 2.9.3 for details for requirements for submitting information and resumes for key personnel who will be involved in executing this contract.***

The following is a list of Molina Healthcare, Inc., Key Corporate Personnel. Molina Healthcare Inc., is a Delaware corporation (NYSE: MOH), ownership, executive officers, Board of Directors and members of the Committees of the Board of Directors is provided below.

Ownership, Board, Management and Committee structure

Holders of More than 5% of Stock:

- John C. Molina, as Trustee
- William Dentino, as Trustee
- Curtis Pedersen, as Trustee
- Mary R. Molina Living Trust
- Molina Marital Trust
- BlackRock, Inc.
- Capital World Investors
- FMR LLC

Management, Board of Directors, and Committees of the Board

The Management of Molina Healthcare, Inc.

- President and Chairman of the Board – Joseph M. Molina, MD
- Chief Financial Officer – John C. Molina
- Chief Operating Officer – Terry P. Bayer
- Chief Legal Officer and Secretary – Jeff D. Barlow
- Chief Accounting Officer – Joseph W. White

The Board of Directors of Molina Healthcare, Inc.

- Joseph M. Molina, MD
- John C. Molina
- Garrey E. Carruthers, PhD
- Daniel Cooperman
- Frank E. Murray, MD
- John P. Szabo, Jr.
- Charles Z. Fedak
- Steven G. James

- Steven J. Orlando
- Ronne E. Romney
- Dale B. Wolf

Committees of the Board of Directors of Molina Healthcare, Inc.

Audit Committee

- Steven J. Orlando
- Charles Z. Fedak
- Steve G. James
- John P. Szabo, Jr.
- Daniel Cooperman

Compensation Committee

- Dale B. Wolf
- Charles Z. Fedak
- Steven J. Orlando
- Ronna E. Romney
- John P. Szabo, Jr.

Governance and Nominating Committee

- Daniel Cooperman
- Garrey E. Carruthers, PhD
- Frank E. Murray, MD
- Ronna E. Romney
- Dale B. Wolf

Compliance Committee

- Garrey E. Carruthers, PhD
- Frank E. Murray, MD
- Steven G. James
- John C. Molina

3.2.5.2.3 Information About Key Project Personnel.

- ***Provide name and a general description of proposed Key Personnel as set forth in Section 2.9.3 of RFP Attachment 1. Scope of Work. Include the qualifications, number of years of experience in their field, and the proposed location from which the position shall be based. Provide resumes for each of these Key Personnel behind Tab 6 of the Bid Proposal. If they key staff person is not yet identified, state so in the response to this subsection.***

Contract Administrator/CEO/COO (President)

Paul Muench is the interim Administrator/CEO/COO (President) with clear authority over the general administration and implementation of the requirements detailed in the Contract. Mr. Muench is responsible for overseeing the entire operations of Molina Healthcare of Iowa and has full and final responsibility for contract compliance and will foster a success-oriented, accountable environment. This position provides the leadership, management and vision necessary to ensure that Molina has the proper administrative and reporting procedures and people systems in place to effectively support growth. Refer to Tab 6 Attachment 3.2.7.3-1 for the Contract Administrator/CEO/COO's (Plan President) Paul Muench resume.

Medical Director (Chief Medical Officer)

Bery Engebretsen, M.D. is the interim Medical Director (Chief Medical Officer), who is a licensed physician in the State of Iowa in good standing and will be located in Iowa. The Chief Medical Officer is responsible for oversight of all clinical functions including, but not limited to, disease management and care coordination programs, the development of clinical care guidelines and utilization management; also, responsible for the coordination and implementation of the Quality Management and Improvement Program. The Medical Director will attend and actively participate in any scheduled quality committee meetings as directed by DHS, and will direct Molina's internal utilization management committee. Refer to Tab 6 Attachment 3.2.7.3-2 for the Medical Director's resume.

Chief Financial Officer (CFO) (Vice President, Finance and Analytics) (To be hired)

The Vice President, Finance and Analytics is responsible for overseeing Molina's budget, accounting systems and financial reporting for the program.

Compliance Officer (To be hired)

The Compliance Officer is accountable to Molina's executive leadership and dedicated full-time to the Contract. This individual will be the primary liaison with the State (or its designees) to facilitate communications between DHS, the State's contractors and the Contractor's executive leadership and staff. This individual will maintain a current knowledge of federal and state legislation, legislative initiatives and regulations that may impact the program. The Compliance Officer is responsible for complying with all HIPAA and privacy regulations as well as coordinate reporting to the State and to review the timeliness, accuracy and completeness of reports and data submissions to the State. The Compliance Officer, in close coordination with other Key Personnel, has primary responsibility for ensuring all Contractor functions are in compliance with the terms of the Contract.

Pharmacy Director/Coordinator (To be hired)

The Pharmacy Director is an Iowa licensed pharmacist who oversees the pharmacy benefits under the Contract. The Pharmacy Director has experience as a Medicaid Pharmacy Director or equivalent Medicaid pharmacy experience, inclusive of drug rebate and is responsible for oversight and coordination of all Contractor and Pharmacy Benefit Manager (PBM) pharmacy requirements including drug rebate. The Pharmacy Director will attend DHS Pharmaceutical & Therapeutics (P&T) Committee and Drug Utilization Review (DUR) Commission meetings.

Grievance and Appeals Manager (To be hired)

The Grievance and Appeals Manager manages Molina's grievance and appeals process, ensuring compliance with processing timelines and policy and procedure adherence.

Quality Management Manager (To be hired)

The Quality Manager is an Iowa licensed registered nurse, physician or physician's assistant or a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (HCQM) by the American Board of Quality Assurance and Utilization Review Physicians. The Quality Manager is responsible for overseeing Molina's Quality Management and Improvement program and ensuring compliance with quality management requirements and quality improvement initiatives.

Utilization Management Manager (To be hired)

The Utilization Manager is an Iowa licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations. This position manages all elements of the Contractor's utilization management program and staff under the supervision of the Medical Director. This includes, but is not limited to functions related to prior authorization, medical necessity determinations, concurrent and retrospective reviews, and other clinical and medical management programs as described in Section 11.

Behavioral Health Manager (To be hired)

The Behavioral Health Manager is an Iowa licensed behavioral health professional such as a psychologist, psychiatrist, social worker, psychiatric nurse, marriage and family therapist or mental health counselor with experience in both mental health and substance use disorder services. The Behavioral Health Manager is responsible for ensuring that Molina's behavioral health operations, which include the operations of any behavioral health subcontractors, are in compliance with the terms of the Contract. The Behavioral Health Manager coordinates with all functional areas, including quality management, utilization management, network development and management, provider relations, member outreach and education, member services, contract compliance and reporting.

Member Services Manager (To be hired)

The Member Services Manager is responsible for oversight of the member services functions of the Contract, including, but not limited to, member helpline telephone performance, member e-mail communications, member education, the member website, member outreach programs, development, approval and distribution of member materials. The Member Services Manager oversees the interface with the state or its subcontractors regarding such issues as member enrollment and disenrollment.

Provider Services Manager (To be hired)

The Provider Services Manager is responsible for the oversight of the provider services function of the Contract. This includes, but is not limited to, the provider services helpline, provider recruitment, contracting and credentialing, facilitating the provider claims dispute process, developing and distributing the provider manual and education materials and developing provider outreach programs. The Provider Services Manager, in close coordination with other Key Personnel, is responsible for ensuring that all of the Contractor's provider services operations are in compliance with the terms of the Contract.

Information Systems Manager (To be hired)

The Information Systems (IS) Manager serves as a liaison between Molina and DHS regarding encounter claims submissions, capitation payment, member eligibility, enrollment and other data transmission interface and management issues. The IS Manager, in close coordination with other Key Personnel, is responsible for ensuring all information system security and controls, program data transactions, data exchanges other information system requirements are in compliance with the terms of the Contract, and all data submissions required for federal reporting.

Claims Administrator (To be hired)

The Claims Administrator is responsible for ensuring prompt and accurate provider claims processing in accordance with the terms of the Contract.

Care Coordination Manager (To be hired)

The Care Coordination Manager is responsible for oversight care coordination and community-based case management programs. The Care Management Manager is a registered nurse or other medical professional with extensive experience in providing care coordination to a variety of populations. The individual will be responsible for overseeing care coordination and community-based case management teams, care plan development and care plan implementation.

Program Integrity Manager (To be hired)

The Program Integrity Manager is responsible for oversight of Molina's special investigations unit (SIU) activity. The Program Integrity Manager will serve as the liaison between the MCO and state agencies, law enforcement, and federal agencies. The Program Integrity Manager must be informed of current trends in fraud, waste, and abuse as well as mechanisms to detect such activity.

Long Term Care Manager (To be hired)

The Long Term Care Manager is responsible for oversight of Molina's implantation of the state's community based and facility programs. The Long Term Care Manager has at least five years of experience in long term care policy and has a comprehensive understanding of CMS rules and regulations. The Long Term Care Manager is responsible for overseeing long-term care provider reviews, utilization reviews, member satisfaction surveys, and member health and welfare.

Upon award of the Contract, Molina will deliver the final staffing plan within ten (10) calendar days of the execution of the contract, including a resume for each Key Personnel member.

3.2.5.3 Reserved

This page reserved for Section 3.2.5.3 per RFP Amendment 2.

3.2.5.4 Termination, Litigation, and Investigation.
Bid Proposals must indicate whether any of the following conditions have been applicable to the bidder, or a holding company, parent company, subsidiary, or intermediary company of the bidder during the past five (5) years that relate to services contemplated by this RFP unless otherwise noted. If any of the following conditions are applicable, then the bidder shall state the details of the occurrence. If none of these conditions is applicable to the bidder, the bidder shall so indicate.

- ***List any contract for services that the bidder has had that was terminated for convenience, non-performance, non-allocation of funds, or any other reason for which termination occurred before completion of all obligations under the contract provisions.***

Molina Healthcare of Iowa, Inc. has not had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason during the past five (5) years before completion of its obligations under any contractual provisions.

Molina Healthcare, Inc., the parent corporation of Molina Healthcare of Iowa, Inc., is also the parent corporation of 12 other licensed health plans operating in the states and/or territories of California, Florida, Illinois, Michigan, New Mexico, Ohio, Puerto Rico, South Carolina, Texas, Utah, Washington, and Wisconsin. Each health plan is in good standing in its relevant state, and the Medicaid contract between each health plan and its state remains in full force and effect. None of these contracts have been subject to early termination for any reason, including but not limited to convenience, non-performance, non-allocation of funds during the past five (5) years.

- ***List any occurrences where the bidder has either been subject to default or has received notice of default or failure to perform on a contract. Provide full details related to the default or notice of default including the other party's name, address, and telephone number.***

There are no occurrences where Molina has either been subject to default or has received notice of default or failure to perform on a contract.

- ***List any damages, penalties, disincentives assessed, or payments withheld, or anything of value traded or given up by the bidder under any of its existing or past contracts as it relates to services performed that are similar to the services contemplated by this RFP. Include the estimated cost of that incident to the bidder with the details of the occurrence.***

Molina has not paid any damages or penalties, had any disincentives assessed or payment withheld, or given up anything of value under any of its existing or past contracts as it relates to services performed that are similar to the services contemplated by this RFP.

- ***List and summarize any current pending or threatened litigation, administrative or regulatory proceedings, or similar matters related to the subject matter of the services sought in this RFP. Bidders may limit disclosure of these matters to a material threshold established by GAAP requirements.***

Refer to Attachment 3.2.5.4-1 Litigation Chart.

- ***List any irregularities that have been discovered in any of the accounts maintained by the bidder on behalf of others. Describe the circumstances of irregularities or variances and detail how the issues were resolved.***

There have been no irregularities discovered in any of the accounts maintained by the bidder on behalf of others.

- ***List any details of whether the bidder or any owners, officers, primary partners, staff providing services or any owners, officers, primary partners, or staff providing services of any subcontractor who may be involved with providing the services sought in this RFP, have ever had a founded child or dependent adult abuse report, or been convicted of a felony. Staff providing services shall include anyone having contact with members or member data.***

Molina is unaware of any cases.

Note: Failure to disclose information about the matters in this section may result in rejection of the Bid Proposal or in termination of any subsequent contract. The subject matter in the sixth unnumbered bullet of this subsection is a continuing disclosure requirement. Any such matter commencing after submission of a Bid Proposal, and with respect to the successful bidder after the execution of a contract, shall be disclosed in a timely manner in a written statement to the Agency. For purposes of this subsection, timely means within thirty (30) days from the date of conviction, regardless of appeal rights.

3.2.6 Information to Include Behind Tab 5: Attachments

Any attachments that the Bidder deems necessary to further clarify or support its proposal may be placed behind this Tab.

MOLINA HEALTHCARE

Thank you

for Participating in Molina Rewards Program!

Please fill in below to receive your free gift.

First Name:

Last Name:

Street:

Suite/Apt:

City:

State:

Zip Code:

Email:

Phone:

All items must be complete in order to fill your order.

Items take 7-10 days for delivery. Your items will come directly from Walmart. We are not able to deliver to PO Boxes.

Items may be replaced with a different item of the same value, if available.

❑ The Night Before Kindergarten

❑ A Walk to Remember

❑ Aveeno Baby Wash Shampoo

❑ Desitin

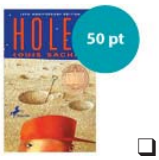
❑ The Rescue

❑ Huggies Natural Care Wipes

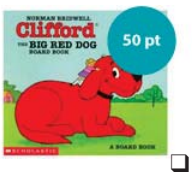
❑ Pacifier Clip

❑ The Bucket List DVD

❑ The Notebook



❑ Holes



❑ Clifford

❑ Pampers Natural Clean Wipes

38540CORP0814

Bedtime Lotion

Pampers Soft Care Baby Wipes

Mini Bottles

Catching Fire

Miracle DVD

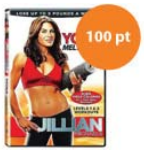
Pilates Mini Ball

Baby Massage Book

Boy Sleep-n-Play Pajamas

Girl Sleep-n-Play Pajamas

Baby Sign Language



Jillian Michaels Yoga Meltdown DVD

Medipeds Diabetes Socks Large

The Help DVD

The Help

The Hunger Games

Onesies

Formula Dispenser

Chutes and Ladders

Gold's Loops

Green Eggs and Ham

Gold's Tube

Very Hungry Caterpillar

Safety Gate

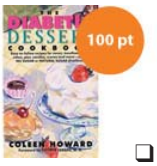
Girl's Baby Sleeper

Girl Bottles Mini

Curious George Book Set

Sleepers

Mickey Mouse Clubhouse DVD



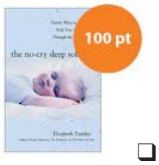
Diabetic Dessert Cookbook

Big Board First 100 Words

Child Proofing Kit

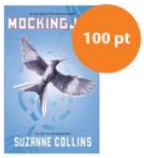
Twister

Blanket



The No-Cry Sleep Solution

First 100 Animals



Mocking Jay

Toes, Ears, and Nose Book

Thermometer

Medipeds Diabetes Socks Medium

Spider Man DVD

Boys Baby Blanket

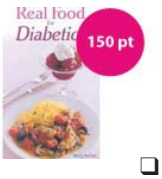
Teether

The Sandlot DVD

Tone Fitness Jump Rope

The Notebook WS DVD

Grins and Giggles Cleanser



Real Food for Diabetics

Jenga

150 pt
Bright Starts Remote

150 pt
Munchkin Toddler Feeding Set

150 pt
PG
Despicable Me DVD

150 pt
First Aid Kit

150 pt
Pacifiers

150 pt
Tile Lock Scrabble

950 pt
TI-84 Plus Calculator

150 pt
5.4 Quart Sharps Collector

150 pt
Vicks - Pediatric Baby Thermometer

150 pt
Pink Yoga Mat

150 pt
Altus Weighted Jump Rope

150 pt
Girl Bibs

150 pt
New Balance Duffle Bag

150 pt
Stott Pilates Water Bottle

150 pt
PG 13
Home Run DVD

150 pt
Monopoly

150 pt
Girl's Bottles Large

150 pt
Evenflo Galaxy

150 pt
First Years Take and Toss

150 pt
Boy Bibs

150 pt
PG 13
Transformers DVD

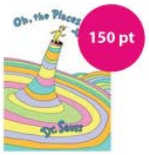
150 pt
Bather

150 pt
New Balance Stopwatch

150 pt
Bottles

150 pt
ProForm Squeeze Water Bottle

150 pt
Mancala Game



150 pt
Oh the Places You'll Go

150 pt
ReliOn Prime Blood Glucose Test Strips

150 pt
Yoga Mat

150 pt
Scattergories

150 pt
Where the Sidewalk Ends

150 pt
Sportline Pedometer

150 pt
Proform Nano Arm Band

150 pt
First Years Take and Toss Variety

150 pt
Official SAT Guide

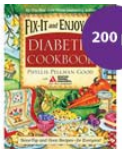
150 pt
Fisher Price First Blocks

150 pt
Wipes

150 pt
Where the Wild Things Are

150 pt
What to Expect

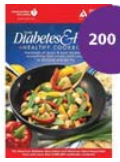
200 pt
Grooming Kit



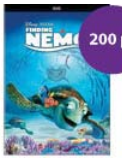
200 pt
Fix-It and Enjoy Cookbook

200 pt
G
Cinderella DVD

200 pt
Don't Break the Ice



200 pt
Diabetes and Heart Healthy Cookbook



200 pt
G
Finding Nemo DVD

500 pt
Shark Mop

200 pt
Baby Gym

200 pt
PG 13
Safe Haven DVD

ReliOn Primer Blood Glusose Monitor

Monsters, Inc. DVD

Peter Pan DVD

Lincoln DVD

Potty Training System

Cars DVD

The Avengers DVD

VTech - Learn & Dance Interactive Zoo

Travelers Luggage Set

Yahtzee

Vicks Warm Steam Vaporizer

Sterilizer

Leslie Sansone Walk it Off DVD

Safety 1st Easy Care Swing Tray Booster Seat

Chair Cart Cover

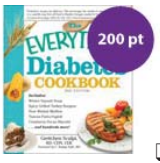
Munchkin Traveler Set

Brave DVD

The Lion King DVD

Dora the Explorer Nap Mat

Kodak FZ51-SL



Everything Diabetes Cookbook

Cars Nap Mat

Gold's Exercise Ball

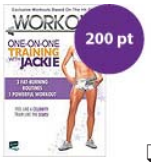
Aluratek Photo Frame

Cars 2 DVD

Fresh Baby Cookbook Pack

Care Timer

iHome iP90



Workout One-on-One Training

Apples to Apples

Bright Starts Giraffe

The Great Gatsby DVD

Toppers Sun Seeker Canvas Tote

Up

Therafirm Women's Ribbed Trouser socks

Guess Who

Carrier

Stability Ball

Swaddle Blankets

Operation Game

Eating Well Diabetes Cookbook

Princess and the Frog Saucer Chair

SmartKnit Seamless Diabetic Wide Crew Socks

Toy Story Saucer Chair

Wreck It Ralph DVD

Richard Simmons Blast and Tone

Pedometer

Danskin Now Yoga Mat

Healthy Carb Diabetes Cookbook

Baker Eze Bakeware Set

Vertigo MP3 Player

Billy Blanks Tae Bo Power DVD

Sportline 480 Tough Timer Stopwatch

Toppers Sport Bag

Maglite Flashlight

LG DVD Player

Apollo Tool Kit

Baby Monitor

Car Seat

Booster Seat

Crock Pot

Apple iPod Shuffle

Shop Vac

La Crosse Clock

Hamilton Food Processor

Trademark Drill Set

Baby Trend Victoria

Leap Frog Leap Pad 2

NEXT Girls Bike

Surge Boys Bike

InStep Jogger

Philips DVD Player

❑ Baby Trend Deluxe Havenwood

Diapers

- ❑ 0-10 lbs
- ❑ 8-14 lbs
- ❑ 12-18 lbs
- ❑ 16-28 lbs

Huggies Little Snugglers Diapers

- ❑ 0-10 lbs
- ❑ 10-14 lbs
- ❑ 12-18lbs

Huggies Snug and Dry Diapers

- ❑ 8-14 lbs
- ❑ 12-18 lbs
- ❑ 16-28 lbs
- ❑ 22-37 lbs
- ❑ Over 27 lbs
- ❑ Over 35 lbs

Parent's Choice Value Pack

- ❑ 16-28 lbs
- ❑ 22-37 lbs
- ❑ 27 lbs,
- ❑ 35+ lbs

Molina Healthcare, Inc.'s Member Rewards Program
Agreement and Waiver of Liability

Molina Healthcare is starting a Member Rewards Program for members like you. This program gives points for doing things that are good for your health. You can use the points you earn to get gifts. Joining the Member Rewards Program is up to you. It is ok if you decide not to do it. Your Molina membership will not change.

If you would like to take part in the Member Rewards Program, you have to agree to follow the program rules. One of the rules is that you cannot hold Molina responsible if a program gift hurts you. This means you cannot sue Molina if you or your family is hurt by a gift. You take risks when using some of the gifts offered in the Member Rewards Program.

Terms and Conditions:

1. I understand being in the Member Rewards Program is at my own risk.
2. I am responsible if my family gets sick or hurt by using gifts from the program.
3. I will not blame Molina for any harm that happens to me or my family from using the gifts from the Member Rewards Program.
4. I release Molina from any liability it may have for program gifts.

☐ By checking the box you are saying you understand the terms and conditions of this Member Rewards Program. You are also saying that you agree to follow the rules.

Signature _____ Date _____

Print Name _____ Relation to Molina Member _____

3.2.7 Information to Include Behind Tab 6: RFP Forms, Financial Statements, Resumes, and Contract Lists

The following items should be included in Tab 6 and will not count toward the 1000 page limit:

3.2.7.1 RFP Forms
The forms listed below are exhibits to this RFP. Fully complete and return these forms behind Tab 3:

- ***Release of Information Form***
- ***Primary Bidder Detail & Certification Form***
- ***Subcontractor Disclosure Form (one for each proposed subcontractor)***

Refer to Attachment 3.2.7.1-1 Exhibit A. Release of Information Form.
Refer to Attachment 3.2.7.1-2 Exhibit B. Primary Bidder Detail & Certification Form.
Refer to Attachment 3.2.7.1-3 Exhibit C. Subcontractor Disclosure Forms and LOA.

Exhibit A: Release of Information

(Return this completed form behind Tab 6 of the Bid Proposal.)

Molina Healthcare of Iowa, Inc. (name of bidder) hereby authorizes any person or entity, public or private, having any information concerning the bidder's background, including but not limited to its performance history regarding its prior rendering of services similar to those detailed in this RFP, to release such information to the Agency.

The bidder acknowledges that it may not agree with the information and opinions given by such person or entity in response to a reference request. The bidder acknowledges that the information and opinions given by such person or entity may hurt its chances to receive contract awards from the Agency or may otherwise hurt its reputation or operations. The bidder is willing to take that risk. The bidder agrees to release all persons, entities, the Agency, and the State of Iowa from any liability whatsoever that may be incurred in releasing this information or using this information.

Molina Healthcare of Iowa, Inc.
Printed Name of Bidder Organization

Phyllis Simon
Signature of Authorized Representative

May 4, 2015
Date

Phyllis Simon
Printed Name

Exhibit B: Primary Bidder Detail Form & Certification

(Return this completed form behind Tab 6 of the Proposal. If a section does not apply, label it "not applicable".)

Primary Contact Information (individual who can address issues re: this Bid Proposal)	
Name:	Phyllis Simon
Address:	200 Oceangate, Long Beach, California 90802
Tel:	(562) 901-1038
Fax:	
E-mail:	Phyllis.Simon@MolinaHealthcare.com

Primary Bidder Detail	
Business Legal Name ("Bidder"):	Molina Healthcare of Iowa, Inc.
"Doing Business As" names, assumed names, or other operating names:	N/A
NAIC Number:	To Be Assigned
Parent Corporation, if any:	Molina Healthcare, Inc.
Form of Business Entity (i.e., corp., partnership, LLC, etc.):	Corporation
State of Incorporation/organization: **Primary Address:**	Iowa Hub Tower, 699 Walnut Street, 4th Floor, Des Moines, IA 50309
Tel:	
Fax:	
Local Address (if any):	
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	200 Oceangate, Long Beach, California 90802
Number of Employees:	To Be Determined
Number of Years in Business:	0
Primary Focus of Business:	Healthcare
Federal Tax ID:	To Be Assigned
Bidder's Accounting Firm:	
If Bidder is currently registered to do business in Iowa, provide the Date of Registration:	
Do you plan on using subcontractors if awarded this Contract? {If "YES," submit a Subcontractor Disclosure Form for each proposed subcontractor.}	**YES**

Request for Confidential Treatment (See Section 3.1)		
Location in Bid (Tab/Page)	**Statutory Basis for Confidentiality**	**Description/Explanation**
Tab 1, pp 3 - 4	Proprietary	Molina Key Relationships
Tab 1, pp 4 - 5	Proprietary	Provider Incentive Programs
Tab 1, pp 7 - 8	Proprietary	Attachment 3.2.1-1 IPCA-Iowa Letter of Support (Entire Attachment Removed; Not Included in Public Copy)
Tab 3, pp 16 - 18	Proprietary	Recommendations

Tab 3, pp 19 - 20	Proprietary	Recommendations
Tab 3, pp 21 - 23	Proprietary	Recommendations
Tab 3, p 32	Proprietary	Key Relationships
Tab 3, p 35	Proprietary	Future QHP Filing
Tab 3, p 39	Proprietary	Performance Guarantees
Tab 3, p 64	Proprietary	Implementation Plan
Tab 3, p 223	Proprietary	Palantir
Tab 3, p 234	Proprietary	Palantir
Tab 3, pp 262 - 269	Proprietary	Value-added Services
Tab 3, p 269	Proprietary	Value-added Services Outcomes
Tab 3, p 358	Proprietary	Letters of Intent
Tab 3, p 358	Proprietary	Key Providers
Tab 3, pp 358 - 359	Proprietary	Provider Network Partnerships
Tab 3, pp 359 - 360	Proprietary	FQHC Provider Partnerships
Tab 3, pp 362 - 363	Proprietary	On With Life Partnership
Tab 3, p 369	Proprietary	Anticipated Network Development Challenges
Tab 3, pp 371-372	Proprietary	Value-based Reimbursement Approach
Tab 3, pp 402 - 403	Proprietary	Provider Network Partnerships
Tab 3, p 413	Proprietary	Letters of Intent
Tab 3, p 612	Proprietary	Palantir
Tab 3, p 613	Proprietary	Pay-for-Performance
Tab 3, pp 619 - 652	Proprietary	Attachment 10.2.5-1 QI Draft Work Plan (Entire Attachment Removed; Not Included in Public Copy)
Tab 3, pp 669 - 670	Proprietary	Palantir
Tab 3, p 673	Proprietary	Palantir
Tab 3, pp 723 - 734	Proprietary	Attachment 12.1-1 Draft Compliance Plan (Entire Attachment Removed; Not Included in Public Copy)
Tab 3, pp 735 - 766	Proprietary	Attachment 12.1-2 Draft FWA Plan (Entire Attachment Removed; Not Included in Public Copy)

Tab 3, p 771	Proprietary	Palantir
Tab 3, pp 823 - 833	Proprietary	Attachment 13.1.4-1 Project Implementation Plan (Entire Attachment Removed; Not Included in Public Copy)
Tab 3, pp 869 - 937	Proprietary	Attachment 13.2.1-1 Sample BC-DR Plan (Entire Attachment Removed; Not Included in Public Copy)
Tab 4, pp 957 - 959	Proprietary	Attachments 3.2.5.1.4-1, 3.2.5.1.4-2 and 3.2.5.1.4-3 Letters of Reference (Each Attachment Removed; Not Included in Public Copy)
Tab 4, pp 970 - 974	Proprietary	Attachment 3.2.5.4-1 Litigation Chart (Entire Attachment Removed; Not Included in Public Copy)
Tab 5, pp 976 - 983	Proprietary	Attachment 6.1.1-1 Molina Provider Network GeoAccess Maps (Entire Attachment Removed; Not Included in Public Copy)
Tab 6, pp 999 – 1011	Proprietary	Exhibit C Subcontractor Forms (Each of the Four Attachments Removed; Not Included in Public Copy)
Tab 6, pp 1017 - 1018	Proprietary	Attachment 3.2.7.3-1 Paul Muench Resume (Entire Attachment Removed; Not Included in Public Copy)
Tab 6, pp 1019 - 1022	Proprietary	Attachment 3.2.7.3-2 Bery Engebretsen, MD Resume (Entire Attachment Removed; Not Included in Public Copy)
Tab 6, pp 1105 - 1115	Proprietary	Attachment 2.14.1-1 Project Implementation Plan (Entire Attachment Removed; Not Included in Public Copy)

BID PROPOSAL CERTIFICATION

By signing below, Bidder certifies that:

1. Reserved.
2. Bidder accepts all capitation rates established by the Agency via the Agency's actuary.
3. Bidder has reviewed the Additional Certifications, which are incorporated herein by reference, and by signing below represents that Bidder agrees to be bound by the obligations included therein.
4. Bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;
5. Reserved;
6. Bidder has received any amendments to this RFP issued by the Agency;
7. Bidder either is currently registered to do business in Iowa or agrees to register if Bidder is awarded a Contract pursuant to this RFP;
8. The person signing this Bid Proposal certifies that he/she is the person in the Bidder's organization responsible for, or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive agreements outlined above;
9. Bidder specifically stipulates that the Bid Proposal is predicated upon the acceptance of all terms and conditions stated in the RFP and the Sample Contract without change.
10. Bidder certifies that the Bidder organization has sufficient personnel resources available to provide all services proposed by the Bid Proposal, and such resources will be available on the date the RFP states services are to begin. Bidder guarantees personnel proposed to provide services will be the personnel providing the services unless prior approval is received from the Agency to substitute staff;
11. Bidder certifies that if the Bidder is awarded the contract and plans to utilize subcontractors at any point to perform any obligations under the contract, the Bidder will (1) notify the Agency in writing prior to use of the subcontractor, and (2) apply all restrictions, obligations, and responsibilities of the resulting contract between the Agency and contractor to the subcontractors through a subcontract. The contractor will remain responsible for all Deliverables provided under this contract.
12. Bidder guarantees the availability of the services offered and that all Bid Proposal terms, including price, will remain firm until a contract has been executed for the services contemplated by this RFP or one year from the issuance of this RFP, whichever is earlier; and,
13. Bidder certifies it is either a) registered or will become registered with the Iowa Department of Revenue to collect and remit Iowa sales and use taxes as required by Iowa Code chapter 423; or b) not a "retailer" of a "retailer maintaining a place of business in this state" as those terms are defined in Iowa Code subsections 423.1(42) & (43). The Bidder also acknowledges that the Agency may declare the bid void if the above certification is false. Bidders may register with the Department of Revenue online at: http://www.state.ia.us/tax/business/business.html.

By signing below, I certify that I have the authority to bind the Bidder to the specific terms, conditions and technical specifications required in the Agency's Request for Proposals (RFP) and offered in the Bidder's Proposal. I understand that by submitting this Bid Proposal, the Bidder agrees to provide services described herein which meet or exceed the specifications of the Agency's RFP unless noted in the Bid Proposal and at the prices quoted by the Bidder. I certify that the contents of the Bid Proposal are true and accurate and that the Bidder has not made any knowingly false statements in the Bid Proposal.

Signature:	Phyllis Simon
Printed Name/Title:	Phyllis Simon, Molina Healthcare, Inc. Associate VP Proposal Responses
Date:	May 4, 2015

3.2.7.2 Financial Statements.
The bidder shall submit audited financial statements from independent auditors for the last three (3) years for the bidder and the ultimate controlling parent of the bidder, if any. Entities not required to have audited financial statements may submit CPA-prepared. Entities not required to have audited financial statements may submit CPA-prepared unaudited financial statements. Please submit your NAIC number in Exhibit B. While considered a part of Tab 6, copies of financial statements should be bound and labeled separately from the rest of the proposals. Please see the table Section 3.1 for further instructions on how to submit financial statements.

Molina has submitted its Audited Financial Statements as indicated below:

Refer to Attachment 3.2.7.2-1 Audited Financial Statement for 2014.
Refer to Attachment 3.2.7.2-2 Audited Financial Statement for 2013.
Refer to Attachment 3.2.7.2-3 Audited Financial Statement for 2012.

Please see separate binder labeled "Financial Statements" for Attachment 3.2.7.2-1 in compliance with the State's requirements in RFP Amendment 2.

Please see separate binder labeled "Financial Statements" for Attachment 3.2.7.2-2 in compliance with the State's requirements in RFP Amendment 2.

Please see separate binder labeled "Financial Statements" for Attachment 3.2.7.2-3 in compliance with the State's requirements in RFP Amendment 2.

3.2.7.3 Resumes
Put staff resumes referenced in RFP Section 3.2.5.2.3 here.

Refer to Attachment 3.2.7.3-1 Paul Muench Resume for the resume of the Contract Administrator/CEO/COO and Attachment 3.2.7.3-2 Bery Engebretsen, MD Resume for the resume of the Chief Medical Officer.

Upon award of the Contract, Molina will deliver the final staffing plan within ten (10) calendar days of the execution of the contract, including a resume for each Key Personnel member.

3.2.7.4 Contract Lists
3.2.7.4.1 Reserved.
3.2.7.4.2 Table
1. Identify in table format all of your publicly-funded managed care contracts for Medicaid, CHIP and other low-income populations within the last five (5) years. If a Bidder does not have direct experience, it may include the experience of its parent company if it includes a parent guarantee with its proposal. For each prior experience identified, provide a brief description of the following:
a. Scope of work and covered benefits (state whether physical health, behavioral health, and long-term services and supports (LTSS) were in or out of scope);
b. Duration of the contract;
c. Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s);
d. Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s);
e. Contact name and phone number, and email address;
f. Number of members served by population type;
g. Annual contract payments and description if payment was capitated;
h.Any improvements made in utilization trends and quality indicators;
i. How the contract emphasizes member choice, access, safety, independence, and responsibility; and
j. The role of subcontractors, if any.

See Attachment 3.2.7.4.2-1 Managed Care Contracts for Molina's publicly-funded managed care contracts for Medicaid, CHIP and other low-income populations within the last five (5) years.

2. Identify and describe any debarment or suspension, regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity within the last five (5) years.

Molina Healthcare of Iowa, Inc. is a newly formed entity, formed for the purposes of participating in various Iowa Medicaid programs. Molina Healthcare of Iowa, Inc. has not had any debarment or suspension, regulatory action, or sanction imposed on it by any federal or state regulatory entity.

3. Identify and describe any letter of deficiency issued by or corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relates to Medicare, Medicaid, CHIP, or the Substance Abuse Use Prevention and Treatment Block Grant.

Molina Healthcare of Iowa, Inc. is a newly formed entity, formed for the purposes of participating in various Iowa Medicaid programs. Consequently, Molina Healthcare of Iowa, Inc. has not been issued any letters of deficiency nor has it received any requests for corrective actions.

3.2.7.4.3 Description of all contracts and projects currently undertaken by the bidder. This shall include all contracts that have not expired, have not been completed, or have not been terminated. Descriptions of similar services (above) do not need to be repeated again in this section. If a Bidder does not have current contracts and projects, it may include those of its parent company if it includes a parent guarantee with its proposal.

Refer to Attachment 3.2.7.4.2-1 Managed Care Contracts for a description of all Molina's contracts and projects currently under taken by Molina.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Molina Healthcare of California California Dept. of Health Care Services – Medi-Cal Managed Care Division									
Medi-Cal Geographic Managed Care (GMC), Sacramento County, Primary– Contract between Department of Health Care Services and Molina Healthcare of California Partner Plan, Inc. (No. 07-65851); provides healthcare services to eligible Medi-Cal recipients within the scope of benefits including coordination and approval of all medically necessary services, claims processing, member services, provider relations and network development. Is "physical health coverage" within the scope of this contract? (yes/no) –yes (when medically necessary)	01/01/2008 - 12/31/2019	Original Start Date: 10/26/2001 Original End Date: 12/31/2002 Were there any alterations to this original time frame? Yes If so, please provide reasons for the alterations: Contract Extensions	*	Tereza Majkovica, DHCS Contract Manager, 916-449-5106 Tereza.Majkovica@dhcs.ca.gov	Medicaid Lives as of 3/2015 = 55,085 Population Type: Medicaid, ABD, TANF	2014 Annual Revenue = $171,398,249 Capitated	Healthcare Effectiveness Data and Information Set (HEDIS®) is mostly widely used set of health care performance measure on important preventive and clinical services across five domains of care. Annual HEDIS® rates are analyzed and evaluated to determine the outcome of preventive health services delivered to and utilized by members, including but not limited to age recommended and disease specific preventive health services. A set of performance measures are selected annually, referred to as External Accountability Set measures, to evaluate the quality of care delivered by a Managed Care Plan to Medi-Cal and Medicare members. In comparison to the previous year's rates, 2014 HEDIS® results, evaluating the performance of 2013 measurement year, indicated overall	The contract emphasizes Member choice for PCP selection, requirements regarding appointment access standards and safety, independence and responsibility in the member rights and responsibilities	• Pharmacy Benefit Management Services

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes –with limitations outlined in contract Are LTSS within the scope of this contract? (yes/no) No							improvements in multiple measures. In contrast to commonly challenging HEDIS® measures, Medi-Cal population showed statistically significant improvements in the following HEDIS® measures, demonstrating significantly higher rates of preventive services and screenings received or controlled outcomes in comparison to the previous year, further inferring that implemented interventions to address commonly challenging barriers were effective.		
Medi-Cal Geographic Managed Care (GMC) San Diego Primary – Contract between Department of Health Services and Molina Healthcare of California Partner Plan, Inc. (No. 09-86161); provides healthcare services to eligible Medi-Cal recipients within the scope of benefits including coordination and	10/01/2010 – 06/30/2020	Original Start Date: 6/1/2005 Original End Date: 12/31/2007 Were there any alterations to this original time frame? Yes If so, please provide reasons for the alterations:	*	Tereza Majkovica, DHCS Contract Manager, 916-449-5106 Tereza.Majkovica@dhcs.ca.gov	Medicaid Lives as of 3/2015 = 172,285 Population Type: Medicaid, ABD, TANF	2014 Annual Revenue = $429,817,172 Capitated	Healthcare Effectiveness Data and Information Set (HEDIS®) is mostly widely used set of health care performance measure on important preventive and clinical services across five domains of care. Annual HEDIS® rates are analyzed and evaluated to determine the outcome of preventive health services delivered to and utilized by members, including but not limited to age recommended and disease specific preventive health	The contract emphasizes Member choice for PCP selection, requirements regarding appointment access standards and safety, independence and responsibility in the member rights and responsibilities	• Pharmacy Benefit Management Services

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
approval of all medically necessary services, claims processing, member services, provider relations and network development. Is "physical health coverage" within the scope of this contract? (yes/no) Yes – (when medically necessary) Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes –with limitations outlined in contract Are LTSS within the scope of this contract? (yes/no) Yes		Contract extensions					services. A set of performance measures are selected annually, referred to as External Accountability Set measures, to evaluate the quality of care delivered by a Managed Care Plan to Medi-Cal and Medicare members. In comparison to the previous year's rates, 2014 HEDIS® results, evaluating the performance of 2013 measurement year, indicated overall improvements in multiple measures. In contrast to commonly challenging HEDIS® measures, Medi-Cal population showed statistically significant improvements in the following HEDIS® measures, demonstrating significantly higher rates of preventive services and screenings received or controlled outcomes in comparison to the previous year, further inferring that implemented interventions to address commonly challenging barriers were effective.		
Medi-Cal Two-	11/01/2013 –	Original Start	*	Tereza Majkovica, DHCS	Medicaid Lives as	2014 Annual	Healthcare Effectiveness	The contract	• Pharmacy Benefit

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Plan, Imperial County, Primary – Contract between Department of Health Care Services and Molina Healthcare of California Partner Plan, Inc. (No. 13-90285); Provides healthcare services to eligible Medi-Cal recipients within the scope of benefits including coordination and approval of all medically necessary services, claims processing, member services, provider relations and network development. Is "physical health coverage" within the scope of this contract? (yes/no) Yes – (when medically necessary) Is "behavioral health coverage" within the scope of this contract? (yes/no)	10/31/2023	Date: 11/1/2013 Original End Date: 10/31/2018 Were there any alterations to this original time frame? Yes If so, please provide reasons for the alterations: Contract extensions	*	Contract Manager, 916-449-5106 Tereza.Majkovica@dhcs.ca.gov	of 3/2015 = 15,872 Population Type: Medicaid, ABD, TANF	Revenue = $30,035486 Capitated	Data and Information Set (HEDIS®) is mostly widely used set of health care performance measure on important preventive and clinical services across five domains of care. Annual HEDIS® rates are analyzed and evaluated to determine the outcome of preventive health services delivered to and utilized by members, including but not limited to age recommended and disease specific preventive health services. 2015 will be the baseline year for Imperial County.	emphasizes Member choice for PCP selection, requirements regarding appointment access standards and safety, independence and responsibility in the member rights and responsibilities	Management Services

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Yes –with limitations outlined in contract Are LTSS within the scope of this contract? (yes/no) No									
Medi-Cal Two-Plan, Los Angeles County – Molina is a sub-contracted health plan under HealthNet in Los Angeles County; Molina provides healthcare services to eligible Medi-Cal recipients within the scope of benefits including coordination and approval of all medically necessary services, claims processing, provider relations and network development. Is "physical health coverage" within the scope of this contract? (yes/no) Yes –with limitations outlined	02/01/1996 – 12/31/2019	Original Start Date: 2/1/1996 Original End Date: Dependent on HN's Contract with the State Were there any alterations to this original time frame? Yes If so, please provide reasons for the alterations: Contract Extensions	*	Sean O'Brien, Director, Medicaid Expansion & Ancillary Programs, 818-543-9021 Sean.O'Brien@healthnet.com	Medicaid Lives as of 3/2015 = 124,794 Population Type: Medicaid, ABD, TANF	2014 Annual Revenue = $319,983,900 Capitated	Healthcare Effectiveness Data and Information Set (HEDIS®) is mostly widely used set of health care performance measure on important preventive and clinical services across five domains of care. Annual HEDIS® rates are analyzed and evaluated to determine the outcome of preventive health services delivered to and utilized by members, including but not limited to age recommended and disease specific preventive health services. A set of performance measures are selected annually, referred to as External Accountability Set measures, to evaluate the quality of care delivered by a Managed Care Plan to Medi-Cal	The contract emphasizes Member choice for PCP selection, requirements regarding appointment access standards and safety, independence and responsibility in the member rights and responsibilities	• Pharmacy Benefit Management Services

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
in contract Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes – (when medically necessary) Are LTSS within the scope of this contract? (yes/no) Yes							and Medicare members. In comparison to the previous year's rates, 2014 HEDIS® results, evaluating the performance of 2013 measurement year, indicated overall improvements in multiple measures. In contrast to commonly challenging HEDIS® measures, Medi-Cal population showed statistically significant improvements in the following HEDIS® measures, demonstrating significantly higher rates of preventive services and screenings received or controlled outcomes in comparison to the previous year, further inferring that implemented interventions to address commonly challenging barriers were effective.		
Medi-Cal Two-Plan, Riverside/San Bernardino counties, Primary – Contract between Department of Health Care Services and Molina Healthcare of California	08/01/2006 – 03/31/2020	Original Start Date: 4/2/1996 Original End Date: 3/21/2002 Were there any alterations to	*	Tereza Majkovica, DHCS Contract Manager, 916-449-5106 Tereza.Majkovica@dhcs.ca.gov	Medicaid Lives as of 3/2015 = 156,970 Population Type: Medicaid, ABD, TANF	2014 Annual Revenue = $334,105,260 Capitated	Healthcare Effectiveness Data and Information Set (HEDIS®) is mostly widely used set of health care performance measure on important preventive and clinical services across five domains of care. Annual HEDIS® rates are analyzed and evaluated to	The contract emphasizes Member choice for PCP selection, requirements regarding appointment access standards and safety, independence and responsibility in the	• Pharmacy Benefit Management Services

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Partner Plan, Inc. (No. 06-55498); Provides healthcare services to eligible Medi-Cal recipients within the scope of benefits including coordination and approval of all medically necessary services, claims processing, member services, provider relations and network development. Is "physical health coverage" within the scope of this contract? (yes/no) Yes – (when medically necessary) Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes –with limitations outlined in contract Are LTSS within the scope of this		this original time frame? Yes If so, please provide reasons for the alterations: Contract Extensions					determine the outcome of preventive health services delivered to and utilized by members, including but not limited to age recommended and disease specific preventive health services. A set of performance measures are selected annually, referred to as External Accountability Set measures, to evaluate the quality of care delivered by a Managed Care Plan to Medi-Cal and Medicare members. In comparison to the previous year's rates, 2014 HEDIS® results, evaluating the performance of 2013 measurement year, indicated overall improvements in multiple measures. In contrast to commonly challenging HEDIS® measures, Medi-Cal population showed statistically significant improvements in the following HEDIS® measures, demonstrating significantly higher rates of preventive services and screenings received or controlled outcomes in	member rights and responsibilities	

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
contract? (yes/no) Yes							comparison to the previous year, further inferring that implemented interventions to address commonly challenging barriers were effective.		
Medicare–Medicaid Plan (MMP) – Molina is contracted with DHCS and CMS to provide enrollees in Los Angeles, San Diego, Riverside and San Bernardino counties with all services provided under Medicare Part A; all services provided under Medicare Part B; all services provided under Medicare Part D; certain pharmacy products that are covered by Medi-Cal and may not be covered under Medicare Part D; and access to all standard Medi-Cal fee-for-service benefits (excluding ICF/MR services, County-administered	12/18/13-12/31/15, and renews in one-year terms through 12/31/17	Original Start Date: 12/18/13 Original End Date: 12/31/15 Were there any alterations to this original time frame? No If so, please provide reasons for the alterations:	*	Tereza Majkovica, Contract Manager, 916-449-5106 Tereza.Majkovica@dhcs.ca.gov Shirley Jih, Contract Manager, 415-744-3694 Shirley.Jih@cms.hhs.gov	MMP Lives as of 3/2015 = 17,443 Population Type: Medicare/Medicaid Dual Eligible	2014 Annual Revenue = $113,175,719 Capitated	Healthcare Effectiveness Data and Information Set (HEDIS®) is mostly widely used set of health care performance measure on important preventive and clinical services across five domains of care. Annual HEDIS® rates are analyzed and evaluated to determine the outcome of preventive health services delivered to and utilized by members, including but not limited to age recommended and disease specific preventive health services. 2015 will be the baseline year for MMP.	The contract emphasizes Member choice for PCP selection, requirements regarding appointment access standards and safety, independence and responsibility in the member rights and responsibilities.	• Pharmacy Benefit Management Services

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Medi-Cal Specialty Mental Health Services and substance use disorder services, State and County activities to administer IHSS, and Medi-Cal Dental Services, known as Denti-Cal). Is "physical health coverage" within the scope of this contract? (yes/no) Yes – (when medically necessary) Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes –with limitations outlined in contract Are LTSS within the scope of this contract? (yes/no) Yes									
Medicare – Contract between Centers for Medicare &	01/01/2015 - 12/31/2015 (Renews annually	01/01/2006 - 12/31/2006	*	Holly Robinson, CMS Plan Manager, 206-615-3673 Holly.robinson@cms.hhs.gov	Medicare 2014 Average Lives = 9,059 **Population Type:**	2014 Annual Revenue = 113,548,000 Capitated	Improvement demonstrated from reporting year 2013-2014 in:	The contract does not contain language pertaining to member choice,	Molina utilizes pharmacy benefit managers as well as vendors for supplemental benefits

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Medicaid Services (CMS) and Molina Healthcare of California, Inc.; Molina Medicare covers Part A (hospital) Medicare benefits, including hospital inpatient care, skilled nursing facility (SNF) care, home health care, hospice care (through CMS contractors), blood; Part B (medical), including doctor's services, outpatient medical / surgical services & supplies, diagnostic tests, outpatient therapy, outpatient mental health services, some preventive health care services; Part D (prescription drugs); additional benefits including routine transportation, preventive / comprehensive dental, and routine vision and hardware.	unless terminated)				Medicare/Medicaid Dual Eligible		• Colorectal cancer screening • Annual flu vaccine • Adult BMI assessment • Diabetic eye exam • Rheumatoid arthritis management • Fall risk reduction • Plan all-cause readmissions • CAHPS customer service • CAHPS care coordination • Complaints about the plan • Overall rating of healthcare quality • Reviewing appeals decisions • Overall rating of drug plan • Getting prescriptions filled easily • Medication adherence for diabetes • Medication adherence for HTN • Medication adherence for	safety, independence, and responsibility.	including vision, dental, hearing, and transportation.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
							cholesterol		
Molina Healthcare of Florida Florida Agency for Health Care Administration									
Statewide Medicaid Managed Care – Contract between Florida Agency for Health Care Administration and Molina Healthcare of Florida, Inc.; provides or arranges for health care services to eligible Medicaid enrollees (TANF, SSI) residing in the Service Area; scope of benefits includes coordination and approval of all medically necessary services, preventive care, claims processing, member services, provider relations and network development; Contract also includes providing and arranging for Long Term Care services for enrollees residing in the Service	01/01/2014 - 12/31/2018	Original Start Date: contract signed 1/31/2014 Original End Date: 12/31/2018 Were there any alterations to this original time frame? There was a rollout schedule based on region. LTC went live in Feb 2014 under the SMMC contract; MMA went live in July 2014. If so, please provide reasons for the alterations: see above	*	Erica Baker, (850) 412-4321 erica.baker@ahca.myflorida.com	MMA 7/12014-12/31/2014: 156,588 LTC 2014: 5,192	MMA 7/12014-12/31/2014: $130,847,296 LTC 2014: $177,716,218 Capitated	2014 is the baseline year for HEDIS and Quality measures for this contract. UM Trends: Every LTC member is case managed. Initial visit is completed with 5-7 days. Monthly telephone contacts and quarterly face to face assessments. Quality Trends for FL Medicaid: Improvement demonstrated from reporting year 2013-2014 in: • Breast cancer screening • Chlamydia screening in women • Appropriate testing for children with pharyngitis • Antidepressant medication management • Children and adolescents' access to primary care practitioners	Member choice: Members can choose their PCP. • Freedom of Choice: Members can choose to live at home or a nursing facility. • Recipients can choose plan through the state's enrollment broker • Contract has specific network adequacy requirements and weekly network reporting Emphasis on person-centered/self-directed care, member choice of health plan and providers. The state approves LTC care plans, has regular reporting requirement, and	• PBM • Behavioral Health • Dental • Vision • Participant Directed Option vendor (LTC) • Case Management Region 11 • Transportation

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Area; Long Term Care scope of benefits includes coordination and approval of Home and Community Based Services and Institutional Services, claims processing, member services, provider relations and network development. Is "physical health coverage" within the scope of this contract? (yes/no) Yes, medical benefits are covered Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes Are LTSS within the scope of this contract? (yes/no) YES								requires plan submit self-audits quarterly. Emphasis on critical incidents and health, safety and welfare monitoring. Must report abuse, neglect and exploitation within 24 hours of suspicion. Required Level 2 Background Screenings for providers and case managers.	
Nursing Home Diversion – Contract between Florida	06/01/2012-01/31/2014	Original Start Date: 06/01/2012 signed	*	Gary Smith, 850-414-2061 smithg@elderaffairs.org.	2012: 8 2013: 555 2014: 471	2012: $27,145 2013: $5,591,729 2014: $632, 827	UM Trends: Every member was case managed Quality Trends: N/A	Independence: Goal of program is to keep individuals in a home and	N/A

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Department of Elder Affairs and Molina Healthcare of Florida, Inc. The Nursing Home Diversion pilot project was designed to provide frail elders age 65 and older with an alternative to nursing home care. The program offers integrated acute and long term care services to dually eligible Medicare and Medicaid recipients by contracting with HMOs and Other Qualified providers. The program enables seniors to remain safely in the community by providing home and community based services to would otherwise qualify for Medicaid nursing home placement. Is "physical health coverage" within		Original End Date: 8/31/2012 Amendment 002 extended the contract end date to 8/31/2013. Amendment 003, extended the contract end date to 1/31/2014 Were there any alterations to this original time frame? Due to rollout of SMMC, NHD ended 1/31/2014. Region 11 ended 11/30/2013 and LTC went live 12/1/2013 under a LTC only contract which was rolled into SMMC in 2014. Region 5&6 ended 1/31/2014 and SMMC LTC went live 2/1/2014 in Region 5&6.				Capitated		community setting outside of a nursing home and provide services to help keep them living independently	

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
the scope of this contract? (yes/no) No Is "behavioral health coverage" within the scope of this contract? (yes/no) No Are LTSS within the scope of this contract? (yes/no) Yes, some LTSS services were covered under this contract. There were home and community based services that are now under Long Term Care; however not all LTSS services were offered under this contract		If so, please provide reasons for the alterations: see above							
Long Term Care – Contract between Florida Agency for Health Care Administration and Molina Healthcare of Florida, Inc provides or arranges for Long Term Care services	12/1/2013-1/31/2014 (contract rolled into the SMMC Contract)	Original Start Date: 4/22/2013 signed Original End Date: 8/31/2018 Were there any	*	Erica Baker, (850) 412-4321 erica.baker@ahca.myflorida.com	2013: 2,727 (contract rolled into the SMMC Contract)	2013: 6,161,881 (contract rolled into the SMMC Contract) Capitated	N/A (contract rolled into the SMMC Contract)	N/A (contract rolled into the SMMC Contract)	N/A (contract rolled into the SMMC Contract)

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
for Long Term Care enrollees. The scope of benefits includes coordination and approval of Home and Community Based Services and Institutional Services, claims processing, member services, provider relations and network development. Is "physical health coverage" within the scope of this contract? (yes/no) Yes, some medical benefits like OT,PT,ST,RT are covered. Not all medical benefits are covered though. Is "behavioral health coverage" within the scope of this contract? (yes/no) YES Are LTSS within the scope of this contract? (yes/no)		alterations to this original time frame? Yes. If so, please provide reasons for the alterations: Due to Region rollout schedule, Molina of FL did not go live under 12/1/2013 in Region 11. In February 2014 we went live in Region 5&6 but the SMMC contract replaced this contract at that time.							

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
YES									
AHCA Medicaid Contract 2009-2012 – Contract between Florida Agency for Health Care Administration and Molina Healthcare of Florida, Inc provides or arranges for health care services to eligible Medicaid enrollees (TANF, SSI) residing in the Service Area; scope of benefits includes coordination and approval of all medically necessary services, preventive care, claims processing, member services, provider relations and network development; Is "physical health coverage" within the scope of this contract? (yes/no) Yes, medical benefits are covered	9/01/2009-8/31/2012	Original Start Date: 8/31/2009 signed Original End Date: 8/31/2012 Were there any alterations to this original time frame? No If so, please provide reasons for the alterations: NA	*	Erica Baker, (850) 412-4321 erica.baker@ahca.myflorida.com	2009: 50,090 2010: 60,997 2011: 68,137 2012: 70,660	2009: $102,231,901 2010: $163,966,031 2011: $194,970,895 2012: $125,030,714 Capitated	Launched multiple interventions to increase HEDIS measures.	• Critical incident reporting requirements. Members can choose their PCP. • Recipients can choose plan through the state's enrollment broker	• CVS/Caremark: PBM • Psychcare: Behavioral Health • DentaQuest: Dental • March Vision: Vision • Logisticare: Transportation

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Is "behavioral health coverage" within the scope of this contract? (yes/no) YES Are LTSS within the scope of this contract? (yes/no) NO									
AHCA Medicaid Contract 2012-2015 – Contract between Florida Agency for Health Care Administration and Molina Healthcare of Florida, Inc provides or arranges for health care services to eligible Medicaid enrollees (TANF, SSI) residing in the Service Area; scope of benefits includes coordination and approval of all medically necessary services, preventive care,	9/1/2012-07/31/3014 (transitioned to SMMC Contract)	Original Start Date: 8/30/2012 signed Original End Date: 8/31/2015 Were there any alterations to this original time frame? Yes. SMMC rolled out prior to the end date of this contract. Region 11 ended with this contract on 6/30/2014 and transitioned to SMMC on	*	Erica Baker, (850) 412-4321 erica.baker@ahca.myflorida.com	2012: 72,475 2013: 84,924 2014: (01/01/2014-06/30/2014): 51,686	2012: $91,166,473 2013: $245,072,490 2014 (01/01/2014-06/30/2014): $117,123,541 Capitated	Multiple improvements in HEDIS measures. Well Child Visit increased from 77% in 2012 to 82% in 2014 in Reform counties. BMI HEDIS measure increased from 49% 2012 to 73% in 2014 Reform counties. Cervical Cancer Screening measure increased from 60% in 2012 to 65% in 2014. Breast Cancer Screening increased from 53.28% in 2012 to 56% in 2014.	• Critical incident reporting requirements. Members can choose their PCP. • Recipients can choose plan through the state's enrollment broker	• CVS/Caremark: PBM • Psychcare: Behavioral Health • DentaQuest: Dental • March Vision: Vision • Logisticare: Transportation

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
claims processing, member services, provider relations and network development; Is "physical health coverage" within the scope of this contract? (yes/no) Yes, medical benefits are covered Is "behavioral health coverage" within the scope of this contract? (yes/no) YES Are LTSS within the scope of this contract? (yes/no) No		7/1/2014. While Region 7&9 ended with this contract on 7/31/2014 and transitioned 8/1/2014 to SMMC. If so, please provide reasons for the alterations: See above							
Medicare – Contract between The Centers for Medicare & Medicaid Services (CMS) and Molina Healthcare of Florida, Inc.; Molina Medicare	01/01/2015 - 12/31/2015 (Renews annually unless terminated)	01/01/2010 - 12/31/2010	*	Holly Robinson, CMS Plan Manager, 206-615-3673 Holly.robinson@cms.hhs.gov	Medicare 2014 Average Lives = 891 **Population Type:** Medicare/Medicaid Dual Eligible	2014 Annual Revenue = 11,646,000 Capitated	Improvement demonstrated from reporting year 2013-2014 in: • Colorectal cancer screening • Adult BMI assessment	The contract does not contain language pertaining to member choice, safety, independence, and responsibility.	Molina utilizes pharmacy benefit managers as well as vendors for supplemental benefits including vision, dental, hearing, and transportation.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
covers Part A (hospital) Medicare benefits, including hospital inpatient care, skilled nursing facility (SNF) care, home health care, hospice care (through CMS contractors), blood; Part B (medical), including doctor's services, outpatient medical / surgical services and supplies, diagnostic tests, outpatient therapy, outpatient mental health services, some preventive health care services; Part D (prescription drugs); additional benefits including routine transportation, preventive / comprehensive dental, over-the-counter health supplies, and routine vision and hardware.							• Controlling high blood pressure • Medication adherence for HTN • Medication adherence for cholesterol		
Molina Healthcare of Illinois State of Illinois, Department of Healthcare and Family Services, Bureau of Managed Care									
Medicaid (ABD)	08/30/2013 –	Original Start	*	Laura Ray	Medicaid 2014	2014 Annual	Molina Healthcare is	• Emphasis on	• Transportation

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Integrated Care Program – Contract between Department of Healthcare and Family Services and Molina Healthcare of Illinois, Inc. (No. 2013-24-003) for furnishing health services pursuant to Section 5-11 of the Illinois Public Aid Code (305 ILCS 5/5-11); Scope of services includes: Service Package 1 - including all standard Medicaid medical services; Service Package 2 - including Long Term Supports and Services (LTSS), including those in nursing facilities or those who receive Home and Community-Based Services (HCBS) waivers; waiver services through the Home Services Program (HSP), the Community Care Program (CCP) and the	08/30/2018	Date: N/A Original End Date: N/A Were there any alterations to this original time frame? N/A If so, please provide reasons for the alterations: N/A		217-524-7478 laura.ray@illinois.gov	Average Lives = 5106	Revenue = 66,237,692.99 Capitated	currently preparing for our first HEDIS submission for the Integrated Care Program. 2015 is considered a baseline year, in which the results will be analyzed, and subsequently, programs and initiatives will be developed and implemented to increase our quality metrics and indicators. These initiatives will support our quality program to drive our HEDIS rates and Accreditation.	person-centered/self-directed care, member choice of health plan and providers. • Emphasis on critical incidents and health, safety and welfare monitoring. Required monthly reporting to monitor abuse, neglect and exploitation. • The Federal Waiver Assurances for Health Safety and Welfare outline specific waiver performance measures to monitor health plans' performance in regards to person-centered care and health & safety monitoring.	• Pharmacy Benefit Manager • Dental • Vision & Eyeglasses • SNFst • Assessments for members unable to locate

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Supportive Living Program (SLP), including Long Term Supports and Services (LTSS), including those in nursing facilities or those who receive Home and Community-Based Services (HCBS) waivers; and waiver services through the Home Services Program (HSP), the Community Care Program (CCP) and the Supportive Living Program (SLP); and Service Package 3 – waiver services for persons with developmental disabilities; Service Package 3 implementation scheduled for future date. Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage"									

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
within the scope of this contract? (yes/no) Yes Are LTSS within the scope of this contract? (yes/no) Yes									
Medicaid-Medicare Alignment Initiative (MMAI) - Federal–State partnership to implement Medicare-Medicaid Alignment Initiative (Demonstration) to better serve individuals eligible for both Medicare and Medicaid (Medicare-Medicaid Enrollees). Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage"	11/5/2013-12/31/2017 Start date for three-way agreement between ODM, CMS and Molina was November 5, 2013, and runs through December 31, 2015; contract is renewed annually through December 31, 2017.	Original Start Date: N/A Original End Date: N/A Were there any alterations to this original time frame? N/A If so, please provide reasons for the alterations: N/A	*	Laura Ray 217-524-7478 laura.ray@illinois.gov Chad Johnson, 312-353-1269 benjamin.johnson@cms.hhs.gov	MMP 2014 Average Lives = 2020	2014 Annual Revenue = 4,180,756.76 Capitated	Molina Healthcare of Illinois' first HEDIS submission for MMAI will not be until 2016. 2016 is considered a baseline year, in which the results will be analyzed, and subsequently, programs and initiatives will be developed and implemented to increase our quality metrics and indicators. These initiatives will support our quality program to drive our HEDIS rates and Accreditation.	• Emphasis on person-centered/self-directed care, member choice of health plan and providers. • Emphasis on critical incidents and health, safety and welfare monitoring. Required monthly reporting to monitor abuse, neglect and exploitation. • The Federal Waiver Assurances for Health Safety and Welfare outline specific waiver performance measures to monitor health	• Vision & Eyeglasses • SNFst • Assessments for members unable to locate

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
within the scope of this contract? (yes/no) Yes Are LTSS within the scope of this contract? (yes/no) Yes								plans' performance in regards to person-centered care and health & safety monitoring.	
FHP (Family Health Plan - aka Medicaid) & ACA (Affordable Care Act - aka Expansion Population); provides a comprehensive system of medical and healthcare delivery, including preventive, primary, specialty, and ancillary health services for enrollees in Medicaid and those eligible through the Affordable Care Act, including, but not limited to: Network Access & Availability, Utilization Management, Quality of Care, Member Services, Grievance &	07/1/2014 - 06/30/2019	Original Start Date: N/A Original End Date: N/A Were there any alterations to this original time frame? N/A If so, please provide reasons for the alterations: N/A	*	Laura Ray 217-524-7478 laura.ray@illinois.gov	Medicaid 2014 Average Lives = 44,659 TANF= 35,915 ACA= 8,744	2014 Annual Revenue = 27,536,499 TANF= 17,158,468.49 ACA= 10,378,031.45 Capitated	Molina Healthcare of Illinois' first HEDIS submission for the Family Health Plan will not be until 2016. 2016 is considered a baseline year, in which the results will be analyzed, and subsequently, programs and initiatives will be developed and implemented to increase our quality metrics and indicators. These initiatives will support our quality program to drive our HEDIS rates and Accreditation.	• Emphasis on person-centered/self-directed care, member choice of health plan and providers. • Emphasis on critical incidents and health, safety and welfare monitoring. Required monthly reporting to monitor abuse, neglect and exploitation. • The Federal Waiver Assurances for Health Safety and Welfare outline specific waiver performance measures to monitor health	• Vision & Eyeglasses • SNFst • Assessments for members unable to locate

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Appeals, Benefit Administration, Oversight and Monitoring. Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes Are LTSS within the scope of this contract? (yes/no) Yes								plans' performance in regards to person-centered care and health & safety monitoring.	
Molina Healthcare of Michigan Michigan Department of Community Health									
Medicaid – Contract between the State of Michigan and Molina Healthcare of Michigan, Inc. (as amended); provides comprehensive healthcare services including physical and behavioral health services to Medicaid	10/1/2011 - 9/30/2015	Original Start Date: 10/01/2011 Original End Date: 12/31/2015 Were there any alterations to this original time frame? **Yes**	*	Steve Fitton, Medicaid Director, Department of Community Health (DCH) , (517) 241-7882 fittons@michigan.gov	Enrollment count 2014 (year-end): 223,082 Population Type: Medicaid	2014 Annual Revenue = Capitated $648,899,000 This includes tax and ACA fee, excl other pass thru	In 2013, MHM met 8 out of the 11 measures. MHM has successfully improved its performance on several key HEDIS and CAHPS measures through various initiatives. Improvement demonstrated from reporting year 2013-2014 in: • Adult BMI assessment • Weight assessment and counseling for nutrition and physical activity for	Member selection of PCP, Network adequacy requirements. Members are treated with respect with recognition of dignity and right to privacy. Member handbook contains list of rights & responsibilities.	Transportation, Administrative Subcontractor Type A, B and C providing administrative services including human resources, premium collection, credentialing functions, business development/strategic planning including training and website design and maintenance, print and fulfillment, enrollee and provider call centers, nurse

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
beneficiaries in the service area; provides comprehensive health care services for MIChild (CHIP) beneficiaries in the service area. Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes Are LTSS within the scope of this contract? (yes/no) No		If so, please provide reasons for the alterations: State RFP process delayed so the state extended contract					children/adolescents – nutrition & physical activity components • Human papillomavirus vaccine for female adolescents • Breast cancer screening • Appropriate treatment for children with URI • Avoidance of antibiotic treatment in adults with acute bronchitis • Use of spirometry testing in the assessment and diagnosis of COPD • Medication Management for People With Asthma • Asthma Medication Ratio • Diabetic eye exam • Diabetic kidney disease monitoring • Antidepressant medication management • Follow-up care for children prescribed ADHD medication • Adults' access to preventive/ambulatory health services • Prenatal and postpartum care - Prenatal • Well-child visits in the third, fourth, fifth and sixth years of life		advise line, facilities and facilities management, pharmacy services, enrollment services and materials, premium collection, insurance, utilization management functions, claims processing and administration, contract development and negotiations, accounting and finance services, information systems, marketing, actuarial and underwriting services, analytical support and report generation services, and legal services.
MiChild Program (SCHIP) – Contract between the State of Michigan and	10/1/2014 - 9/30/2015	Original Start Date: Original End Date:	*	Kathy Stiffler, Director, Plan Management Section, Department of Community Health (DCH) , (517) 241-9944 stifflerk@michigan.gov	Enrollment 2014 (year-end): 40,524	2014 Annual Revenue = Capitated $7,385,000	State requested service area expansions. The original 4 counties were expanded to 35. The July 2014 MiChild	Choices for care , The durable power of attorney for health care (DPAHC) is the	Transportation, Administrative Subcontractor Type A, B and C providing administrative services

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Molina Healthcare of Michigan, Inc. (as amended); provides comprehensive healthcare services including physical and behavioral health services to Medicaid beneficiaries in the service area; provides comprehensive health care services for MIChild (CHIP) beneficiaries in the service area. Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes Are LTSS within the scope of this contract? (yes/no) No		12/31/2015 Were there any alterations to this original time frame? Yes If so, please provide reasons for the alterations: State RFP process delayed so the state extended contract				This includes tax and ACA fee, excl other pass thru	Performance Monitoring report showed MHM 2nd out of 13 competing health plans in Well-child visits 3-6 years and 7-11 years. MHM met the Encounter Data Reporting and the Pharmacy Encounter Data Reporting initiatives. MHM achieved one of three 100% overall scores, matching Total Healthcare and United Healthcare. Ultimately, MHM met 4 out of 4 measures.	form of advance directive recognized by the Michigan Department of Community Health (1998, Public Act 386). This lets you choose another person to make decisions about your care, custody, and medical treatment if you cannot make these decisions for yourself. This way, your desire to accept or refuse medical treatment is honored when you cannot make that choice yourself.	including human resources, premium collection, credentialing functions, business development/strategic planning including training and website design and maintenance, print and fulfillment, enrollee and provider call centers, nurse advise line, facilities and facilities management, pharmacy services, enrollment services and materials, premium collection, insurance, utilization management functions, claims processing and administration, contract development and negotiations, accounting and finance services, information systems, marketing, actuarial and underwriting services, analytical support and report generation services, and legal services.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
MMP Federal–State partnership to implement Medicare-Medicaid Alignment Initiative (Demonstration) to better serve individuals eligible for both Medicare and Medicaid (Medicare-Medicaid Enrollees). Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes Are LTSS within the scope of this contract? (yes/no) Yes	Demonstration Starts May 1, 2015	Demonstration Starts May 1, 2015	*	Medicaid Director, Steve Fitton Phone: (517) 241-7882 fittons@michigan.gov	Currently Molina has the highest enrollment rate for this product line in the state.	0	Yet to be seen Molina Healthcare is currently preparing for our first HEDIS submission for the MMP Program. 2015 is considered a baseline year, in which the results will be analyzed, and subsequently, programs and initiatives will be developed and implemented to increase our quality metrics and indicators.	All of the those—patient-centered, member focused	Transportation, Administrative Subcontractor Type A, B and C providing administrative services including human resources, premium collection, credentialing functions, business development/strategic planning including training and website design and maintenance, print and fulfillment, enrollee and provider call centers, nurse advise line, facilities and facilities management, pharmacy services, enrollment services and materials, premium collection, insurance, utilization management functions, claims processing and administration, contract development and negotiations, accounting and finance services, information systems, marketing, actuarial and underwriting services, analytical support and report generation services, and legal services.
Medicare – Contract between	01/01/2015 - 12/31/2015	01/01/06 - 12/31/06	*	Holly Robinson, CMS Plan Manager, 206-615-3673	Medicare 2014 Average Lives =	2014 Annual Revenue =	Improvement demonstrated from	The contract does not contain	Molina utilizes pharmacy benefit managers as well

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
The Centers for Medicare & Medicaid Services (CMS) and Molina Healthcare of Michigan, Inc.; Molina Medicare covers Part A (hospital) Medicare benefits, including hospital inpatient care, skilled nursing facility (SNF) care, home health care, hospice care (through CMS contractors), blood; Part B (medical), including doctor's services, outpatient medical / surgical services & supplies, diagnostic tests, outpatient therapy, outpatient mental health services, some preventive health care services; Part D (prescription drugs); additional benefits including routine transportation, preventive / comprehensive dental, over-the-	(Renews annually unless terminated)			Holly.robinson@cms.hhs.gov	10,980 **Population Type:** Medicare/Medicaid Dual Eligible	173,199,000 Capitated	reporting year 2013-2014 in: • Colorectal cancer screening • Annual flu vaccine • Adult BMI assessment • Rheumatoid arthritis management • Fall risk reduction • Timely appeals decisions • Complaints about the plan • Appeals auto-forward • High risk medications • Medication adherence for diabetes • Medication adherence for HTN Medication adherence for cholesterol	language pertaining to member choice, safety, independence, and responsibility.	as vendors for supplemental benefits including vision, dental, hearing, and transportation.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
counter health supplies, and routine vision and hardware.									
Molina Healthcare of New Mexico State of New Mexico, Human Services Department									
Medicaid (Centennial Care) Is "physical health coverage" within the scope of this contract? Yes Is "behavioral health coverage" within the scope of this contract? Yes Are LTSS within the scope of this contract? Yes	5 years (with optional one-year renewals thereafter)	2/1/2013 – 12/31/2017	*	Tina Rigler 505-348-0464 Tina.Rigler@MolinaHealthCare.com Nancy Smith-Leslie, Director Medical Assistance Division/HSD PO Box 2348 Santa Fe, NM 87504 (505) 827-7704 Nancy.smith-leslie@state.nm.us	Medicaid 2014 Average Lives = 201,957	2014 Annual Revenue = $1,111,510,676.14 Capitated	• Centennial Care has eight (8) Performance Measures which are tied to financial sanctions. HEDIS 2015 is our baseline reporting year and HSD will determine thresholds. Based on 2015 results, MHNM will determine any interventions and programs. For 2014 and 2015, the interventions and outreach activities have focused on the Performance Measures. In 2014, MHNM along with HSD and the three (3) other Centennial Care MCOs developed and implemented a new points based Rewards program that is consistent among the MCOs and rewards members for making healthy	• Members are allowed to choose a new MCO every 12 months. • Members are assured of their right to select the PCP of their choice. • Members selecting the Agency Based Community Benefit have a choice of the consumer delegated model or the consumer directed model for personal care services. • Members referred to Health Homes have the ability to choose a different provider. • Members have the choice to receive	Subcontractors are responsible for Prior Authorization issuance and claims processing for vision, dental and transportation. PBM subcontracted.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
							choices/behavior. The Program is coordinated by a third party vendor that is contracted with all four (4) MCOs. • Average Turn-Around Time of 3-5 days for Prior Authorization requests. • Readmission reduction initiatives. • Emergency Room reduction initiatives. • 7/14/30 day follow-up initiatives. • Utilization reports include, but are not limited to, hospital admission and discharge, Emergency Room visits and follow-up, medication management, institutional care, community care and in-home support services. Authorization and claims data are reviewed for monitoring utilization as well as identification of trends and opportunities for	institutional care versus HCBS services. • Members have free choice of any contract providers. • Molina helps to facilitate access to physical, behavioral and Long-Term care services as needed. • Members are assisted to assure access to care during any transition (i.e. between providers and/or between MCOs). • Members with Special Health Needs are assured direct access to a specialist when appropriate. • All contract providers are required to comply with timely access requirements. • Access to non-	

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
							improvement. Claims reports are reviewed to ensure appropriate processing of cross-over claims occurs and is seamless to the providers. Ultimately, Molina's Quality Improvement Committee (QIC) is responsible for reviewing utilization and trend reports to ensure benefits are administered appropriately and identify areas for improvement and education are developed in collaboration with practitioners.	contract providers is assured in the case that medically necessary services are not available through contract providers. • Molina supports and participates in local health councils to create healthier and safer communities. • Assess long-term care needs including environmental safety. • Member rights and responsibilities are included in the Member Handbook, the Centennial Care contract and the Member Rights and Responsibilities policy and procedure.	

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
								• Members can earn points for making healthy choices/behaviors. The program is coordinated by a third party vendor that is contracted with all four (4) MCOs. Members who earn points can redeem them at various retail stores.	
Medicaid (Salud!) Is "physical health coverage" within the scope of this contract? Yes Is "behavioral health coverage" within the scope of this contract? No Are LTSS within the scope of this contract? No	7/1/2005 – 12/31/2013	7/1/ 2005 – 6/30/2009 Were there any alterations to this original time frame? Yes If so, please provide reasons for the alterations: The contract was extended after the original termination date.	*	Tina Rigler 505-348-0464 Tina.Rigler@MolinaHealthCare.com Nancy Smith-Leslie, Director Medical Assistance Division/HSD PO Box 2348 Santa Fe, NM 87504 (505) 827-7704 Nancy.smith-leslie@state.nm.us	Salud! 2014 Average Lives = 103,970	2013 Annual Revenue = $338,020,853.69 Capitated	Under Salud, MHNM had 19 state Performance Measures. MHNM met or exceeded 16 of the 19 Performance Measures in 2014 (2013 HEDIS results). Interventions were focused on the Performance Measures: Well-Child Checks, Prenatal and Postpartum Care, Cervical Cancer Screening, Breast Cancer Screening and Comprehensive Diabetes Care. Interventions included member outreach through telephone calls, mailings and Viva Molina events throughout the state.	Required to demonstrate that our network is sufficient to meet the health care needs of all enrolled members. Written policies and procedures are maintained describing how members and providers receive access to services. Members have the right to access a second opinion from a qualified health care	Subcontractors are responsible for Prior Authorization and claims processing for Vision, Dental and Transportation. PBM subcontracted.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
							Provider Engagement Team outreach was also focused on HEDIS and Performance Measures. Improvement demonstrated from reporting year 2013-2014 in: • Adult BMI assessment • Weight assessment and counseling for nutrition and physical activity for children/adolescents – BMI% & physical activity components • Childhood immunization status – combo 10 • Human papillomavirus vaccine for female adolescents • Lead screening for children • Breast cancer screening • Cervical cancer screening • Appropriate treatment for children with URI • Avoidance of antibiotic treatment in adults with acute bronchitis • Pharmacotherapy management of COPD exacerbation • Use of appropriate medications for people with asthma • Medication Management for People With Asthma • Asthma Medication Ratio • Diabetic kidney disease monitoring	professional within the network and, if necessary, must arrange for members to receive a second opinion from a qualified health care professional outside of the network, at no cost to the member. Provide access to out of network providers if contract providers are unable to provide necessary medical services. Participate in and support local health councils to create healthier and safer communities, with a focus on coordination of efforts, such as DWI councils, maternal and child health councils, tobacco coalitions, safety council, safe kids, and others. Member rights and responsibilities are included in the	

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
								Member Handbook, the Salud contract and the Member Rights and Responsibilities policy and procedure.	
SCI (Medicaid) Is "physical health coverage" within the scope of this contract? Yes Is "behavioral health coverage" within the scope of this contract? No Are LTSS within the scope of this contract? No	7/1/ 2005 – 12/31/2013	7/1/ 2005 – 6/30/2009 Were there any alterations to this original time frame? Yes If so, please provide reasons for the alterations: The contract was extended after the original termination date.	*	Tina Rigler 505-348-0464 Tina.Rigler@MolinaHealthCare.com Nancy Smith-Leslie, Director Medical Assistance Division/HSD PO Box 2348 Santa Fe, NM 87504 (505) 827-7704 Nancy.smith-leslie@state.nm.us	SCI 2013 Average Lives = 9821	2013 Annual Revenue = $49,906,794.98 Capitated	• Under SCI, MHNM had eight (8) Performance Measures and all eight (8) were met for HEDIS 2013 reporting year. Interventions were focused on the Performance Measures: Prenatal and Postpartum Care, Cervical Cancer Screening, Breast Cancer Screening and Comprehensive Diabetes Care. Interventions included member outreach through telephone calls, mailings and Viva Molina events throughout the state. Provider Engagement Team outreach was also focused on HEDIS and Performance Measures.	Members are provided with a list of contract providers, by provider type and specialty, including names, locations, telephone numbers and non-English languages spoken, a means of checking the open/closed panel status, and how to access services. Members are afforded the right to access a second opinion from a qualified health care professional within the network. If a qualified health care professional is not available within the network, the member is assisted to receive a second opinion from a qualified health	N/A

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
								care professional outside the network. Members are provided with clear instructions on how to access services, including those that require prior approval or referral. Such instructions are written at no more than a sixth grade reading level. Molina participates in and supports local health councils in an effort to create healthier and safer communities with a focus on coordination of efforts, such as DWI councils, maternal and child health councils, tobacco coalitions, safety council, safe kids, and others. Member Rights and Responsibilities are included in the Member Handbook, the SCI	

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
								contract and the Member Rights and Responsibilities policy and procedure.	
UNMSCI (Medicaid) Is "physical health coverage" within the scope of this contract? Yes Is "behavioral health coverage" within the scope of this contract? No Are LTSS within the scope of this contract? No	3/1/2007 – 12/31/2013	3/1/2007 – 12/31/2013 Were there any alterations to this original time frame? Yes If so, please provide reasons for the alterations: The contract was extended after the original termination date.	*	Tina Rigler 505-348-0464 Tina.Rigler@MolinaHealthCare.com Nancy Smith-Leslie, Director Medical Assistance Division/HSD PO Box 2348 Santa Fe, NM 87504 (505) 827-7704 Nancy.smith-leslie@state.nm.us	UNMSCI 2013 Average Lives = 9689	2013 Annual Revenue = $60,325,801.61 Capitated	Under UNMSCI MHNM had eight (8) Performance Measures and all eight (8) were met for HEDIS 2013 reporting year. Interventions were focused on the Performance Measures: Prenatal and Postpartum Care, Cervical Cancer Screening, Breast Cancer Screening and Comprehensive Diabetes Care. Interventions included member outreach through telephone calls, mailings and Viva Molina events throughout the state. Provider Engagement Team outreach was also focused on HEDIS and Performance Measures. Our QI Activities for Medicare focused on Risk Adjustment and HEP Programs. For Risk Adjustment Retrospective Chart Chases, our Corporate defined goal was 1046 completed; our actual	By contract, UNM is required to meet applicable standards for timely access to care and services, taking into account the urgency of the need for services. Provide access to services within the regulations as set forth in the established HSD regulations pertaining to SCI. Contract providers are terminated from the plan, with reasonable justification, if it is determined that services are not being properly provided or arranged for, and that such failure poses a threat to the health and safety of members.	N/A

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
							number completed was 1358, which exceeded the goal at 130%. For the HEP Project, the goal was 343 assessments completed; our actual number completed was 382, which exceeded the goal at 111%. Our interventions for the STARs Measures were focused on Cervical Cancer Screening and Comprehensive Diabetes Care. Interventions included member outreach through telephone calls, mailings and Viva Molina events throughout the state. The Provider Engagement Team outreach was also focused on STARs Measures. Average Turn-Around Time of 3-5 days for Prior Authorization requests. Readmission reduction initiatives. Emergency Room reduction initiatives. 7/14/30 day follow-up		

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
							initiatives. HEDIS measures.		
Medicare – Contract between Centers for Medicare & Medicaid Services (CMS) and Molina Healthcare of New Mexico, Inc.; Molina Medicare covers Part A (hospital) Medicare benefits, including hospital inpatient care, skilled nursing facility (SNF) care, home health care, hospice care (through CMS contractors), blood; Part B (medical), including doctor's services, outpatient medical / surgical services & supplies, diagnostic tests, outpatient therapy, outpatient mental health services, some preventive health care services; Part D (prescription drugs); additional	01/01/2015 -12/31/2015 (Renews annually unless terminated)	01/01/2008 - 12/31/2008	*	Holly Robinson, CMS Plan Manager, 206-615-3673 Holly.robinson@cms.hhs.gov	Medicare 2014 Average Lives = 1,317 **Population Type:** Medicare	2014 Annual Revenue = 15,971,000 Capitated	Improvement demonstrated from reporting year 2013-2014 in: • Colorectal cancer screening • Breast cancer screening • Annual flu vaccine • Adult BMI assessment • Diabetic kidney disease management • Fall risk reduction • Plan all-cause readmissions • CAHPS customer service • Overall rating of health care • Overall rating of health plan • High risk medications • Medication adherence for diabetes • Medication adherence for HTN • Medication adherence for	The contract does not contain language pertaining to member choice, safety, independence, and responsibility.	Molina utilizes pharmacy benefit managers as well as vendors for supplemental benefits including vision, dental, hearing, and transportation.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
benefits including routine transportation, preventive / comprehensive dental, over-the-counter health supplies, and routine vision and hardware. Molina Healthcare of New Mexico currently offers both a Medicare Advantage Plan (MAPD) and a Dual Eligible Special Needs Plan (D-SNP). Note: the New Mexico MAPD plan will not be renewed for CY 2015.							cholesterol		
Molina Healthcare of Ohio Ohio Department of Medicaid									
The Ohio Department of Medicaid Ohio Medical Assistance Provider Agreement for Managed Care Plan – Contract between Ohio Department of Medicaid and Molina Healthcare of Ohio, Inc.;	01/01/2013 - Renewed annually on the State Fiscal Year.	Original Start Date: The original start date of MHO's current Statewide contract was 01/01/2013. Original End Date: Renewed annually on the State Fiscal	*	Dale Lehmann, Ohio Department of Medicaid, (614) 752-4778 Dale.Lehmann@medicaid.ohio.gov	Enrollment as of April 1, 2015: Total: 310,953 CFC: 223,430 ABD Kids: 4,515 ABD Adults: 23,562 **Population Type:** Healthy Start (S/CHIP), Healthy	2014 = $1,781,827,630 Medicare = $30,389,974, Medicaid = $1,750,575,268 Capitated	• MHO exceeded the State Average Rate on 10 quality measures • MHO equaled or exceeded the State Average National Percentile on 15 measures. • MHO was the top-scoring MCP (based on reported rates) on 5 measures: o Comprehensive Diabetes Care: HbA1c Adequate	Ohio's Medicaid Managed Care Provider Agreement provides for a care management program that is goal-oriented, outcomes focuses, person centered and culturally competent. Highlights of plan requirements	Credentialing/recredentialing Care Coordination Activities Complex Case Management Primary Source Verification Oral interpretation/written translation Claims processing support services Printing PBM Health and Wellness Programs Transportation Vision

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
provides or arranges for the provision of medically necessary physical, preventive health, dental, vision and mental health care services Aged, Blind or Disabled (ABD) members, Covered Families and Children (CFC) members, Children with Special Health Care Needs (CSHCN) members, and Adult Extension (AEP) members. [Contract prior to 2013? (Iowa would like to know of agreements within the last 5 years)] Is "physical health coverage" within the scope of this contract? (yes/no) Is "behavioral health coverage" within the scope of this contract? (yes/no)		Year. Were there any alterations to this original time frame? N/A If so, please provide reasons for the alterations: N/A Contract History: 2005: Contract to serve CFC population 2007: Contracted expanded to begin serving Aged, Blind and Disabled population. 2013: Contract expanded to include Children with Special Healthcare Needs. 2014: Expanded			Families, TANF, Transitional, other Medicaid and ABD beneficiaries		Control (<8.0%) o Comprehensive Diabetes Care: LDL-C Screening o Comprehensive Diabetes Care: Eye Exam Performed o Cholesterol Management: LDL-C Screening o Cholesterol Management: LDL-C Control <100 mg/dL	include: ▪ Identification of individual with complex needs; ▪ Assessment of needs and assignment of a care manager; ▪ Development of an individualized care plan; ▪ Assistance with accessing needed medical , social, behavioral and other support services; monitoring the effectiveness and appropriatenes s of the care plan; and ▪ Collaborating with providers and the member throughout all steps of the care management process.	

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Are LTSS within the scope of this contract? (yes/no)		service to Medicaid Adult Extension Population (childless adults and parents up to 138% FPL);							
For members who opt to receive both Medicare and Medicaid services through **MyCare Ohio,** plan to provide access to all services provided under Ohio's Medicaid State Plan (excluding habilitation and targeted case management for individuals with developmental disabilities) and HCBS for individuals eligible enrolled in MyCare Ohio 1915 (c) HCBS Waiver; in addition, plan is to provide access to all Medicare Part A, Part B, and Part D services, as well as particular pharmacy products covered by	02/11/2014 - 12/31/2017 Start date for three-way agreement between ODM, CMS, and Molina was February 11, 2014 and runs through December 31, 2015; contract is renewed annually through December 31, 2017. Start date for Medicaid agreement between ODM and MHO was February 20, 2014; term of Medicaid	Original Start Date: 02/11/2014 Original End Date: 12/31/2017 Were there any alterations to this original time frame? No If so, please provide reasons for the alterations:	*	Brian Panke, Ohio Department of Medicaid, 614-752-4716 Brian.Panke@medicaid.ohio.gov Chad Johnson, 312-353-1269 benjamin.johnson@cms.hhs.gov	Enrollment as of April 1, 2015: 16,062	Capitated We do not have this separated out.	The MyCare Ohio Program, which launched just last year, will be measured by the following: Measures required by CMS which will be used by all demonstration projects –Evaluate access –wellness & prevention –quality of life –care coordination/transitions –behavioral health –patient experience National measurement sets – Healthcare Effective Data and Information Set (HEDIS) and National Quality Forum (NQF) Ohio specific measures focused on transition, diversion and balance	The MyCare Ohio program contract emphasis the following: ▪ Single point of contact for members. ▪ Person-centered care. ▪ Care management support 24/7. ▪ Focus on prevention and wellness. ▪ Nurse Advice Line ▪ Seamless transition between care settings.	Credentialing/recredentialing Waiver Service Coordination and/or Care Mgt. Dental Vision Printing Services Language Translation services Transportation Claims processing Primary Source Verification Health Home/CM Payroll/Claims processing Health and Wellness programs Data conversion

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Medicaid and may not be covered under Medicare Part D. Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes Are LTSS within the scope of this contract? (yes/no) Yes	contract mirrors three-way agreement between ODM, CMS, and Molina Healthcare of Ohio.								
Medicare – Contract between Centers for Medicare & Medicaid Services (CMS) and Molina Healthcare of Ohio, Inc.; Molina Medicare covers Part A (hospital) Medicare benefits, including hospital inpatient care, skilled nursing facility (SNF) care, home health care,	01/01/2015 - 12/31/2015 (Renews annually unless terminated)	01/01/2009 - 12/31/2009	*	Holly Robinson, CMS Plan Manager, 206-615-3673 Holly.robinson@cms.hhs.gov	Medicare 2014 Average Lives = 723 **Population Type:** Medicare/Medicaid Dual Eligible	2014 Annual Revenue = 10,558,000 Capitated	Improvement demonstrated from reporting year 2013-2014 in: • Colorectal cancer screening • Adult BMI assessment • Diabetic eye exam • Controlling high blood pressure • High risk medications Medication adherence for cholesterol	The contract does not contain language pertaining to member choice, safety, independence, and responsibility.	Molina utilizes pharmacy benefit managers as well as vendors for supplemental benefits including vision, dental, hearing, and transportation.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
hospice care (through CMS contractors), blood; Part B (medical), including doctor's services, outpatient medical / surgical services & supplies, diagnostic tests, outpatient therapy, outpatient mental health services, some preventive health care services; Part D (prescription drugs); additional benefits including transportation, preventive / comprehensive dental, over-the-counter health supplies, and routine vision and hardware.									
Molina Healthcare of Puerto Rico Commonwealth of Puerto Rico, Government Health Plan ("GHP") administered by Puerto Rico Health Insurance Administration ("ASES")									
Government Health Plan (GHP) provides integrated physical and Behavioral Health services to the Medicaid, CHIP, and Commonwealth population	2 years ending on June 30th, 2017, with an option to renew for an additional year.	Original Start Date: October 31, 2014. Original End Date: June 30th, 2017. Were there any	*	Ana C. Rivera, AVP Government Contracts, 787-200-3401 Ana.Rivera@MolinaHealthCare.com	Approx. 357,000 between two regions, majority (approx. 95%) are Medicaid and CHIP populations.	$761,356,936.32, capitated.	No data available, as we just went live on 4/1/2015.	GHP emphasizes access by providing all services without the requirement of a Referral within the PPN, and not requiring cost-sharing for services within the PPN.	-Behavioral Health -Dental -Non-emergent transportation services -Credentialing

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
(comprised of various groups). MHPR was assigned two regions of the GHP, Southwest and East. MHPR has contracted with Primary Medical Groups that provide, manage, and direct health services, including coordination with Behavioral Health personnel and specialist services, in a timely manner. Development of Preferred Provider Network ("PPN"), composed of physician specialists, clinical laboratories, radiology facilities, hospitals, and Ancillary Service Providers that render Covered Services to persons enrolled in the GHP. Facilitate access to quality Primary		alterations to this original time frame? Yes. If so, please provide reasons for the alterations: Contract did not start on original start date. Contract was executed late November of 2014, and thus was not in effect until said date.						Quality retention fund for incentive programs: -performance measures for effectiveness of medical care and access -preventive clinical programs -emergency room use indicators	

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Care and specialty services within the PPN by providing all services without the requirement of a Referral, and not requiring cost-sharing for services within the PPN. Ensure that, other than through appropriate Utilization control measures, services to Enrollees in the GHP are not refused, restricted, or reduced, including by reason of pre-existing conditions or waiting periods Support the Health Department and the Puerto Rico Mental Health and Against Addiction Services Administration (Administración de Servicios de Salud Mental y Contra la Adicción, "ASSMCA") in health education efforts focusing on lifestyle changes,									

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
HIV/AIDS prevention, the prevention of drug and substance abuse, and maternal and child health. Provide a focus on preventive services for Enrollees. Is "physical health coverage" within the scope of this contract? Yes. Is "behavioral health coverage" within the scope of this contract? Yes. Are LTSS within the scope of this contract? As of now, no. Current contract is shifting model towards a "full" managed-care model that was not the norm in PR.									
Molina Healthcare of South Carolina South Carolina Dept. of Health & Human Services									
Health Plan MCO – Molina (Traditional Coverage) – Contract between	07/01/2014 – 06/30/2016	Original Start Date: 1/1/2014 Original End Date: 6/30/2014	*	Kathie Reed Wanket, 803-898-2801 reed@scdhhs.gov	Medicaid 2014 Average Lives = 119,000	2014 Annual Revenue = $396,204,529 Capitated	Molina Healthcare of South Carolina is currently preparing for our first HEDIS submission. 2014 was	Our current Medicaid contract focuses on the administration of the benefits and	March Vision administers our routine vision & Eyeglass benefit on our behalf.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
the State of South Carolina and Molina Healthcare of South Carolina, Inc.; provides or arranges for healthcare services to eligible Traditional Medicaid enrollees residing in the Service Area; scope of work includes coordination and approval of all medically necessary covered services and preventive care; claims processing; member services; provider relations and network development. Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes		Were there any alterations to this original time frame? No. If so, please provide reasons for the alterations: N/A			(First members enrolled 1/1/2014; current membership enrolled under contract ending 6/30/2014; new contract retroactive to 7/1/2014 with no disruption to member service delivery) Population Type: TANF, ABD		considered a baseline year, in which the results will be analyzed, and subsequently, programs and initiatives will be developed and implemented to increase our quality metrics and indicators. These initiatives will support our quality program to drive our HEDIS rates and Accreditation.	requirements of the health plan associated therewith and does not focus as heavily on these areas.	CVS Caremark assists with the administration of our pharmacy benefit. We also have an in house Pharmacy Department.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Are LTSS within the scope of this contract? (yes/no) No									
Health Plan MCO – MMP Duals Demonstration – Contract between CMS, the State of South Carolina and Molina Healthcare of South Carolina, Inc.; provides or arranges for healthcare services to dual eligible enrollees ages 65 and over who are not residing in a nursing home at the time of enrollment. Service area encompasses 23 of the 46 counties in the state.scope of work includes coordination and approval of all medically necessary covered services and preventive care; claims processing; member services; provider relations and network development.	09/5/2014 – 12/31/2017	Original Start Date: 9/5/2014 Original End Date: 12/31/2017 Were there any alterations to this original time frame? No If so, please provide reasons for the alterations: N/A	*	Teeshla Curtis, 803-898-0070 curtist@scdhhs.gov	MMP 2014 Average Lives = 0 (First members enrolled 2/1/2015); Population Type: Dual Eligibles	2014 Annual Revenue = 0 (First members enrolled 2/1/2015); Capitated	This program is currently in the first quarter of operation. As such, Molina has not yet had an opportunity to obtain baseline data to analyze. Once we have had an opportunity to do so, we will implement programs and initiatives to increase our quality metrics and indicators.	This contract emphasizes person-centered/self-directed care through the care model that is outlined, which requires that each member have a care coordinator that is their single point of contact in the plan and that ICT meetings are required with the member as an active participant should they so desire. There are several other tenets throughout the contract such as the flexibility of the plans to offer LTSS to members regardless of their waiver status and the extended continuity of care provisions that focus on access, choice, independence and member safety.	March Vision administers a supplemental routine vision & Eyeglass benefit on our behalf. Avesis administers a routine hearing and materials benefit on our behalf. CVS Caremark assists with the administration of our pharmacy benefit. We also have an in house Pharmacy Department.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes Are LTSS within the scope of this contract? (yes/no) Yes									
Molina Healthcare of Texas Texas Health and Human Services Commission									
Children's Health Insurance Program (CHIP) and CHIP Perinate – Contract for CHIP Rural Service Area (174 counties) between Texas Health and Human Services Commission and Molina Healthcare of Texas Insurance Company; provides comprehensive healthcare services through a managed care delivery	09/1/2013 - 08/31/2015	Original Start Date: 9/1/2010 Original End Date: 8/31/2013 Were there any alterations to this original time frame? Yes If so, please provide reasons for the alterations: Contract for reprocurement	*	Gary Jesse, Deputy Director, Program Operations, Texas Health and Human Services Commission Medicaid /CHIP Division, (512) 462-6295 gary.jesse@hhsc.state.tx.us	CHIP 2014 Average Lives = 52,662 Population Type: CHIP and CHIP Perinate	2014 Annual Revenue = $72,510,158 Capitated	Improvement demonstrated from reporting year 2013-2014 in: • Weight assessment and counseling for nutrition and physical activity for children/adolescents • Immunizations for adolescents • Human papillomavirus vaccine for female adolescents • Breast cancer screening • Cervical cancer screening • Appropriate testing for children with pharyngitis • Appropriate treatment for children with URI • Use of spirometry testing in the	Uniform Managed Care Contract 1.16- Establishes access to care for all covered services by both wait time for services and distance to a service provider,. Also where Possible, our regulatory agency will make MCO assignments for enrollees based on an enrollee's prior history with and geographic proximity to a PCP to help facilitate member choice.	Pharmacy Benefit Manager

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
system for the CHIP and CHIP Perinate programs in Texas Rural Service Area (174 counties); Contract awarded January 1, 2010 with an Operational Start Date of September 1, 2010. Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes Are LTSS within the scope of this contract? (yes/no)No		was extended					assessment and diagnosis of COPD • Pharmacotherapy management of COPD exacerbation • Use of appropriate medications for people with asthma • Medication Management for People With Asthma • Asthma Medication Ratio • Comprehensive diabetes care – A1c testing • Comprehensive diabetes care – eye exam • Follow-up care for children prescribed ADHD medication – initiation phase • Follow-up after hospitalization for mental illness • Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication • Diabetes monitoring for people with diabetes and schizophrenia • Cardiovascular monitoring for people with cardiovascular disease and schizophrenia • Adherence to antipsychotic medications for individuals with		

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
							schizophrenia • Adults' access to preventive/ambulatory health services Note: All Medicaid population for Molina Healthcare of Texas are combined.		
CHIP/CHIP Perinate, STAR and STAR+PLUS (Medicaid) – Contract between Texas Health and Human Services Commission and Molina Healthcare of Texas, Inc.; provides for services in the following Service Areas: Harris (CHIP/CHIP Perinate, STAR & STAR+PLUS); Bexar (STAR+PLUS); Jefferson (CHIP/CHIP Perinate; STAR and STAR+PLUS); Dallas		Original Start Date: 3/1/2012 Original End Date: 8/31/2015 Were there any alterations to this original time frame? No If so, please provide reasons for the alterations: N/A	*	Gary Jesse, Deputy Director, Program Operations, Texas Health and Human Services Commission Medicaid /CHIP Division, (512) 462-6295 gary.jesse@hhsc.state.tx.us	Medicaid 2014 Average Lives = 167,264 Population Type: CHIP, CHIP Perinate Medicaid and Medicaid ABD	2014 Annual Revenue = $880,615,324 Capitated	Improvement demonstrated from reporting year 2013-2014 in: • Weight assessment and counseling for nutrition and physical activity for children/adolescents • Immunizations for adolescents • Human papillomavirus vaccine for female adolescents • Breast cancer screening • Cervical cancer screening • Appropriate testing for children with pharyngitis • Appropriate treatment for children with URI • Use of spirometry testing in the assessment and diagnosis of COPD • Pharmacotherapy management of COPD exacerbation • Use of appropriate medications for people with asthma • Medication Management for People With Asthma	Uniform Managed Care Contract 2.13- This contract outlines the contractual obligations for Managed Care Organizations to establish member choice by maintaining at least two health plans per service area. Accesses to care requirements are based on distance to the nearest provider and depending on the provider type this distance varies. In addition, there are wait periods for both prior authorizations and appointment time. ABD members have access to Service coordination that helps this population to better access needed services in the community and for follow up to ensure services being delivered are timely and appropriate.	• Pharmacy Benefit Manager • Dental • Vision

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
(CHIP/CHIP Perinate and STAR); El Paso (STAR and STAR+PLUS); and Hidalgo (STAR & STAR+PLUS); provides comprehensive healthcare services through a managed care delivery system for the CHIP, STAR and STAR+PLUS Medicaid programs in Bexar Service Area; Dallas Service Area; El Paso Service Area; Harris Service Area; Hidalgo Service Area; Jefferson Service Area. Contract awarded August 1, 2011 with an Operational Start Date of March 1, 2012. Is "physical health coverage" within the scope of this contract? (yes/no) yes Is "behavioral							• Asthma Medication Ratio • Comprehensive diabetes care – A1c testing • Comprehensive diabetes care – eye exam • Follow-up care for children prescribed ADHD medication – initiation phase • Follow-up after hospitalization for mental illness • Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication • Diabetes monitoring for people with diabetes and schizophrenia • Cardiovascular monitoring for people with cardiovascular disease and schizophrenia • Adherence to antipsychotic medications for individuals with schizophrenia • Adults' access to preventive/ambulatory health services Note: All Medicaid population for Molina Healthcare of Texas are combined.	The MCO contracted for Medicaid ABD population must participate in the Texas Promoting Independence (PI) initiative. The initiative is Texas's response to Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999), which requires states to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services.	

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
health coverage" within the scope of this contract? (yes/no) yes Are LTSS within the scope of this contract? (yes/no) Yes									
STAR+PLUS (Medicaid) – Contract for Dallas Service area only between Texas Health and Human Services Commission and Molina Healthcare of Texas, Inc.; provides comprehensive healthcare services through a managed care delivery system for the STAR+PLUS program in Dallas Service Area; Contract awarded June 2010 with Operational Start Date of February 1, 2011. Is "physical health coverage" within the scope of this contract? (yes/no)	09/01/2013 - 08/31/2015	Original Start Date: 2/1/2011 Original End Date: 8/31/2013 Were there any alterations to this original time frame? Yes If so, please provide reasons for the alterations: contract term was extended before reprocurement	*	Gary Jesse, Deputy Director, Program Operations, Texas Health and Human Services Commission Medicaid /CHIP Division, (512) 462-6295 gary.jesse@hhsc.state.tx.us	Medicaid 2014 Average Lives = 32,944 Population Type: Medicaid ABD	2014 Annual Revenue = $302,257,849 Capitated	Improvement demonstrated from reporting year 2013-2014 in: • Weight assessment and counseling for nutrition and physical activity for children/adolescents • Immunizations for adolescents • Human papillomavirus vaccine for female adolescents • Breast cancer screening • Cervical cancer screening • Appropriate testing for children with pharyngitis • Appropriate treatment for children with URI • Use of spirometry testing in the assessment and diagnosis of COPD • Pharmacotherapy management of COPD exacerbation • Use of appropriate medications for people with asthma • Medication Management for People	Uniform Managed Care Contract 1.18 This contract outlines the contractual obligations for Managed Care Organizations to establish member choice by maintaining at least two health plans per service area. Accesses to care requirements are based on distance to the nearest provider and depending on the provider type this distance varies. In addition, there are wait periods for both prior authorizations and appointment time. ABD members have access to Service coordination that helps this population to better access needed services in the community and for follow up to ensure services being delivered are timely and	• Pharmacy Benefit Manager • Dental • Vision

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Yes Is "behavioral health coverage" within the scope of this contract? (yes/no) No Are LTSS within the scope of this contract? (yes/no) Yes							With Asthma • Asthma Medication Ratio • Comprehensive diabetes care – A1c testing • Comprehensive diabetes care – eye exam • Follow-up care for children prescribed ADHD medication – initiation phase • Follow-up after hospitalization for mental illness • Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication • Diabetes monitoring for people with diabetes and schizophrenia • Cardiovascular monitoring for people with cardiovascular disease and schizophrenia • Adherence to antipsychotic medications for individuals with schizophrenia • Adults' access to preventive/ambulatory health services Note: All Medicaid population for Molina Healthcare of Texas are combined.	appropriate. The MCO contracted for Medicaid ABD population must participate in the Texas Promoting Independence (PI) initiative. The initiative is Texas's response to Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999), which requires states to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services.	

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
MMP MMP Duals Demonstration – Contract between CMS, the State of Texas and Molina Healthcare of Texas provides or arranges for healthcare services to dual eligible enrollees ages and over. Service area encompasses 5 counties in the state scope of work includes coordination and approval of all medically necessary covered services and preventive care; claims processing; member services; provider relations and network development. Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage" within the scope of this contract?	11/18/2014 to 12/31/2015	Original Start Date: N/A Original End Date: Were there any alterations to this original time frame? N/A If so, please provide reasons for the alterations: N/A	*	Gary Jesse, Deputy Director, Program Operations, Texas Health and Human Services Commission Medicaid /CHIP Division, (512) 462-6295 gary.jesse@hhsc.state.tx.us	Contract operational start date is 3/1/2015	Capitated	This program is currently in the first quarter of operation. As such, Molina has not yet had an opportunity to obtain baseline data to analyze. Once we have had an opportunity to do so, we will implement programs and initiatives to increase our quality metrics and indicators	This MMP contract emphasizes person-centered/self-directed care outlined in the Individual Service Plan (ISP) which requires that each member have a care coordinator that is their single point of contact. and the continuity of care provisions that focus on access, choice, independence and member safety.	• Pharmacy Benefit Manager • Hearing • Vision • Dental

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
(yes/no) Yes Are LTSS within the scope of this contract? (yes/no) **Yes**									
Medicare – Contract between Centers for Medicare & Medicaid Services (CMS) and Molina Healthcare of Texas, Inc.; Molina Medicare covers Part A (hospital) Medicare benefits, including hospital inpatient care, skilled nursing facility (SNF) care, home health care, hospice care (through CMS contractors), blood; Part B (medical), including doctor's services, outpatient medical / surgical services & supplies, diagnostic tests, outpatient therapy, outpatient mental health services, some preventive	01/01/2015 - 12/31/2015 (Renews annually unless terminated)	01/01/2008 - 12/31/2008	*	Holly Robinson, CMS Plan Manager, 206-615-3673 Holly.robinson@cms.hhs.gov	Medicare 2014 Average Lives = 5,008	2014 Annual Revenue = 71,420,000 Capitated	Improvement demonstrated from reporting year 2013-2014 in: • Breast cancer screening • Diabetic eye exam • Diabetic kidney disease monitoring • Complaints about the plan • Voluntary disenrollment • Medication adherence for diabetes • Medication adherence for HTN • Medication adherence for cholesterol	The contract does not contain language pertaining to member choice, safety, independence, and responsibility.	Molina utilizes pharmacy benefit managers as well as vendors for supplemental benefits including vision, dental, hearing, and transportation.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
health care services; Part D (prescription drugs); additional benefits include routine transportation, preventive / comprehensive dental, over-the-counter health supplies, and routine vision and hardware.									
Molina Healthcare of Utah Utah Dept. of Health, Medicaid and Health Financing									
CHIP – Molina Healthcare of Utah – Contract between the Utah Department of Health and Molina Healthcare of Utah, Inc. (as amended); provides or arranges for healthcare services to eligible Children's Health Insurance Program (CHIP) enrollees statewide; scope of work includes coordination and approval of all medically necessary covered	07/1/2014 – 6/30/2019 Prior contract term: 01/1/2009 - 06/30/2014	Original Start Date: 8/3/1998 Original End Date: 7/31/2001 Were there any alterations to this original time frame? Yes If so, please provide reasons for the alterations: New contracts were signed and/or extended.	*	Emma Chacon, 801-538-6577 echacon@utah.gov	CHIP 2014 Average Lives = 7,344 Population Type: CHIP	2014 CHIP Annual Revenue = $8,193,539 Capitated	In 2014, Molina conducted the CHIP Child CAHPS survey. Molina showed significant improvement in the composite scores for Customer Service and Rating of Health Plan.	Member choice and access emphasized by allowing members to select a managed care plan of their choice and providers within that plan. Members are also required to be have access to needed specialists – if not available in network, out of network must be arranged. Safety emphasized through required monitoring and reporting of over or under utilization, quality indicators, abuse, and neglect.	Subcontract for mental health, vision, and pharmacy services.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
services and preventive care; claims processing; member services; provider relations and network development. Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes Are LTSS within the scope of this contract? (yes/no) No		Molina has been continuously contracted with the Utah Dept. of Health for CHIP since 1998.						Independence and responsibility emphasized through person-centered/self-directed care. Molina's case management program is designed around a collaborative process of assessment, planning, facilitation, and advocacy using available resources to promote quality, timely, safe, and cost-effective outcomes. Members' rights to information regarding treatment options required in plan procedures, member and provider education materials.	
Contract Name: Health Plan ACO – Molina (Traditional Coverage) – Contract between the Utah Department of Health and Molina Healthcare of Utah, Inc. (as amended); provides or arranges for	01/1/2013 - 12/31/2017	Original Start Date: 4/1/1997 Original End Date: 6/30/1999 Were there any alterations to this original time frame? Yes	*	Emma Chacon, 801-538-6577 echacon@utah.gov	Medicaid – Traditional 2014 Average Lives = 59,409 Population Type: Medicaid, ABD	2014 Medicaid Traditional Annual Revenue = $147,154,729 Capitated	Molina Healthcare of Utah underwent an NCQA accreditation survey in January 2014 for our Medicaid lines of business. MHU received a full accreditation with a Commendable status. Molina also collected and	In the urban counties, member choice and access emphasized by allowing members to select a managed care plan of their choice and providers within that plan. Statewide, members are also allowed a 2nd opinion in or out of the network and access to needed specialists – if not available in network, out	Subcontract for vision and pharmacy services.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
healthcare services to eligible Traditional Medicaid enrollees residing statewide; scope of work includes coordination and approval of all medically necessary covered services and preventive care; claims processing; member services; provider relations and network development. Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage" within the scope of this contract? (yes/no) No Are LTSS within the scope of this contract? (yes/no) No		If so, please provide reasons for the alterations: New contracts were signed and/or extended. Molina has been continuously contracted with the Utah Dept. of Health for Medicaid since 1997.					reported HEDIS rates for our Medicaid lines of business for 2014. Molina's Medicaid HEDIS rates included two measures in the 90th percentile and 14 measures in the 75th percentile. Additionally, 39 HEDIS sub-measures exceeded prior year performance. In 2014, Molina also conducted the Medicaid Child CAHPS survey. In four composite scores: Getting Care Quickly, How Well Doctors Communicate, Rating of All Health Care, and Rating of Personal Doctor, Molina scored in the 90th percentile. Customer Service, with a 4.9% increase, and Rating of Health Plan Molina scored in the 75th percentile.	of network must be arranged. Safety emphasized through required monitoring and reporting of over or under utilization, quality indicators, abuse, and neglect. Independence and responsibility emphasized through person-centered/self-directed care. Molina's case management program is designed around a collaborative process of assessment, planning, facilitation, and advocacy using available resources to promote quality, timely, safe, and cost-effective outcomes. Members' rights to information regarding treatment options required in plan procedures, member and provider education materials.	

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Medicare – Contract between the Centers for Medicare & Medicaid Services (CMS) and Molina Healthcare of Utah, Inc.; Molina Medicare covers Part A (hospital) Medicare benefits, including hospital inpatient care, skilled nursing facility (SNF) care, home health care, hospice care (through CMS contractors), blood; Part B (medical), including doctor's services, outpatient medical / surgical services & supplies, diagnostic tests, outpatient therapy, outpatient mental health services, some preventive health care services; Part D (prescription drugs); additional benefits include routine transportation, preventive /	01/01/2015 - 12/31/2015 (Renews annually unless terminated)	01/01/2006 - 12/31/2006	*	Holly Robinson, CMS Plan Manager, 206-615-3673 Holly.robinson@cms.hhs.gov	Medicare 2014 Average Lives = 8,272 **Population Type:** Medicare/Medicaid Dual Eligible	2014 Annual Revenue = 127,004,000 Capitated	Improvement demonstrated from reporting year 2013-2014 in: • Colorectal cancer screening • Monitoring physical activity • Adult BMI assessment • Osteoporosis management • Diabetic eye exam • Diabetic kidney disease monitoring • Diabetic blood sugar control • Rheumatoid arthritis management • Reducing fall risk • Plan all-cause readmits • Care coordination • Timely appeals decisions • Complaints about the plan	The contract does not contain language pertaining to member choice, safety, independence, and responsibility.	Molina utilizes pharmacy benefit managers as well as vendors for supplemental benefits including vision, dental, hearing, and transportation.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
comprehensive dental, over-the-counter health supplies, and routine vision and hardware.							• Voluntary disenrollment • Appeals auto-forward • Medication adherence for diabetes • Medication adherence for HTN • Medication adherence for cholesterol		
Molina Healthcare of Washington Washington State Health Care Authority									
Healthy Options (includes Medicaid and CHIP) – Contract between the Washington Health Care Authority (HCA) and Molina Healthcare of Washington, Inc. (Contract No. 0812-29012); provides prepaid, comprehensive system of medical and healthcare delivery, including preventive, primary, specialty, and ancillary health services for	1/1/2008 – 6/30/2012	Original Start Date: 1/1/2008 Original End Date: 12/31/2008 Were there any alterations to this original time frame? Yes If so, please provide reasons for the alterations: Mutually agreed upon extension	*	Barbara Lantz, (360) 725-1640 barbara.lantz@hca.wa.gov	Medicaid 2010 Average Lives = 354,852 Medicaid 2011 Average Lives = 355,441 Population Type: Medicaid/CHIP historically a state-funded program offering low cost insurance to low income enrollees	Capitated 2010 Annual Revenue = $661,051,079 2011 Annual Revenue = $688,025,218	Yearly HEDIS submission, programs and initiatives are developed and implemented to increase our quality metrics and indicators. These initiatives support our quality program to drive our HEDIS rates and NCQA accreditation. Improvement demonstrated from reporting year 2013-2014 in: • Immunizations for adolescents • Lead screening for children • Breast cancer screening • Avoidance of antibiotic treatment in adults with	Emphasis on person-centered/self-directed care, member choice of health plan and providers. Emphasis on critical incidents and health, safety and welfare monitoring. Patient safety must be a part of the annual quality work plan Member rights and responsibilities are	• Pharmacy Benefit Manager • Vision • Claims Processing

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
enrollees in Medicaid and CHIP, including but not limited to Network Access & Availability, Utilization Management, Quality of Care, Member Services, Grievance & Appeals, Benefit Administration, Oversight and Monitoring. Is "physical health coverage" within the scope of this contract? (yes/no) yes Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes, outpatient Are LTSS within the scope of this contract? (yes/no) yes		of the contract					acute bronchitis • Comprehensive diabetes care – A1c testing • Comprehensive diabetes care – A1c control <8.0% • Comprehensive diabetes care – eye exam • Comprehensive diabetes care – kidney disease monitoring • Comprehensive diabetes care – blood pressure control <140/80 • Well-child visits in the first 15 months of life	shared with member at time of enrollment and yearly thereafter.	
Medicaid WMIP – Contract between the Washington Health Care Authority (HCA)	4/1/2008 - 2/28/2011	Original Start Date: 4/1/2008 Original End	*	Barbara Lantz, (360) 725-1640 barbara.lantz@hca.wa.gov	Medicaid 2010 Average Lives = 3,967 Population Type:	Capitated 2010 Annual Revenue = $36,223,228	Yearly HEDIS submission, programs and initiatives are developed and implemented to increase	Emphasis on person-centered/self-directed care, member choice of	Pharmacy Benefit Manager

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
and Molina Healthcare of Washington, Inc. (Contract No. 0812-39411); provides prepaid, comprehensive system of medical, mental health, chemical dependency and long-term care services for aged, blind and disabled adults in Snohomish County. Including but not limited to Network Access & Availability, Utilization Management, Quality of Care, Member Services, Grievance & Appeals, Benefit Administration, Oversight and Monitoring. Is "physical health coverage" within the scope of this contract? (yes/no) yes Is "behavioral health coverage" within the scope of		Date: 12/31/2009 Were there any alterations to this original time frame? Yes If so, please provide reasons for the alterations: Mutually agreed upon extension of the contract			ABD/Duals		our quality metrics and indicators. These initiatives support our quality program to drive our HEDIS rates. •	health plan and providers. Emphasis on critical incidents and health, safety and welfare monitoring. Patient safety must be a part of the annual quality work plan Member rights and responsibilities are shared with member at time of enrollment and yearly thereafter.	

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
this contract? (yes/no) yes Are LTSS within the scope of this contract? (yes/no) yes									
Basic Health Contract between the Washington Health Care Authority (HCA) and Molina Healthcare of Washington, Inc. (Contract No. K100) provides prepaid, comprehensive system of medical and healthcare delivery, including preventive, primary, specialty, and ancillary health services for enrollees in State subsidized health insurance plan, including but not limited to Network Access & Availability, Utilization Management, Quality of Care, Member Services, Grievance &	1/1/2010 – 12/31/2010	Original Start Date: 1/1/2010 Original End Date: 12/31/2010 Were there any alterations to this original time frame? No If so, please provide reasons for the alterations:	*	Barbara Lantz, (360) 725-1640 barbara.lantz@hca.wa.gov	Medicaid 2010 Average Lives = 10,299	Capitated 2010 Annual Revenue = $33,699,055	Yearly HEDIS submission, programs and initiatives are developed and implemented to increase our quality metrics and indicators. These initiatives support our quality program to drive our HEDIS rates.	Emphasis on person-centered/self-directed care, member choice of health plan and providers. Up-to-date patient safety standards and process for evaluating safety concerns. Member rights and responsibilities are shared with member at time of enrollment and yearly thereafter.	Pharmacy Benefit Manager

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Appeals, Benefit Administration, Oversight and Monitoring. Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage" within the scope of this contract? (yes/no) yes Are LTSS within the scope of this contract? (yes/no) yes									
Basic Health Contract between the Washington Health Care Authority (HCA) and Molina Healthcare of Washington, Inc. (Contract No. K388) provides prepaid, comprehensive system of medical and healthcare delivery, including preventive, primary, specialty,	1/1/2011 – 7/21/2011	Original Start Date: 1/1/2011 Original End Date: 12/31/2011 Were there any alterations to this original time frame? Yes If so, please provide reasons	*	Barbara Lantz, (360) 725-1640 barbara.lantz@hca.wa.gov	Medicaid 2011 Average Lives = 7,832	Capitated 2011 Annual Revenue = $26,871,572	Yearly HEDIS submission, programs and initiatives are developed and implemented to increase our quality metrics and indicators. These initiatives support our quality program to drive our HEDIS rates.	Emphasis on person-centered/self-directed care, member choice of health plan and providers. Up-to-date patient safety standards and process for evaluating safety concerns. Member rights and responsibilities are shared with	Pharmacy Benefit Manager

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
and ancillary health services for enrollees in State subsidized health insurance plan, including but not limited to Network Access & Availability, Utilization Management, Quality of Care, Member Services, Grievance & Appeals, Benefit Administration, Oversight and Monitoring. Is "physical health coverage" within the scope of this contract? (yes/no) yes Is "behavioral health coverage" within the scope of this contract? (yes/no) yes Are LTSS within the scope of this contract? (yes/no) yes		for the alterations: As a result of the CMS approved Transitional Bridge Waiver, which allows the state to receive federal match on BH enrollees, CMS required BH to be more like Medicaid. The contract was then revised to include language from the HO contract. The revised contract took effect 7/22/2011.						member at time of enrollment and yearly thereafter.	
Basic Health Contract between the Washington	7/22/2011 – 6/30/2012	Original Start Date: 7/22/2011	*	Barbara Lantz, (360) 725-1640 barbara.lantz@hca.wa.gov	See (Contract No. K388) for 2011 See (Contract No.	See (Contract No. K388) for 2011 See (Contract No.	Yearly HEDIS submission, programs and initiatives are	Emphasis on person-centered/self-	Pharmacy Benefit Manager

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Health Care Authority (HCA) and Molina Healthcare of Washington, Inc. (Contract No. K489) provides prepaid, comprehensive system of medical and healthcare delivery, including preventive, primary, specialty, and ancillary health services for enrollees in State subsidized health insurance plan, including but not limited to Network Access & Availability, Utilization Management, Quality of Care, Member Services, Grievance & Appeals, Benefit Administration, Oversight and Monitoring. Is "physical health coverage" within the scope of this contract? (yes/no) Yes		Original End Date: 12/31/2011 Were there any alterations to this original time frame? Yes If so, please provide reasons for the alterations: Mutually agreed upon extension of the contract			1112-19446) for 2012	1112-19446) for 2012	developed and implemented to increase our quality metrics and indicators. These initiatives support our quality program to drive our HEDIS rates.	directed care, member choice of health plan and providers. Up-to-date patient safety standards and process for evaluating safety concerns. Member rights and responsibilities are shared with member at time of enrollment and yearly thereafter.	

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Is "behavioral health coverage" within the scope of this contract? (yes/no) yes Are LTSS within the scope of this contract? (yes/no) yes									
Medicaid WMIP – Contract between the Washington Health Care Authority (HCA) and Molina Healthcare of Washington, Inc. (Contract No. 1112-19446); provides prepaid, comprehensive system of medical, mental health, chemical dependency and long-term care services for aged, blind and disabled adults in Snohomish County. Including but not limited to Network Access & Availability, Utilization Management,	3/1/2011 – 12/31/2013	Original Start Date: 3/1/2011 Original End Date: 6/30/2012 Were there any alterations to this original time frame? Yes If so, please provide reasons for the alterations: Mutually agreed upon extension of the contract	*	Barbara Lantz, (360) 725-1640 barbara.lantz@hca.wa.gov	Medicaid 2011 Average Lives = 4,829 Medicaid 2012 Average Lives = 3,823 Medicaid 2013 Average Lives = 3,055 Population Type: ABD/Duals	Capitated 2011 Annual Revenue = $46,827,556 2012 Annual Revenue = $50,887,317 2013 Annual Revenue = $39,779,387	Yearly HEDIS submission, programs and initiatives are developed and implemented to increase our quality metrics and indicators. These initiatives support our quality program to drive our HEDIS rates.	Emphasis on person-centered/self-directed care, member choice of health plan and providers. Emphasis on critical incidents and health, safety and welfare monitoring. Patient safety must be a part of the annual quality work plan Member rights and responsibilities are shared with member at time of enrollment and yearly thereafter.	Pharmacy Benefit Manager

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Quality of Care, Member Services, Grievance & Appeals, Benefit Administration, Oversight and Monitoring. Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage" within the scope of this contract? (yes/no) yes Are LTSS within the scope of this contract? (yes/no) yes									
Healthy Options and Basic Health (includes Medicaid and CHIP) – Contract between the Washington Health Care Authority (HCA) and Molina Healthcare of Washington, Inc. (Contract No.	7/1/2012 – 12/31/2013	Original Start Date: 7/1/2012 Original End Date: 12/31/2013 Were there any alterations to this original time frame?	*	Barbara Lantz, (360) 725-1640 barbara.lantz@hca.wa.gov	Medicaid 2012 Average Lives = 407,577 Medicaid 2013 Average Lives = 392,533 Population Type: Medicaid/BD/	2012 Annual Revenue = Healthy Options - $824,0699,47 Basic Health - $31,728,307 2013 Annual Revenue =	Yearly HEDIS submission, programs and initiatives are developed and implemented to increase our quality metrics and indicators. These initiatives support our quality program to drive our HEDIS rates and NCQA accreditation.	Emphasis on person-centered/self-directed care, member choice of health plan and providers. Emphasis on critical incidents and health, safety and welfare	Pharmacy Benefit Manager Vision Claims Processing

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
K567); provides prepaid, comprehensive system of medical and healthcare delivery, including preventive, primary, specialty, and ancillary health services for enrollees in Medicaid and CHIP, including but not limited to Network Access & Availability, Utilization Management, Quality of Care, Member Services, Grievance & Appeals, Benefit Administration, Oversight and Monitoring. Is "physical health coverage" within the scope of this contract? (yes/no) yes Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes, outpatient		No If so, please provide reasons for the alterations:			CHIP/Foster Care/Basic Health historically a state-funded program offering low cost insurance to low income enrollees	Healthy Options - $1,016,535,090 Basic Health - $37,944,969 Capitated		monitoring. Patient safety must be a part of the annual quality work plan Member rights and responsibilities are shared with member at time of enrollment and yearly thereafter.	

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Are LTSS within the scope of this contract? (yes/no) yes									
Apple Health (includes Medicaid and CHIP) – Contract between the Washington Health Care Authority (HCA) and Molina Healthcare of Washington, Inc. (Contract No. K1014); provides prepaid, comprehensive system of medical and healthcare delivery, including preventive, primary, specialty, and ancillary health services for enrollees in Medicaid and CHIP, including but not limited to Network Access & Availability, Utilization Management, Quality of Care, Member Services, Grievance & Appeals, Benefit Administration, Oversight and	01/01/2014 - 12/31/2014	Original Start Date: 1/1/2014 Original End Date: 12/31/2014 Were there any alterations to this original time frame? No If so, please provide reasons for the alterations:	*	Barbara Lantz, (360) 725-1640 barbara.lantz@hca.wa.gov	Medicaid 2014 Average Lives = 485,958 Population Type: Medicaid/BD/ CHIP/Foster Care/ Medicaid expansion historically a state-funded program offering low cost insurance to low income enrollees	2014 Annual Revenue = $1,193,874,222 Capitated	Yearly HEDIS submission, programs and initiatives are developed and implemented to increase our quality metrics and indicators. These initiatives support our quality program to drive our HEDIS rates and NCQA accreditation.	Emphasis on person-centered/self-directed care, member choice of health plan and providers. Emphasis on critical incidents and health, safety and welfare monitoring. Patient safety must be a part of the annual quality work plan Member rights and responsibilities are shared with member at time of enrollment and yearly thereafter.	Pharmacy Benefit Manager Vision Claims Processing

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Monitoring. Is "physical health coverage" within the scope of this contract? (yes/no) yes Is "behavioral health coverage" within the scope of this contract? (yes/no) yes Are LTSS within the scope of this contract? (yes/no) yes									
Medicaid WMIP – Contract between the Washington Health Care Authority (HCA) and Molina Healthcare of Washington, Inc. (Contract No. K1101); provides prepaid, comprehensive system of medical, mental health, chemical dependency and long-term care services for aged, blind and disabled	01/01/2014 - 06/30/2014	Original Start Date: 1/1/2014 Original End Date: 6/30/2014 Were there any alterations to this original time frame? No If so, please provide reasons for the alterations:	*	Barbara Lantz, (360) 725-1640 barbara.lantz@hca.wa.gov	Medicaid 2014 Average Lives = 2,052 Population Type: ABD/Duals	2014 Annual Revenue = $14,176,153 Capitated	Yearly HEDIS submission, programs and initiatives are developed and implemented to increase our quality metrics and indicators. These initiatives support our quality program to drive our HEDIS rates.	Emphasis on person-centered/self-directed care, member choice of health plan and providers. Emphasis on critical incidents and health, safety and welfare monitoring. Patient safety must be a part of the annual quality work plan	N/A

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
adults in Snohomish County. Including but not limited to Network Access & Availability, Utilization Management, Quality of Care, Member Services, Grievance & Appeals, Benefit Administration, Oversight and Monitoring. Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage" within the scope of this contract? (yes/no) yes Are LTSS within the scope of this contract? (yes/no) yes								Member rights and responsibilities are shared with member at time of enrollment and yearly thereafter.	
Apple Health (includes Medicaid and CHIP) – Contract between the Washington Health	01/01/2015 - 12/31/2015 (HCA is looking to extend to June 2016)	Original Start Date: 1/1/2015 Original End Date:	*	Barbara Lantz, (360) 725-1640 barbara.lantz@hca.wa.gov	Population Type: Medicaid/BD/ CHIP/Foster Care/ Medicaid expansion historically a state-	Capitated	Yearly HEDIS submission, programs and initiatives will be developed and implemented to increase our quality metrics and	Emphasis on person-centered/self-directed care, member choice of health plan and	Pharmacy Benefit Manager Vision Claims Processing

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
Care Authority (HCA) and Molina Healthcare of Washington, Inc. (Contract No. K1339); provides prepaid, comprehensive system of medical and healthcare delivery, including preventive, primary, specialty, and ancillary health services for enrollees in Medicaid and CHIP, including but not limited to Network Access & Availability, Utilization Management, Quality of Care, Member Services, Grievance & Appeals, Benefit Administration, Oversight and Monitoring. Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage"		12/31/2015 Were there any alterations to this original time frame? pending If so, please provide reasons for the alterations: HCA is looking to extend to June 2016			funded program offering low cost insurance to low income enrollees		indicators. These initiatives will support our quality program to drive our HEDIS rates and NCQA accreditation.	providers. Beginning May 2015 clients can choose their health plan at the time of enrollment. Emphasis on critical incidents and health, safety and welfare monitoring. Patient safety must be a part of the annual quality work plan Member rights and responsibilities are shared with member at time of enrollment and yearly thereafter.	

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
within the scope of this contract? (yes/no) Yes Are LTSS within the scope of this contract? (yes/no) Yes									
Medicare – Contract between the Centers for Medicare & Medicaid Services (CMS) and Molina Healthcare of Washington, Inc.; Molina Medicare covers Part A (hospital) Medicare benefits, including hospital inpatient care, skilled nursing facility (SNF) care, home health care, hospice care (through CMS contractors), blood; Part B (medical), including doctor's services, outpatient medical / surgical services & supplies,	01/01/2015 - 12/31/2015 (Renews annually unless terminated)	01/01/2006 - 01/01/2006	*	Holly Robinson, CMS Plan Manager, 206-615-3673 Holly.robinson@cms.hhs.gov	Medicare 2014 Average Lives = 7,828 **Population Type:** Medicare/Medicaid Dual Eligible	2014 Annual Revenue = 112,893,000 Capitated	Improvement demonstrated from reporting year 2013-2014 in: • Annual flu vaccine • Monitoring physical activity • Adult BMI assessment • Diabetic eye exam • Diabetic kidney disease monitoring • Controlling high blood pressure • Overall rating of health care quality • Care coordination • Complaints about the plan • Appeals auto-forward • Medication adherence for HTN • Medication	The contract does not contain language pertaining to member choice, safety, independence, and responsibility.	Molina utilizes pharmacy benefit managers as well as vendors for supplemental benefits including vision, dental, hearing, and transportation.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
diagnostic tests, outpatient therapy, outpatient mental health services, some preventive health care services; Part D (prescription drugs); additional benefits include routine transportation, preventive / comprehensive dental, over-the-counter health supplies, and routine vision and hardware.							adherence for cholesterol		
a. Scope of Work	**b. Duration of Contract**	**c. Start and End Dates of Contract (as originally entered into)**	**d. Total Value of Contract (at the time it was executed)**	**e. Contact Name, Telephone**	**f. Number of Members Served by Population Type**	**g. Annual Contract Payment Capitated or Non-capitated**	**h. Any improvements made in utilization trends and quality indicators**	**i. How the contract emphasizes member choice, access, safety, independence, and responsibility**	**j. The role of subcontractors, if any**
Molina Healthcare of Wisconsin Wisconsin Dept. of Health Services									
Contract for BadgerCare Plus and/or Medicaid SSI HMO Services Between the HMO and the Wisconsin Department of Health Services; provides	01/01/2014 - 12/31/2015 (Renews annually unless terminated)	Original Start Date: 01/01/2010 (BadgerCare and SSI) 09/01/2010 (BadgerCare only)	*	Ashley Davis, Managed Care Policy Analyst Wisconsin Department of Health Services, (608) 261-7798 ashley.davis@wisconsin.gov	Medicaid 2014 Average Lives = 83,322 Population Type: Medicaid TANF, CHIP, SSI	2014 Annual Revenue = $137,794,745 Capitated	IP Utilization decreases: SSI ALOS= ↓7.5% Admits/K=↓ 16% IP Days/K= ↓ 22.5% TANF ALOS=↓ 2% Admits/K= ↓ 1.6% IP Days/K= ↓ 3.7%	Emphasis on Primary Care Provider Assignment Emphasis on Choice of Health Care Professional	**Medicaid** • Herslof – provides vision services • Interlink – provides organ transplant services • Quest Diagnostics – provides laboratory

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
comprehensive healthcare services to members enrolled in the HMO under the State of Wisconsin BadgerCare Plus and/or Medicaid SSI program for the further purpose of promoting coordination and continuity of preventive health services and other medical care including prenatal care, emergency care, and HealthCheck services. Agreements prior to 01/01/14? Effective 1/1/10, Abri Health Plan entered into an agreement with the State of WI to provide Medicaid (BadgerCare and SSI) coverage in specified regions within the State. In 2010, Molina Healthcare and Abri entered into an agreement to		Original End Date: 12/31/11 (BadgerCare and SSI) 12/31/13 (BadgerCare only) Were there any alterations to this original time frame? No. The State typically enters into two-year contracts with HMOs. Upon expiration of the contract year, the State issues a new contract to cover the next two-year period. If so, please provide reasons for the alterations: N/A					Quality Indicator: MY2014 rates are not available until 4th quarter 2015. Notable Improvements HEDIS measures 2012 v 2013 • Breast Cancer Screening: Preventative Care o 2.7% improvement from 2012 o On track to demonstrate significant improvement in 2014 o Focused PIP for MY2014 (the document we submit to Metastar) • Follow Up after Hospitalization: Behavioral Health Care o 6.26% improvement from 2012 o On track to maintain improvement in 2014 o Focused workflow between quality and HealthCare Services team demonstrated results	Emphasis on Notifications to Members regarding termination, suspension, or reduction of an ongoing benefit especially in a rural area. Emphasis on Provider Network and Access Requirements The HMO must provide medical care to its BadgerCare Plus and/or Medicaid SSI members that are as accessible to them, in terms of timeliness, amount, duration, and scope.. Emphasis on an Online Provider Directory Emphasis on Emergency Medical Conditions Emphasis on court related substance abuse services Emphasis on safety	services Scion Dental – provides dental services

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
jointly respond to an RFP for the State Medicaid contract. As part of that agreement, the parties agreed that Molina Healthcare would acquire Abri upon winning the RFP. Molina Healthcare and Abri won the RFP. On September 1, 2010, Molina acquired Abri and took over the 1/1/10 Medicaid agreement and also entered into an agreement with the State to provide Medicaid (BadgerCare only) in specific regions in the State of WI. From 2010 through the end of 2013, Molina Healthcare maintained two separate Medicaid Contracts, as described above. In 2014, the State of WI consolidated the contracts into a								of members most notably Medicaid SSI members.	

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
single agreement. Is "physical health coverage" within the scope of this contract? (yes/no) Yes Is "behavioral health coverage" within the scope of this contract? (yes/no) Yes Are LTSS within the scope of this contract? (yes/no) No Is pharmacy coverage within the scope of this contract? (yes/no) No									
Contract between Centers for Medicare & Medicaid Services (CMS) and Molina Healthcare of Wisconsin, Inc. Molina Medicare covers Part A (hospital) Medicare benefits, including hospital inpatient care, skilled	01/01/2015 - 12/31/2015 (Renews annually unless terminated)	01/01/2014 - 12/31/2014	*	Holly Robinson, CMS Plan Manager, 206-615-3673 Holly.robinson@cms.hhs.gov	Medicare 2014 Average Lives = 295 **Population Type:** Medicare/Medicaid Dual Eligible	2014 Annual Revenue = 3,414,000 Capitated	New plan - data unavailable.	The contract does not contain language pertaining to member choice, safety, independence, and responsibility.	Molina utilizes pharmacy benefit managers as well as vendors for supplemental benefits including vision, dental, hearing, and transportation.

a. Scope of Work	b. Duration of Contract	c. Start and End Dates of Contract (as originally entered into)	d. Total Value of Contract (at the time it was executed)	e. Contact Name, Telephone, and email address	f. Number of Members Served by Population Type	g. Annual Contract Payment Capitated or Non-capitated	h. Any improvements made in utilization trends and quality indicators	i. How the contract emphasizes member choice, access, safety, independence, and responsibility	j. The role of subcontractors, if any
nursing facility (SNF) care, home health care, hospice care (through CMS contractors), blood; Part B (medical), including doctor's services, outpatient medical / surgical services & supplies, diagnostic tests, outpatient therapy, outpatient mental health services, some preventive health care services; Part D (prescription drugs); additional benefits include routine transportation, preventive / comprehensive dental, over-the-counter health supplies, and routine vision and hardware.									

* Contract value is not specified at execution because it is subject to final rate negotiation and selection of the MCO by members.

3.2.7.5 Select Attachments Not Included in Page Count

Some reports and attachments may be included behind Tab 6 and will not count toward the 1000 page limit. These include:

- EQRO Reports referenced in Attachment 5: Technical Proposal Response Template Section 14 question 5.
- Implementation Plan referenced in Attachment 1: Scope of Work Section 2.14
- HEDIS Scores referenced in Attachment 1: Scope of Work Section 10.1
- Provider Contract Agreement Templates referenced in Attachment 1: Scope of Work Section 6.1.2.

Molina Healthcare of Iowa, Inc.
Provider Services Agreement

SIGNATURE AUTHORIZATION

In consideration of the promises, covenants, and warranties stated, the parties agree as set forth herein. The Authorized Representative for each party executes this Agreement with the intent to bind the parties in accordance with applicable Laws. The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and proper authorization to act on behalf of Provider. The Authorized Representative further acknowledges he/she received and reviewed the entirety of this Agreement.

Provider Signature

Provider's Legal Name ("Provider") – as listed on applicable tax form (i.e. Tax Form W-9) and any doing business as name		
Authorized Representative's Signature	Title	Signature Date
Authorized Representative's Name – Printed	Provider Telephone Number	

Provider Information

Mailing Address – Official Correspondence	Billing / Payment Address – if different than Mailing Address
Fax Number – Official Correspondence	Tax ID Number – as listed on applicable tax form
E-mail Address – Official Correspondence	NPI Number – that corresponds to the listed Tax ID Number

Health Plan Signature and Information

Molina Healthcare of Iowa, Inc., a Iowa Corporation ("Health Plan")		
Authorized Representative's Signature	Title	Countersignature Date
Authorized Representative's Name – Printed	Mailing Address – Official Correspondence	
E-mail Address – Official Correspondence		

DRAFT

PROVIDER SERVICES AGREEMENT

This Agreement is entered into between Health Plan and Provider as set forth and made effective as of the date of Health Plan's countersignature ("Effective Date").

RECITALS

A. Health Plan arranges for the provision of certain health care services to Members pursuant to contracts with various government sponsored health products/programs ("Government Programs") and other products/programs, as applicable. Health Plan intends to participate in additional Government Programs and offer other health products/programs as the opportunities become available.

B. Health Plan is a domiciled corporation that has been issued a certificate of authority by the appropriate state licensing agency to provide health care services to Members. Health Plan also is certified, licensed and/or approved by all other required agencies to provide health care services to eligible recipients.

C. Health Plan arranges for the provision of certain health care services to Members by entering into provider service agreements with individual physicians, groups of physicians, individual practice associations, hospitals, clinics, ancillary health providers, and other health providers.

D. Provider is licensed to render certain health care services and desires to provide such services to Health Plan's Members in connection with Health Plan's contractual obligations to provide and/or arrange for health care services for Health Plan's Members.

Now, therefore, in consideration of the promises, covenants and warranties stated herein, Health Plan and Provider agree as follows:

ARTICLE ONE – DEFINITIONS

1.1 Capitalized words or phrases in this Agreement have the meaning set forth in Attachment A.

ARTICLE TWO – PROVIDER OBLIGATIONS

2.1 **Provision of Provider Services.** Provider agrees to provide Provider Services to Members within the scope of Provider's business, practice and license, and in accordance with applicable Law and the terms of this Agreement including, but not limited to, the Provider Manual, Health Plan's QI and UM Programs and applicable Accreditation Organization standards.

2.2 **Provider Standards.**

a. **Standard of Care.** Provider will provide Provider Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and standards of professional conduct, and any controlling governmental licensing requirements.

b. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel and administrative services will be at a level and quality as necessary to perform Provider's duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.

c. **Prior Authorization.** If Provider determines that it is Medically Necessary to consult or obtain services from other health professionals that are Medically Necessary, Provider will obtain the prior authorization of Health Plan in accordance with Provider Manual unless the situation is one involving the delivery of Emergency Services. Upon and following such referral, Provider will coordinate the provision of such Covered Services to Members and ensure continuity of care. Except in the case of Emergency Services, prior to rendering Provider Services, Provider shall obtain prior authorization of Health Plan in accordance with Provider Manual, for those services that require a prior authorization. Failure to receive prior authorization from Health Plan may result in Claim denial.

d. **Use of Participating Providers.** Except in the case of Emergency Services or where Provider obtains the prior authorization of Health Plan, Provider will utilize Health Plan's Participating Providers to provide Provider Services to Members. Should Health Plan have no Participating Provider to render Medically Necessary Provider Services, Health Plan will use reasonable efforts to coordinate an out of network agreement with an appropriate provider.

e. **Member Eligibility Verification.** Provider will verify eligibility of Members prior to rendering services unless the situation is one involving the delivery of Emergency Services.

f. **Admissions.** Provider will cooperate with and comply with Health Plan's hospital admission and prior authorization procedures.

g. **Emergency Room Referral.** If Provider refers a Member to an emergency room for Covered Services, Provider will notify Health Plan within twenty-four (24) hours of the referral.

h. **Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Provider will abide by Health Plan's drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider will obtain prior authorization from Health Plan if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

i. **Availability of Services.** Provider will make necessary and appropriate arrangements to assure the availability of Provider Services to Members on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of Member patient visits after hours. Provider will meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

j. **Treatment Alternatives.** Health Plan encourages open Provider-Member communication regarding appropriate treatment alternatives. Health Plan promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of limitations on Covered Services. Provider is free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Health Plan's decision to terminate or refuse to contract with a Provider will not be based in whole or in part on the fact that the Provider discussed medical treatment options with a Member.

2.3 **Rights of Members.** Provider will observe, protect and promote the rights of Members.

2.4 **Corrective Action.** Health Plan and certain state and federal regulators routinely monitor the level, manner, and quality of Covered Services provided pursuant to this Agreement as well Provider's compliance with the terms of this Agreement. In the event a deficiency is identified, Health Plan or regulator, in their sole discretion, may choose to issue a corrective action plan, and Provider will be required to accept and implement such a corrective action plan. A corrective action plan is not required to be given to Provider before issuing a Termination with Cause or an Immediate Termination.

2.5 **Promotional Activities.** At the request of Health Plan, Provider will: (i) display Health Plan promotional materials in its offices and facilities as practical; and (ii) cooperate with and participate in all reasonable Health Plan marketing efforts so long as it does not violate applicable Law. Provider will not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan.

2.6 **Nondiscrimination.**

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

b. **Employment.** Provider will not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual's ability to perform the duties of the particular job or position.

2.7 **Recordkeeping.**

a. **Maintaining Member Medical Record.** Provider will maintain a medical and billing record for each Member to whom Provider renders health care services. Provider will open each Member's medical record upon the Member's first Encounter with Provider. The Member's medical record will contain all information required by Law, generally accepted and prevailing professional practice, applicable Government Programs, and all Health Plan policies and procedures. Provider will retain all such records for as long as required by applicable Law and/or Government Contracts. This section will survive the termination of this Agreement or an individual product/program.

b. **Confidentiality of Member Health Information.** Provider will comply with all applicable Law, Health Plan's policies and procedures, Government Program requirements regarding privacy and confidentiality of Members' health information and medical records, including mental health records. Provider will not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision will not affect or limit Provider's obligation to make available medical records, Encounter Data and information concerning Member care to Health Plan, any authorized state or federal agency, or other providers of health care upon authorized referral.

DRAFT

c. **HIPAA.** Provider will comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act and any regulations promulgated thereunder (collectively the "HIPAA Rules").

d. **Delivery of Patient Care Information.** Provider will promptly deliver to Health Plan, upon request and/or as may be required by Law, Health Plan's policies and procedures, applicable Government Programs, Health Plan's contracts with the government agencies, or third party payors, any information, statistical data, Encounter Data, or patient treatment information pertaining to Members served by Provider, including but not limited to, any and all information requested by Health Plan in conjunction with Health Plan's UM Program, grievances, peer review, Healthcare Effectiveness Data and Information Set ("HEDIS") studies, Health Plan's QI Program, Consumer Assessment of Healthcare Providers and Systems ("CAHPS"), Medicare and/or Medicaid risk adjustment, or Claims payment. The party producing the records will be responsible for any fees associated with producing such records. Provider will further provide direct access to said patient care information as requested by Health Plan and/or as required by any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan. Health Plan will have the right to withhold compensation from Provider in the event that Provider fails or refuses to promptly provide any such information to Health Plan. This section will survive the termination of this Agreement or an individual product/program.

e. **Member Access to Health Information.** Provider will give Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with applicable Law, applicable Government Programs, and Health Plan's policies and procedures. This section will survive the termination of this Agreement or an individual product/program.

2.8 **Program Participation.**

a. **Participation in Grievance Program.** Provider will participate in Health Plan's Grievance Program and will cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.

b. **Participation in Quality Improvement Program.** Provider will participate in Health Plan's Quality Improvement Program and will cooperate with Health Plan in conducting peer review and audits of care rendered by Provider.

c. **Participation in Utilization Review and Management Program.** Provider will participate in and comply with Health Plan's Utilization Review and Management Program, including all policies and procedures regarding prior authorizations, and will cooperate with Health Plan in audits to identify, confirm, and/or assess utilization levels of Provider Services.

d. **Participation in Credentialing.** Provider will cooperate with, participate in and satisfy all credentialing and re-credentialing criteria established by Health Plan prior to the Effective Date and provision of Covered Services set forth in and in accordance with and throughout the term of this Agreement. Provider will immediately notify Health Plan in writing of any change in the information submitted or relied upon by Provider in order to achieve or maintain credentialed status. All Participating Providers must be credentialed in accordance with Health Plan's policies and procedures, by Health Plan or its designee, prior to treating Members.

e. **Provider Manual.** Provider will comply with and render Covered Services in accordance with the contents, instructions and procedures set forth in the Provider Manual, which is incorporated herein by reference and which may be unilaterally amended from time to time by Health Plan. Health Plan's Provider Manual is made available to Provider at Health Plan's website.

f. **Supplemental Materials.** In addition to the contents, instructions, and procedures set forth in the Provider Manual, Health Plan may periodically promulgate bulletins or other written materials that may or may not be used to supplement the Provider Manual or may be used to provide additional instruction, guidance or information to Provider ("Supplemental Materials"). Health Plan may issue such Supplemental Materials in an electronic format. Provider can obtain paper copies upon request. Revisions to the Supplemental Materials shall become binding upon Provider as of the effective date indicated on the Supplemental Materials. If applicable, such effective date shall be determined in accordance with the terms of this Agreement.

g. **Health Plan's Electronic Processes and Initiatives.** Provider will participate in and comply with Health Plan's electronic processes and initiatives, including but not limited to, electronic submission of prior authorization, Health Plan access to electronic medical records, electronic claims filing, electronic data interchange ("EDI"), electronic remittance advice and electronic funds transfers, registration and use of Health Plan's interactive web portal. Such programs, registration, and use are contained and described in the Provider Manual or Supplemental Materials.

DRAFT

h. **Government Contracts.** Provider acknowledges that Health Plan has entered into contracts with state and federal agencies for the arrangement of health care services for Members through Government Programs. Provider will comply with any term or condition of those Government Contracts that are applicable to the Provider Services to be performed under this Agreement. Health Plan will give Provider a copy of any applicable Government Contract(s), upon request by Provider.

i. **Health Education/Training.** Provider will participate in and cooperate with Health Plan's Provider education and training efforts as well as Member education and related efforts. Provider will also comply with all Health Plan health education, Health Plan's Cultural Competency Plan, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Provider will ensure prompt delivery to any constituent providers all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Provider Services to Members.

2.9 **Practitioner Information.** Provider will deliver to Health Plan a complete list of its healthcare providers, facilities, and business/practice locations that it uses to provide Covered Services, together with specific information required for credentialing and administration in a format acceptable to Health Plan. Provider will deliver such information prior to the execution of this agreement and every six (6) months thereafter or promptly provide notice when there is any change to such information. Health Plan also reserves the right to request such information at any time.

2.10 **Licensure and Standing.**

a. **Licensure.** Provider warrants and represents that it is appropriately licensed to render health care services within the scope of Provider's practice, including having and maintaining a current narcotics number, where appropriate, issued by all proper authorities. Provider will provide evidence of licensure to Health Plan upon request. Provider will maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider will immediately notify Health Plan of any change in Provider's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider.

b. **Unrestricted Status.** Provider warrants and represents that it has not been and is not currently excluded from, and will immediately notify Health Plan in the event it becomes excluded from, participation in Medicare and/or state health care programs pursuant to Section 1128 of the Social Security Act (42 U.S.C. 1320a-7) ("Section 1128") for any of the following: (i) conviction of a crime; (ii) assessment of a civil penalty; (iii) entered into a contractual relationship with an entity convicted of a crime; and/or (iv) taken any other action that would prohibit it from participation in Medicare and/or state health care programs, all as set forth under Section 1128.

c. **Malpractice and Other Actions.** Provider will give immediate notice to Health Plan of: (i) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (ii) any criminal investigations or proceedings against Provider; (iii) any convictions of Provider for crimes involving moral turpitude or felonies; and (iv) any civil claim asserted against Provider that may jeopardize Provider's financial soundness.

d. **Staffing Privileges for Providers.** Consistent with community standards, Provider will have staff privileges with at least one Health Plan contracted hospital as necessary to provide services to Members under this Agreement, and will authorize each hospital at which he/she maintains staff privileges to notify Health Plan should any disciplinary or other action of any kind be initiated against such provider which could result in any suspension, reduction or modification of Provider's hospital privileges.

e. **Liability Insurance.** Throughout the term of this Agreement, Provider will maintain premises and professional liability insurance: (i) in coverage amounts appropriate for the size and nature of Provider's facility and the nature of Provider's health care activities; and (ii) in compliance with applicable Law and Government Program requirements. If the coverage is claims made or reporting, Provider agrees to purchase similar "tail" coverage upon termination of the Provider's present or subsequent policy(ies). Provider will deliver copies of such insurance policy(ies) to Health Plan within five (5) business days of a written request by Health Plan, and will give at least fifteen (15) business days advance written notice to Health Plan prior to any change, reduction, cancellation or termination of such insurance coverage.

2.11 **Claims Payment.**

a. **Submitting Claims.** Provider will promptly submit to Health Plan Claims for Provider Services rendered to Members. All Claims will be submitted in a standard form (CMS-1500, UB-04 or successor format) acceptable to and approved by Health Plan, and will include any and all medical records pertaining to the Claim if requested by Health Plan or otherwise required by Health Plan's policies and procedures. Provider will not be eligible for payment

for any Claims submitted within a period of time from the Date of Service that exceeds: (i) the number of days required by the timeframes specified by applicable Law and Government Program requirements; or (ii) ninety (90) days from the Date of Service, whichever is greater. Notwithstanding the foregoing, for any Claims associated with coordination of benefits, Provider will not be eligible for payment within a period of time that exceeds: (i) the number of days required by the timeframes specified by applicable Law and Government Program requirements; or (ii) ninety (90) days from the date the primary payor adjudicated the Claim, whichever is greater.

b. **National Provider Identifier ("NPI").** Provider will comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (45 CFR Section 162.402, et seq.) and use only the NPI to identify HIPAA covered health care providers in standard transactions. Provider will utilize an NPI from the National Plan and Provider Enumeration System ("NPPES") for itself or for any subpart of the Provider. Provider will make best efforts to report its NPI and any subparts to Health Plan. Provider will report any changes in its NPI or subparts to Health Plan within thirty (30) days of the change. Provider will use its NPI to identify itself on all Claims and Encounters (both electronic and paper formats) submitted to Health Plan.

c. **Compensation.** Health Plan will pay Provider for Clean Claims for Provider Services provided to Members, including Emergency Services, in accordance with applicable Law, Government Program requirements, and in accordance with the terms of this Agreement. Such payment will be made within the lessor of: (i) the timeframes specified by applicable Law and Government Program requirements, or (ii) sixty (60) days of the date such Clean Claim is delivered by Provider to Health Plan and Health Plan determines such claim is a Clean Claim for Provider Services and/or Emergency Services. Provider agrees to accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for Provider Services provided to Members as deemed Medically Necessary and appropriate under this Agreement, Health Plan's Quality Improvement and Utilization Review and Management Programs. Provider will not balance bill Members for any Provider Services.

d. **Co-payments and Deductibles.** Provider is responsible for collection of co-payments, co-insurances and deductibles, if any.

e. **Member Hold Harmless.** Provider agrees that in no event, including but not limited to, nonpayment, insolvency, or breach of this Agreement by the Health Plan, will Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member, or person acting on Member's behalf, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-insurance, deductibles, or co-payments as specifically provided in the Member's evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor. This provision will survive the termination of this Agreement or an individual product/program regardless of the reason for the termination, including the insolvency of Health Plan.

f. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider will make reasonable inquiry of Members to learn whether Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type, and Provider will immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Provider will be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payors, not to exceed the amount specified in the Compensation Schedule.

g. **Offset.** In the event of an Overpayment, Provider will make repayment to Health Plan within thirty (30) days of receipt of written notification by Health Plan of the Overpayment or within thirty (30) days of Provider's identification of the Overpayment. In addition to any other contractual or legal remedy, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider. As a material condition to Health Plan's obligations under this Agreement, Provider agrees that the offset and recoupment rights set forth herein will be deemed to be and to constitute rights of offset and recoupment authorized under applicable Law or in equity to the maximum extent legally permissible, and that such rights will not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Provider.

h. **Claim Review**. Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, current Uniform Billing ("UB") manual and editor, Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS"), federal, and state billing and payment rules, National Correct Coding Initiatives ("NCCI") Edits, and Federal Drug Administration ("FDA") definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Furthermore, Provider acknowledges Health Plan's right to conduct medical necessity reviews and apply clinical practices to determine

appropriate payment. Payment may exclude certain items not billed in accordance with industry standard billing and payment rules or certain items which do not meet certain medical necessity criteria.

i. **Claim Auditing.** Provider acknowledges Health Plan's right to conduct post-payment billing audits. Provider shall cooperate with Health Plan's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan shall use established industry claims adjudication and/or clinical practices, state, and federal guidelines, and/or Health Plan's policies and data to determine the appropriateness of the billing, coding and payment.

j. **Payments which are the Responsibility of a Capitated Provider.** Provider agrees that if Provider provides Covered Services that are the financial responsibility of a Capitated Provider, Provider will look solely to the Capitated Provider, and not Health Plan, for payment of such Covered Services. Pursuant to the terms in the agreement between the Capitated Provider and the Health Plan, if Provider provides Covered Services that are the financial responsibility of the Capitated Provider, Capitated Provider will compensate the Provider at the rate set forth in the Agreement between the Provider and the Capitated Provider. In the event there is not an agreement between the Capitated Provider and Provider, or where the Capitated Provider and Provider have not agreed to compensation terms, Provider will be reimbursed, as determined by the Provider and the Capitated Provider, at: (i) one hundred percent (100%) of the governing rates provided by applicable Law specific to the Member's enrolled benefit plan (i.e. Medicaid or Medicare, etc.) in place at the time services are rendered; or (ii) at the rates set forth in this Agreement. Except as specifically stated in this section, Provider agrees that the other compensation terms of the Agreement will continue to be binding upon Provider. Furthermore, for the avoidance of doubt, Provider will abide by all provisions of this Agreement relating to non-billing of Members with respect to all services and treatment.

k. **Timely Submission of Encounter Data**. Provider understands that Health Plan may have certain contractual reporting obligations which require timely submission of encounter data. Therefore, as applicable, Provider shall submit Encounter Data to Health Plan within thirty (30) days of the Date of Service.

2.12 **Compliance with Law.** Provider will comply with all applicable Laws governing the delivery of Provider Services to Members including, but not limited to, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Balanced Budget Act of 1997; and the Americans with Disabilities Act. In addition, Provider shall comply with the program specific requirements set forth in the attachments to this Agreement as they apply to each product and region.

2.13 **Provider Non-solicitation Obligations.** Provider will not unilaterally assign or transfer patients served under this Agreement to another medical group, Independent Practice Association ("IPA"), or provider without the prior written approval of Health Plan. Nor will Provider solicit or encourage Members to select another health plan. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

2.14 **Fraud and Abuse Reporting.** Provider will report to Health Plan's compliance officer all cases of suspected fraud or abuse, as defined in 42 CFR 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) days of the date when Provider first becomes aware of, or is on notice of, such activity. Provider will establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and abuse in the provision of health care services under the Medicaid program. Upon the request of Health Plan and/or the state, Provider will consult with the appropriate state agency prior to and during the course of any such investigations.

2.15 **Advance Directive.** Provider will document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other applicable Law.

2.16 **Reassignment of Members.** Health Plan reserves the right to reassign Members from Provider to another provider or to limit or deny the assignment or selection of new Members to Provider during any termination notice period or if Health Plan determines that assignment of Members to Provider poses a threat to the Members' health and safety. If Provider requests reassignment of a Member, Health Plan, in its sole discretion, will make the determination regarding reassignment based upon good cause shown by the Provider. When the Health Plan reassigns Member(s), Provider will forward copies of the Member's medical records to the new provider within ten (10) business days of receipt of the Health Plan's or the Member's request to transfer the records.

2.17 **Reciprocity Agreements.** Provider will cooperate with Affiliates of Health Plan and agrees to provide Provider Services to Members enrolled in the various products and programs offered by any Affiliate and to assure reciprocity of such health care services. Provider will comply with the procedures established by Health Plan or its Affiliates and this

Agreement for reimbursement of such services or treatment. Provider will not encourage Members to receive Provider Services from non-Participating Providers. Provider will abide by all provisions of this Agreement relating to non-billing of Members with respect to all services and treatment subject to this reciprocity arrangement.

2.18 **Notification of Network Change.** Where Provider is a medical group, independent practice association, or any other similar entity/organization, Provider will provide Health Plan and Members with timely prior written notification in the event a constituent provider terminates its contract with Provider. Said written notification will be in compliance with applicable Law or Government Program requirements.

2.19 **Members Condition Changes or Deaths.** Upon becoming aware of or suspecting: (i) a significant change in a Member's health or functional status that could affect Member's level of care determination; (ii) a Member is being abused or neglected; or (iii) a Member death, Provider will notify Health Plan's Member Services Department as soon as possible but not later than seven (7) days.

ARTICLE THREE – HEALTH PLAN'S OBLIGATIONS

3.1 **Compensation.** Health Plan will pay Provider in accordance with the terms and conditions of this Agreement.

3.2 **Member Eligibility Determination.** Health Plan will maintain data on Member eligibility and enrollment. Health Plan will promptly verify Member eligibility at the request of Provider.

3.3 **Prior Authorization Review.** Health Plan will timely respond to requests for prior authorization and/or determination of Provider Services.

3.4 **Medical Necessity Determination.** Health Plan's determination with regard to Medically Necessary services and scope of Provider Services, including determinations of level of care and length of stay benefits available under the Member's health program will govern. The primary concern with respect to all medical determinations will be in the interest of the Member.

3.5 **Member Services.** Health Plan will provide services to Members including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan Participating Providers.

3.6 **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Provider Services, limitations and exclusions, and coordination of benefits information. Health Plan will make available a Provider Services Department that, among other Health Plan duties, will be available to educate Provider regarding Health Plan's policies and procedures.

3.7 **Medical Director.** Health Plan will retain a physician as medical director who will be responsible for the management of the scientific, technical, medical and behavioral health aspects of Health Plan.

ARTICLE FOUR – TERM AND TERMINATION

4.1 **Term.** This Agreement will commence on the Effective Date indicated by Health Plan and will continue in effect for one (1) year; thereafter, it will automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with the provisions of this Agreement or in accordance with applicable state and federal provisions set forth in the Attachments hereto.

4.2 **Termination without Cause.** At any time during this Agreement, this Agreement, a product/program provided pursuant to this Agreement, or an individual Provider under this Agreement, may be terminated without cause by either party on at least one hundred twenty (120) days written notice to the other party.

4.3 **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach may give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination will have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this thirty (30) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the party who provided the notice of termination will have the right to immediately terminate this Agreement, a product/program provided pursuant to this Agreement, or an individual Provider under this Agreement. Notwithstanding the forgoing, either party may immediately terminate this Agreement, a product/program provided pursuant to this Agreement, or an individual Provider under this Agreement, without providing the other party the opportunity to cure a material breach should the terminating party reasonably believe the material breach of this Agreement to be non-curable.

4.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, or unless otherwise mutually agreed to in writing by both parties, this Agreement, a product/program provider pursuant to this Agreement, or an individual Provider under this Agreement, may immediately be terminated upon written notice to the other party in the event of any of the below. Upon termination, Health Plan may transfer Member(s) to another provider.

a. Provider's license or certificate to render health care services is limited, suspended or revoked, or disciplinary proceedings are commenced against Provider by the state licensing authority;

b. Either party fails to maintain insurance required by this Agreement;

c. Provider has not or is unable to comply with Health Plan's credentialing requirements, including but not limited to, having or maintaining credentialing status;

d. Either party becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider or Health Plan is appointed by appropriate authority;

e. If Provider is capitated and Health Plan determines Provider is financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;

f. Health Plan reasonably determines that Provider's facility or equipment is insufficient to render Provider Services;

g. Either party is excluded from participation in Medicare or state health care programs pursuant to Section 1128;

h. Provider is terminated as a provider by any state or federal health care program;

i. Either party engages in fraud or deception, or permits fraud or deception by another in connection with each party's obligations under this Agreement;

j. Health Plan reasonably determines that health care services are not being properly provided, or arranged for by Provider, and that such failure poses a threat to Members' health and safety;

k. Provider violates any state or federal law, statute, rule, regulation or executive order; or

l. Provider fails to satisfy the terms of a corrective action plan.

4.5 **Continuation of Care.** Where Provider is a primary care provider or practitioner, Provider will furnish health care services to each Member assigned to their panel for ninety (90) days after the date of the notice of a termination for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure statute, for each assigned Member:

a. Who was receiving health care services from Provider before the notice of termination; and

b. Who after receiving notice of the termination of Provider, requests to continue receiving health care services from Provider.

4.6 **Notice of Nonrenewal or Termination.** Health Plan will provide written notice of nonrenewal or termination of Provider to the Members served by Provider as soon as practicable, but in no event later than fifteen (15) days following termination. Provider will not contact Health Plan's Members upon termination of this Agreement, a product/program provided pursuant to this Agreement, or an individual Provider under this Agreement. Immediate written notice will be provided without sixty (60) days' notice in the event Provider's license has been disciplined by a state licensing board.

ARTICLE FIVE – GENERAL PROVISIONS

5.1 **Indemnification.** Each party will indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

5.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor will it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained will prevent any of the parties from entering into similar arrangements with other parties. Each of the parties will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will be construed to create, any right in any third party, including but not limited to, Members. Nor will any third party have any right to enforce the terms of this Agreement.

5.3 **Governing Law.** The laws of the State of Iowa will govern this Agreement.

5.4 **Entire Agreement.** This Agreement, including attachments, addenda, amendments, and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations

imposed by this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, between the parties and relating to the subject matter of this Agreement are of no force or effect. Additionally, as to the Medicaid products offered by Health Plan, the State Contract is incorporated herein by reference and shall be the guiding and controlling document when interpreting the terms of this Agreement.

5.5 **Severability.** If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.

5.6 **Headings and Construction.** The headings in this Agreement are for reference purposes only and shall not be considered a part of this Agreement in construing or interpreting any of its provisions. It is the parties' desire that if any provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is to be construed against its drafter shall not apply to the interpretation of the ambiguous provision.

5.7 **Non-exclusivity.** This Agreement will not be construed to be an exclusive Agreement between Health Plan and Provider. Nor will it be deemed to be an Agreement requiring Health Plan to refer Members to Provider for health care services.

5.8 **Amendment.** Health Plan may, without Provider's consent, immediately amend this Agreement to maintain consistency and/or compliance with any applicable Law, policy, directive, or Government Program requirement. Health Plan may otherwise amend this Agreement upon thirty (30) days prior written notice to Provider. If Provider does not deliver to Health Plan a written notice of rejection of the amendment within that thirty (30) day period, the amendment will be deemed accepted by and will be binding upon Provider.

5.9 **Delegation or Subcontract.** Provider will not delegate or enter into any subcontract agreement for the provision of Provider Services without the prior written consent of Health Plan. Any subcontract agreement entered into by Provider for the delivery of Provider Services will be in writing and will bind the subcontractor to the terms and conditions of this Agreement including, but not limited to, licensure, insurance, and billing of Members for Provider Services.

5.10 **Assignment.** Provider may not assign or transfer, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Health Plan and Provider and their respective successors in interest and assigns.

5.11 **Disputes and Venue.** Any claim or controversy arising out of or in connection with this Agreement will first try to be resolved through the Grievance Program and Health Plan's internal appeals process. In the event that the claim or controversy cannot be resolved through the Grievance Program or Health Plan's internal appeal process, Provider and Health Plan will engage in mandatory good faith meetings and discussions, which can include multiple writings, telephonic meetings or in person meetings, but will at least include one written communication by each party setting forth their position and one in person meeting, with decision makers present to try and resolve the claim or controversy. Any remaining claim or controversy, which results in a court action or proceeding with respect to this Agreement, will commence and proceed in Des Moines, Iowa.

5.12 **Notice.** All notices required or permitted by this Agreement will be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, by Federal Express or other overnight courier that guarantees next day delivery, by facsimile transmission, or by electronic mail or other means of electronic delivery, including but not limited to, Health Plans website and interactive web portal. All notices will be deemed sufficiently given if served in the manner specified in this section. The mailing names and addresses set forth under the Signature Authorization section of this Agreement will be the particular party's address for delivery or mailing of notice purposes. Each party may change their name and address through written notice in compliance with this section. Any notice sent by registered or certified mail, return receipt requested, will be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery will be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice will be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

5.13 **Waiver.** A failure or delay of any party to exercise or enforce any provision of this Agreement shall not be deemed a waiver of any right of that party. Any waiver must be specific, in writing and executed by both the Health Plan and Provider.

5.14 **Execution in Counterparts and Duplicates**. This Agreement shall be executed in duplicate and each duplicate may also be executed in counterparts, each of which shall be deemed a duplicate original, but all of which together shall constitute one and the same instrument. It is further agreed that facsimile signatures, electronic signature, pdf signatures, or a signature scanned and sent via e-mail shall have the same effect as original signatures.

5.15 **Conflict with Health Plan Product**. Nothing in this Agreement modifies any benefits, terms or conditions contained in the Member's Health Plan product. In the event of a conflict between this Agreement and the benefits, terms, and conditions of the Health Plan product, the benefits, terms or conditions contained in the Member's Health Plan product will govern.

5.16 **Force Majeure.** Neither party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either party's employees, or any other similar cause beyond the reasonable control of such party.

5.17 **Confidentiality.** Any information maintained or generated by either party in fulfillment of its obligations under this Agreement, including healthcare information, shall be kept confidential in accordance with and to the extent required by applicable Laws. Further, all information provided to Provider, including, but not limited to, Member lists, QI Program, credentialing criteria, compensation methodologies and rates, and any other administrative protocols or procedures of Health Plan, is the proprietary property of Health Plan. Provider shall not disclose or release such material to any third party without the written consent of Health Plan.

DRAFT

ATTACHMENT A
DEFINITIONS

Capitalized words or phrases in this Agreement mean the following:

1.1 **Accreditation Organization** means any organization, including, without limitation, the National Committee for Quality Assurance ("NCQA"), engaged in accrediting or certifying Health Plan or Provider.

1.2 **Advance Directive** means a Member's written instructions, recognized under Law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under Law. Examples of Advance Directives are living wills and durable powers of attorney for health care.

1.3 **Affiliate** means an entity owned or controlled by Health Plan or Molina Healthcare, Inc. ("Molina").

1.4 **Agreement** means this Provider Services Agreement, including all attachments addenda, amendments, and incorporated documents or materials.

1.5 **Authorized Representative** means the person with legal authority to agree to and execute this Agreement.

1.6 **Capitated Provider** shall mean a provider that has accepted financial responsibility for certain Covered Services and Members, which can be demonstrated through the agreement the Capitated Provider has with Health Plan.

1.7 **Centers for Medicare and Medicaid Services ("CMS")** means an administrative agency of the United States Government, responsible for administering the Medicare program.

1.8 **C.F.R** means Code of Federal Regulations.

1.9 **Claim** means an invoice for Provider Services rendered to a Member by Provider, submitted in a format approved by Health Plan and with all service and Encounter information required by Health Plan.

1.10 **Clean Claim** means a Claim for Provider Services that is submitted on an industry standard form (e.g. CMS-1500, UB-04), and has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the Claim.

1.11 **Completion of Audit** means the completion of audit by the Department of Health and Human Services ("DHHS"), the Government Accountability Office ("GAO"), or their designees of Health Plan, Medicare and Medicaid Plan contractor or related entity.

1.12 **Covered Services** means those health care services, supplies and benefits that are (i) Medically Necessary, (ii) benefits of the applicable Health Plan Product(s)/Program(s), and (iii) required to be provided by Health Plan pursuant to the Government Contract(s) as applicable, which covers the Member(s).

1.13 **Cultural Competency Plan** means a plan that ensures Covered Services are provided to Members in a manner that takes into account, but is not limited to: developmental disabilities, physical disabilities, differential abilities, cultural and ethnic backgrounds and limited English proficiency.

1.14 **Date of Service** means the date on which Provider renders services to a Member, or for inpatient services, the date the Member is discharged.

1.15 **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between a health plan (or applicant) and a First Tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.16 **Emergency Services** are health care services furnished in the emergency department of a hospital for the treatment of a medical emergency; ancillary services routinely available to the emergency department of a hospital for the treatment of a medical emergency; and emergency medical services transportation.

1.17 **Encounter** means a distinct set of services provided to a Member enrolled by Health Plan on the dates that the services were delivered.

1.18 **Encounter Data** means (i) all data captured during the course of a single health care Encounter that specify the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative) pharmaceuticals, medical devices and equipment associated with a Member receiving services during the Encounter; (ii) the identification of the Member receiving and the provider delivering the health care services during the single Encounter; and (iii) a unique, i.e. unduplicated, identifier for the single Encounter.

1.19 **Final Contract Period** means the final term of the contract between CMS and the Health Plan.

1.20 **First Tier Entity** means any Party that enters into a written arrangement, acceptable to CMS, with Health Plan to provide administrative services or health care services for a Medicare eligible Member under the Medicare Advantage program.

1.21 **Iowa Department of Human Services ("DHS")** means the agency within the State of Iowa that is responsible for the oversight and administration of the Medicaid and CHIP programs.

1.22 **Government Contracts** means those contracts between Health Plan and state and federal agencies for the arrangement of health care service for Members through Government Programs, including but not limited to, the State Contract(s).

1.23 **Grievance Program** means the procedures established by Health Plan to timely address Member and Provider complaints or grievances.

1.24 **Health Plan** means Molina Healthcare of Iowa, Inc., a Iowa Corporation.

1.25 **Law(s)** mean all federal and state statutes and regulations applicable to the subject matter of this Agreement or the parties' performance of their duties and obligations hereunder.

1.26 **Medicaid** means the joint federal-state program provided for under Title XIX of the Social Security Act, as amended.

1.27 **Medically Necessary** means care that is based upon generally accepted medical practices in light of conditions at the time of treatment, and are services that are: (i) appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible Member's medical condition; (ii) compatible with the standards of acceptable medical practice in the community; (iii) provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms; (iv) not provided solely for the convenience of the Member or the convenience of the provider; and (v) not primarily custodial care unless custodial care is a covered service or benefit under the Member's evidence of coverage.

1.28 **Medicare** means the various insurance health plans provided under Title XVIII of the Social Security Act, as amended.

1.29 **Medicare Advantage ("MA")** means an alternative to the traditional Medicare program in which private plans, run by health insurance companies, provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

1.30 **Medicare Advantage Special Needs Plan ("MA-SNP")** means an alternative to the traditional Medicare program in which private plans, run by health insurance companies, provide health care benefits to beneficiaries who are eligible for both Medicare and Medicaid.

1.31 **Medicare-Medicaid Program ("MMP")** means an integrated delivery system, payment model, and alternative to the traditional Medicare and Medicaid programs, aimed at improving the quality, coordination, and cost-effectiveness of services, in which private health plans, run by health insurance companies, provide health care benefits to beneficiaries who are dually eligible for both Medicare and Medicaid.

1.32 **Member** means a person enrolled in one of Health Plan's benefit products or a Health Plan Affiliate's benefit product and who is eligible to receive Covered Services.

1.33 **Overpayments** means any payment Provider receives or retains in which Provider, after applicable reconciliation, is not entitled to receive such payment pursuant to Law or the terms of this Agreement.

1.34 **Participating Provider(s)** means those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan.

1.35 **Provider** means the person(s) and/or entity(ies), any constituent physicians, allied health professionals, staff persons, and any employed, subcontracted and/or affiliated entities, and are all bound by the terms and conditions of this Agreement.

1.36 **Provider Manual** means Health Plan's, procedures, standards and specimen documents that have been compiled by Health Plan for the use and instruction of Provider.

1.37 **Provider Services** means those Covered Services that are within the normal scope of practice and licensure of Provider.

1.38 **Quality Improvement Program ("QI Program")** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.

1.39 **Related Entity** means any entity that is related to the Health Plan by common ownership or control and: (i) performs some of the Health Plan's management functions under contract or delegation; (ii) furnishes services to Medicare Members under an oral or written agreement; or (iii) leases real property or sells materials to the Health Plan at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.

1.40 **State Children's Health Insurance Program ("CHIP")** means the program established pursuant to Title XXI of the Social Security Act, as amended.

1.41 **State Contract** means the contract(s) between DHS and Health Plan that govern the provision of Covered Services to Members, as may be amended.

DRAFT

1.42 **Utilization Review and Management Program ("UM Program")** means the policies, procedures and systems developed by Health Plan for evaluating and monitoring the medical necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective reviews, including but not limited to under-utilization and over-utilization.

DRAFT

ATTACHMENT B
PRODUCTS/PROGRAMS

Provider agrees to participate as a Participating Provider for the following products/programs and successor(s).

1.1 **Medicaid** - including but not limited to the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa (hawk-i) programs.

1.2 **Medicare** – including but not limited to Molina Medicare Options (Medicare Advantage), Molina Medicare Options Plus ("MA-SNP").

1.3 **Medicare-Medicaid Program –** including, but not limited to, Dual Options (Capitated Financial Alignment Demonstration ("CFAD").

Comment [MM1]: Ben did not note this in his email but I left it in.

DRAFT

ATTACHMENT C
COMPENSATION SCHEDULE

1.1 **Medicaid**

a. **Provider Services Payments.** Health Plan agrees to compensate Provider for Covered Services rendered to Members, in accordance with the products/programs specified in Attachment B, that are determined by Health Plan to be payable and submitted on a Clean Claim, on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of: (i) Provider's billed charges; or (ii) at an allowable amount equivalent to the payable rate under the applicable Medicaid Fee-For-Service Program fee schedule set forth by the State of Iowa, in effect on the Date(s) of Service. Notwithstanding the foregoing, payment for Covered Services, including, but not limited to, certain Covered Services where there is no payment rate in the Iowa Medicaid Fee-For-Service Program fee schedule as of the Date(s) of Service, will not exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the Date(s) of Service.

1.2 **Medicare**

a. **Provider Services Payments**. Health Plan agrees to compensate Provider for Provider Services rendered to Members, in accordance with Medicare products/programs as specified in Attachment C, that are determined by Health Plan to be payable and submitted on a Clean Claim, on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of; (i) Provider's billed charges, or (ii) at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography), as of the date(s) of service.

DRAFT

ATTACHMENT D
DHS PROGRAM REQUIREMENTS

This attachment sets forth the applicable requirements that are required by the State Contract to be included in agreements between Health Plan and Participating Providers or other provisions necessary to reflect compliance with the Law. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments to the State Contract or changes or modifications to Law or Government Program requirements. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1.1 The parties acknowledge that State Contract has not been completed and that upon completion, this attachment will immediately be amended to conform to any requirement set forth therein.

DRAFT

ATTACHMENT E
Medicare Program Requirements – Healthcare Services

This attachment sets forth the applicable Government Program requirements, covering the provision of health care and related services, that are required by CMS to be included in contracts and/or agreements between; (i) health plans/health maintenance organizations, and (ii) clients or providers of health care or related services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1.1 Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(ies) that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein. (42 CFR 422.504(i)(3)(iii)).

1.2 Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information, including books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under Health Plan's contract with CMS, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period between Health Plan and CMS or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 42 CFR 422.504(e)(3), 42 CFR 422.504(e)(4) and 42 CFR422.504(i)(2)(ii).).

1.3 Confidentiality. Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13).)

1.4 Hold Harmless/Cost Sharing. Provider agrees it may not under any circumstances, including nonpayment of moneys due to the providers by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Member, or any persons other than the Health Plan acting on their behalf, for services provided in accordance with this Agreement. The Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. (42 CFR 422.504(g)(1)(i)) and (42 CFR 422.504(g)(1)(iii).) In addition, for Members who are dually eligible for Medicare and Medicaid and enrolled in a Medicare Advantage Special Needs Plan will not be held liable for Medicare Part A and B cost sharing when the State or another payor such as a Medicaid Managed Care Plan is responsible for paying such amounts. Health Plan will inform providers of applicable Medicare and Medicaid benefits and rules for eligible Members. Provider agrees to accept payment from Health Plan as payment in full, or bill the appropriate State source, for any Medicare Part A and B cost sharing that is covered by Medicaid. Collection from the Member of copayments or supplemental charges in accordance with the terms of the Member's contract with the Health Plan, or charges for services not covered under the Member's contract, may be excluded from this provision.

1.5 Accountability. Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions set forth in Attachment E-1 of this Agreement. (42 CFR 422.504(i)(3)(ii).)

1.6 Delegation. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(3)(iii) and 42 CFR 422.504(i)(4).)

1.7 Prompt Payment. Health Plan and Provider agree that Health Plan will pay all Clean Claims for services that are covered by Medicare within sixty (60) days of the date such Claim is delivered by Provider to Health Plan and Health Plan determines such Claim is complete/clean. Any Claims for services that are covered by Medicare that are not submitted to Health Plan within six (6) months of providing the services that are subject of the Claim will not be eligible for payment, and Provider hereby waives any right to payment therefore. Health Plan reserves the right to deny any Claims that are not in accordance with the Medicare Claims Processing Manual and Medicare rules for billing. (42 CFR 422.520(b).)

1.8 Reporting. Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310. (42 CFR 504(a)(8).)

1.9 Compliance with Medicare Laws and Regulations. Provider will comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v).)

1.10 Benefit Continuation. Provider agrees to provide for continuation of Member health care benefits (i) for all Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Members who are hospitalized on the date Health Plan's contract with CMS terminates, or, in the event of insolvency, through discharge. (42 CFR 422.504(g)(2)(i), 42 CFR 422.504(g)(2)(ii) and 42 CFR 422.504(g)(3).)

1.11 Cultural Considerations. Provider agrees that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. (42 CFR 422.112(a)(8).)

DRAFT

ATTACHMENT E-1
Medicare Program Requirements – Delegated Services

This attachment sets forth the applicable Government Program requirements, covering the delegation to Provider of any management responsibilities or administrative services if any, that are required by CMS to be included in contracts and/or agreements between; (i) health plans/health maintenance organizations, and (ii) clients or providers of health care or related services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1.1 Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(s) that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein. (42 CFR 422.504(i)(3)(iii))

1.2 Medicare Compliance. Provider agrees to require all of its downstream, related entity(s) and transferees to comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v).)

1.3 Confidentiality. Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13).)

1.4 Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 42 CFR 422.504(e)(3), 42 CFR 422.504(e)(4) and 42 CFR 422.504(i)(2)(ii).)

1.5 Responsibilities and Reporting Arrangements. The Agreement specifies the delegated activities and reporting responsibilities if any. To the extent applicable, Provider will support Health Plan in complying with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 310 by providing relevant data. (42 CFR 422.504(i)(4)(i) and 42 CFR 422.504(a)(8).)

1.6 Revocation of Delegated Activities. In the event CMS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities will be revoked. (42 CFR 422.504(i)(4)(ii).)

1.7 Accountability. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(1) and 42 CFR 422.504(i)(3)(iii).)

1.8 Credentialing. If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. Health Plan retains the right to approve, suspend, or terminate any credentialing delegation arrangement. (42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5).)

1.9 Monitoring. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contractual obligations. Health Plan will monitor the performance of first tier, downstream, and related entities. (42 CFR 422.504(i)(1) and 42 CFR 422.504(i)(4).)

1.10 Further Requirements. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with Health Plan's contractual obligations. If Health Plan delegates selection of the providers, contractors, or subcontractor to another organization, Health Plan retains the right to approve, suspend, or terminate any such arrangement. (42 CFR 422.504(i)(3)(iii), 42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5).

DRAFT

Molina Healthcare of Iowa, Inc.
Hospital Services Agreement

SIGNATURE AUTHORIZATION

In consideration of the promises, covenants, and warranties stated, the parties agree as set forth herein. The Authorized Representative for each party executes this Agreement with the intent to bind the parties in accordance with applicable Laws. The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and proper authorization to act on behalf of Hospital. The Authorized Representative further acknowledges he/she received and reviewed the entirety of this Agreement.

Hospital Signature

Hospital's Legal Name ("Hospital") – as listed on applicable tax form (i.e. Tax Form W-9) and any doing business as name		
Authorized Representative's Signature	Title	Signature Date
Authorized Representative's Name – Printed	Hospital Telephone Number	

Hospital Information

Mailing Address – Official Correspondence	Billing / Payment Address – if different than Mailing Address
Fax Number – Official Correspondence	Tax ID Number – as listed on applicable tax form
E-mail Address – Official Correspondence	NPI Number – that corresponds to the listed Tax ID Number

Health Plan Signature and Information

Molina Healthcare of Iowa, Inc., a Iowa Corporation ("Health Plan")		
Authorized Representative's Signature	Title	Countersignature Date
Authorized Representative's Name – Printed	Mailing Address – Official Correspondence	
E-mail Address – Official Correspondence		

DRAFT

HOSPITAL SERVICES AGREEMENT

This Agreement is entered into between Health Plan and Hospital as set forth and made effective as of the date of Health Plan's countersignature ("Effective Date").

RECITALS

A. Health Plan arranges for the provision of certain health care services to Members pursuant to contracts with various government sponsored health products/programs ("Government Programs") and other products/programs, as applicable. Health Plan intends to participate in additional Government Programs and offer other health products/programs as the opportunities become available.

B. Health Plan is a domiciled corporation that has been issued a certificate of authority by the appropriate state licensing agency to provide health care services to Members. Health Plan also is certified, licensed and/or approved by all other required agencies to provide health care services to eligible recipients.

C. Health Plan arranges for the provision of certain health care services to Members by entering into provider service agreements with individual physicians, groups of physicians, individual practice associations, hospitals, clinics, ancillary health providers, and other health providers.

D. Hospital is licensed to render certain health care services and desires to provide such services to Health Plan's Members in connection with Health Plan's contractual obligations to provide and/or arrange for health care services for Health Plan's Members.

Now, therefore, in consideration of the promises, covenants and warranties stated herein, Health Plan and Hospital agree as follows:

ARTICLE ONE – DEFINITIONS

1.1 Capitalized words or phrases in this Agreement have the meaning set forth in Attachment A.

ARTICLE TWO – PROVIDER OBLIGATIONS

2.1 **Provision of Hospital Services.** Hospital agrees to provide Hospital Services to Members within the scope of Hospital's business, practice and license, and in accordance with applicable Law and the terms of this Agreement including, but not limited to, the Provider Manual, Health Plan's QI and UM Programs and applicable Accreditation Organization standards.

2.2 **Hospital Standards.**

a. **Standard of Care.** Hospital will provide Hospital Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and standards of professional conduct, and any controlling governmental licensing requirements.

b. **Facilities, Equipment, and Personnel.** Hospital's facilities, equipment, personnel and administrative services will be at a level and quality as necessary to perform Hospital's duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.

c. **Prior Authorization.** Prior to admitting any Member as an inpatient or outpatient, Hospital will obtain the prior authorization of Health Plan in accordance with Provider Manual unless the situation is one involving the delivery of Emergency Services. For Emergency Services that result in an admission, Hospital will notify Health Plan or its agent within twenty-four (24) hours of admission and will request authorization from Health Plan prior to the provision of any post-stabilization care. For non-emergent services, regardless of whether prior authorization was received, Hospital will cooperate and participate in Health Plan's notification procedures described in Provider Manual for all inpatient (acute, rehabilitation, mental health and SNF) and outpatient admission on the same day of admission or at a maximum within twenty-four (24) hours of admission. Failure to receive prior authorization from Health Plan may result in Claim denial.

d. **Use of Participating Providers.** Except in the case of Emergency Services or where Hospital obtains the prior authorization of Health Plan, Hospital will utilize Health Plan's Participating Providers to provide Hospital Services to Members. Should Health Plan have no Participating Provider to render Medically Necessary Hospital Services, Health Plan will use reasonable efforts to coordinate an out of network agreement with an appropriate provider.

e. **Member Eligibility Verification.** Hospital will verify eligibility of Members prior to rendering services unless the situation is one involving the delivery of Emergency Services.

f. **Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Hospital will abide by Health Plan's drug formularies and prescription policies, including those regarding the

prescription of generic or lowest cost alternative brand name pharmaceuticals. Hospital will obtain prior authorization from Health Plan if Hospital believes a generic equivalent or formulary drug should not be dispensed. Hospital acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Hospital.

g. **Availability of Services.** Hospital will make Hospital Services available twenty-four (24) hours a day, seven (7) days a week. Hospital will meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

h. **Treatment Alternatives.** Health Plan encourages open Hospital-Member communication regarding appropriate treatment alternatives. Health Plan promotes open discussion between Hospital and Members regarding Medically Necessary or appropriate patient care, regardless of limitations on Covered Services. Hospital is free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Health Plan's decision to terminate or refuse to contract with a Hospital will not be based in whole or in part on the fact that the Hospital discussed medical treatment options with a Member.

2.3 **Standards for Hospital Providers.**

a. **Hospital Providers.** Hospital will have a sufficient number of Hospital Providers to provide Hospital Services and meet the needs of Health Plan and its Members as determined by Health Plan's Quality Improvement Program and in accordance with the Law. Hospital will be responsible for the Hospital Services provided by Hospital Providers.

b. **Contract with Hospital Providers.** Hospital's contract with its Hospital Providers will be in writing and will bind Hospital Providers to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance and billing of Members for Hospital Services.

c. **Hospital Provider Information.** Upon request, Hospital will provide Health Plan with a complete list of its Hospital Providers, together with the provider specific information required by Health Plan for credentialing and for administration of its health programs.

d. **Restriction, Suspension or Termination of Hospital Provider(s).** Hospital will immediately restrict, suspend or terminate Hospital Providers(s) from providing Hospital Services to Members in the following circumstances: (i) the Hospital Provider(s) ceases to meet the licensing/certification requirements or other professional standards as specified in this Article; or (ii) Health Plan or Hospital reasonably determine that there are serious deficiencies in the quality of care of the applicable Hospital Provider(s) which affects or could adversely affect the health or safety of Members. Hospital will immediately notify Health Plan of such action(s).

e. **Staffing Privileges.** Hospital agrees to use its best efforts to arrange staff privileges or other appropriate access for Health Plan's Participating Providers, Health Plan's medical directors and hospitalist providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standard of practice and credentialing standards established by Hospital's medical staff and the bylaws, rules and regulations of Hospital.

f. **Notification.** Hospital will notify Health Plan within five (5) business days should any disciplinary or other action of any kind be initiated against any Health Plan or Hospital Provider which could result in any suspension, reduction or modification of Hospital Provider's hospital privileges. Hospital's notification to Health Plan will state Hospital's actions taken against the Hospital Provider or Health Plan provider. If Hospital fails to act as required by this Article with respect to any of its Hospital Provider(s) or Health Plan reasonably determines and provides documentation to Hospital that there are serious deficiencies in the professional competence, conduct, or quality of care of the Hospital Provider which could adversely affect the health and safety of Members, Health Plan will have the right to prohibit such Hospital Provider(s) from continuing to provide Hospital Services to Members.

2.4 **Rights of Members.** Hospital will observe, protect and promote the rights of Members.

2.5 **Corrective Action.** Health Plan and certain state and federal regulators routinely monitor the level, manner, and quality of Covered Services provided pursuant to this Agreement as well Hospital's compliance with the terms of this Agreement. In the event a deficiency is identified, Health Plan or regulator, in their sole discretion, may choose to issue a corrective action plan, and Hospital will be required to accept and implement such a corrective action plan. A corrective action plan is not required to be given to Hospital before issuing a Termination with Cause or an Immediate Termination.

2.6 **Promotional Activities.** At the request of Health Plan, Hospital will: (i) display Health Plan promotional materials in its offices and facilities as practical; and (ii) cooperate with and participate in all reasonable Health Plan marketing efforts so long as it does not violate applicable Law. Hospital will not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan.

2.7 **Nondiscrimination.**

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

b. Employment. Hospital will not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual's ability to perform the duties of the particular job or position.

2.8 **Recordkeeping.**

a. **Maintaining Member Medical Record.** Hospital will maintain a medical and billing record for each Member to whom Hospital renders health care services. Hospital will open each Member's medical record upon the Member's first Encounter with Hospital. The Member's medical record will contain all information required by Law, generally accepted and prevailing professional practice, applicable Government Programs, and all Health Plan policies and procedures. Hospital will retain all such records for as long as required by applicable Law and/or Government Contracts. This section will survive the termination of this Agreement or an individual product/program.

b. **Confidentiality of Member Health Information.** Hospital will comply with all applicable Law, Health Plan's policies and procedures, Government Program requirements regarding privacy and confidentiality of Members' health information and medical records, including mental health records. Hospital will not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision will not affect or limit Hospital's obligation to make available medical records, Encounter Data and information concerning Member care to Health Plan, any authorized state or federal agency, or other providers of health care upon authorized referral.

c. **HIPAA.** Hospital will comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act and any regulations promulgated thereunder (collectively the "HIPAA Rules").

d. **Delivery of Patient Care Information.** Hospital will promptly deliver to Health Plan, upon request and/or as may be required by Law, Health Plan's policies and procedures, applicable Government Programs, Health Plan's contracts with the government agencies, or third party payors, any information, statistical data, Encounter Data, or patient treatment information pertaining to Members served by Hospital, including but not limited to, any and all information requested by Health Plan in conjunction with Health Plan's UM Program, grievances, peer review, Healthcare Effectiveness Data and Information Set ("HEDIS") studies, Health Plan's QI Program, Consumer Assessment of Healthcare Providers and Systems ("CAHPS"), Medicare and/or Medicaid risk adjustment, or Claims payment. The party producing the records will be responsible for any fees associated with producing such records. Hospital will further provide direct access to said patient care information as requested by Health Plan and/or as required by any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan. Health Plan will have the right to withhold compensation from Hospital in the event that Hospital fails or refuses to promptly provide any such information to Health Plan. This section will survive the termination of this Agreement or an individual product/program.

e. **Member Access to Health Information.** Hospital will give Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with applicable Law, applicable Government Programs, and Health Plan's policies and procedures. This section will survive the termination of this Agreement or an individual product/program.

2.9 **Program Participation.**

a. **Participation in Grievance Program.** Hospital will participate in Health Plan's Grievance Program and will cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.

b. **Participation in Quality Improvement Program.** Hospital will participate in Health Plan's Quality Improvement Program and will cooperate with Health Plan in conducting peer review and audits of care rendered by Hospital.

c. **Participation in Utilization Review and Management Program.** Hospital will participate in and comply with Health Plan's Utilization Review and Management Program, including all policies and procedures regarding prior

authorizations, and will cooperate with Health Plan in audits to identify, confirm, and/or assess utilization levels of Hospital Services.

d. **Participation in Credentialing.** Hospital will cooperate with, participate in and satisfy all credentialing and re-credentialing criteria established by Health Plan prior to the Effective Date and provision of Covered Services set forth in and in accordance with and throughout the term of this Agreement. Hospital will immediately notify Health Plan in writing of any change in the information submitted or relied upon by Hospital in order to achieve or maintain credentialed status. All Participating Providers must be credentialed in accordance with Health Plan's policies and procedures, by Health Plan or its designee, prior to treating Members.

e. **Provider Manual.** Hospital will comply with and render Covered Services in accordance with the contents, instructions and procedures set forth in the Provider Manual, which is incorporated herein by reference and which may be unilaterally amended from time to time by Health Plan. Health Plan's Provider Manual is made available to Hospital at Health Plan's website.

f. **Supplemental Materials.** In addition to the contents, instructions, and procedures set forth in the Provider Manual, Health Plan may periodically promulgate bulletins or other written materials that may or may not be used to supplement the Provider Manual or may be used to provide additional instruction, guidance or information to Hospital ("Supplemental Materials"). Health Plan may issue such Supplemental Materials in an electronic format. Hospital can obtain paper copies upon request. Revisions to the Supplemental Materials shall become binding upon Hospital as of the effective date indicated on the Supplemental Materials. If applicable, such effective date shall be determined in accordance with the terms of this Agreement.

g. **Health Plan's Electronic Processes and Initiatives.** Hospital will participate in and comply with Health Plan's electronic processes and initiatives, including but not limited to, electronic submission of prior authorization, Health Plan access to electronic medical records, electronic claims filing, electronic data interchange ("EDI"), electronic remittance advice and electronic funds transfers, registration and use of Health Plan's interactive web portal. Such programs, registration, and use are contained and described in the Provider Manual or Supplemental Materials.

h. **Government Contracts.** Hospital acknowledges that Health Plan has entered into contracts with state and federal agencies for the arrangement of health care services for Members through Government Programs. Hospital will comply with any term or condition of those Government Contracts that are applicable to the Hospital Services to be performed under this Agreement. Health Plan will give Hospital a copy of any applicable Government Contract(s), upon request by Hospital.

i. **Health Education/Training.** Hospital will participate in and cooperate with Health Plan's provider education and training efforts as well as Member education and related efforts. Hospital will also comply with all Health Plan health education, Health Plan's Cultural Competency Plan, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Hospital will ensure prompt delivery to any constituent providers all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Hospital Services to Members.

2.10 **Hospital Information.** Hospital will deliver to Health Plan a complete list of its healthcare providers, facilities, and business/practice locations that it uses to provide Covered Services, together with specific information required for credentialing and administration in a format acceptable to Health Plan. Hospital will deliver such information prior to the execution of this agreement and every six (6) months thereafter or promptly provide notice when there is any change to such information. Health Plan also reserves the right to request such information at any time.

2.11 **Licensure and Standing.**

a. **Licensure.** Hospital warrants and represents that it is appropriately licensed to render health care services within the scope of Hospital's practice, including having and maintaining a current narcotics number, where appropriate, issued by all proper authorities. Hospital will provide evidence of licensure to Health Plan upon request. Hospital will maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Hospital will immediately notify Health Plan of any change in Hospital's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Hospital.

b. **Unrestricted Status.** Hospital warrants and represents that it has not been and is not currently excluded from, and will immediately notify Health Plan in the event it becomes excluded from, participation in Medicare and/or state health care programs pursuant to Section 1128 of the Social Security Act (42 U.S.C. 1320a-7) ("Section 1128") for any of the following: (i) conviction of a crime; (ii) assessment of a civil penalty; (iii) entered into a contractual relationship with an entity convicted of a crime; and/or (iv) taken any other action that would prohibit it from participation in Medicare and/or state health care programs, all as set forth under Section 1128.

c. **Malpractice and Other Actions.** Hospital will give immediate notice to Health Plan of: (i) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Hospital in settlement or compromise of such a claim, or any payment made by or on behalf of Hospital pursuant to a judgment rendered upon such a claim; (ii) any criminal investigations or proceedings against Hospital; (iii) any convictions of Hospital for crimes involving moral turpitude or felonies; and (iv) any civil claim asserted against Hospital that may jeopardize Hospital's financial soundness.

d. **Liability Insurance.** Throughout the term of this Agreement, Hospital will maintain premises and professional liability insurance: (i) in coverage amounts appropriate for the size and nature of Hospital's facility and the nature of Hospital's health care activities; and (ii) in compliance with applicable Law and Government Program requirements. If the coverage is claims made or reporting, Hospital agrees to purchase similar "tail" coverage upon termination of the Hospital's present or subsequent policy(ies). Hospital will deliver copies of such insurance policy(ies) to Health Plan within five (5) business days of a written request by Health Plan, and will give at least fifteen (15) business days advance written notice to Health Plan prior to any change, reduction, cancellation or termination of such insurance coverage.

2.12 **Claims Payment.**

a. **Submitting Claims.** Hospital will promptly submit to Health Plan Claims for Hospital Services rendered to Members. All Claims will be submitted in a standard form (CMS-1500, UB-04 or successor format) acceptable to and approved by Health Plan, and will include any and all medical records pertaining to the Claim if requested by Health Plan or otherwise required by Health Plan's policies and procedures. Hospital will not be eligible for payment for any Claims submitted within a period of time from the Date of Service that exceeds: (i) the number of days required by the timeframes specified by applicable Law and Government Program requirements; or (ii) ninety (90) days from the Date of Service, whichever is greater. Notwithstanding the foregoing, for any Claims associated with coordination of benefits, Hospital will not be eligible for payment within a period of time that exceeds: (i) the number of days required by the timeframes specified by applicable Law and Government Program requirements; or (ii) ninety (90) days from the date the primary payor adjudicated the Claim, whichever is greater.

b. **National Provider Identifier ("NPI").** Hospital will comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (45 CFR Section 162.402, et seq.) and use only the NPI to identify HIPAA covered health care providers in standard transactions. Hospital will utilize an NPI from the National Plan and Provider Enumeration System ("NPPES") for itself or for any subpart of the Hospital. Hospital will make best efforts to report its NPI and any subparts to Health Plan. Hospital will report any changes in its NPI or subparts to Health Plan within thirty (30) days of the change. Hospital will use its NPI to identify itself on all Claims and Encounters (both electronic and paper formats) submitted to Health Plan.

c. **Compensation.** Health Plan will pay Hospital for Clean Claims for Hospital Services provided to Members, including Emergency Services, in accordance with applicable Law, Government Program requirements, and in accordance with the terms of this Agreement. Such payment will be made within the lessor of: (i) the timeframes specified by applicable Law and Government Program requirements, or (ii) sixty (60) days of the date such Clean Claim is delivered by Hospital to Health Plan and Health Plan determines such claim is a Clean Claim for Hospital Services and/or Emergency Services. Hospital agrees to accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for Hospital Services provided to Members as deemed Medically Necessary and appropriate under this Agreement, Health Plan's Quality Improvement and Utilization Review and Management Programs. Hospital will not balance bill Members for any Hospital Services.

d. **Co-payments and Deductibles.** Hospital is responsible for collection of co-payments, co-insurances and deductibles, if any.

e. **Member Hold Harmless.** Hospital agrees that in no event, including but not limited to, nonpayment, insolvency, or breach of this Agreement by the Health Plan, will Hospital bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member, or person acting on Member's behalf, for Covered Services provided pursuant to this Agreement. This does not prohibit Hospital from collecting co-insurance, deductibles, or co-payments as specifically provided in the Member's evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor. This provision will survive the termination of this Agreement or an individual product/program regardless of the reason for the termination, including the insolvency of Health Plan.

f. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Hospital will make reasonable inquiry of Members to learn whether Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of

any type, and Hospital will immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Hospital will be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payors, not to exceed the amount specified in the Compensation Schedule.

g. **Offset.** In the event of an Overpayment, Hospital will make repayment to Health Plan within thirty (30) days of receipt of written notification by Health Plan of the Overpayment or within thirty (30) days of Hospital's identification of the Overpayment. In addition to any other contractual or legal remedy, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Hospital. As a material condition to Health Plan's obligations under this Agreement, Hospital agrees that the offset and recoupment rights set forth herein will be deemed to be and to constitute rights of offset and recoupment authorized under applicable Law or in equity to the maximum extent legally permissible, and that such rights will not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Hospital.

h. **Claim Review**. Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, current Uniform Billing ("UB") manual and editor, Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS"), federal, and state billing and payment rules, National Correct Coding Initiatives ("NCCI") Edits, and Federal Drug Administration ("FDA") definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Furthermore, Hospital acknowledges Health Plan's right to conduct medical necessity reviews and apply clinical practices to determine appropriate payment. Payment may exclude certain items not billed in accordance with industry standard billing and payment rules or certain items which do not meet certain medical necessity criteria.

i. **Claim Auditing.** Hospital acknowledges Health Plan's right to conduct post-payment billing audits. Hospital shall cooperate with Health Plan's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Hospital's charging policies, and other related data. Health Plan shall use established industry claims adjudication and/or clinical practices, state, and federal guidelines, and/or Health Plan's policies and data to determine the appropriateness of the billing, coding and payment.

j. **Authorized Services.** Health Plan is responsible for the authorization of medical services provided to Members. If Hospital has obtained concurrent or prior authorization for a Covered Service provided to a Member, Health Plan will not retrospectively deny payment for such authorized Covered Service, unless: (i) Hospital's claim and/or medical record for such services do not support the specific services and/or level of care authorized by Health Plan; (ii) Health Plan may do so pursuant to applicable Law or Government Program requirement; or (iii) Hospital has been provided notice of certain policies that Health Plan is adopting through the Provider Manual or Supplemental Materials. Health Plan will conduct medical management throughout the course of treatment. Hospital acknowledges that initial and subsequent authorizations will be obtained as necessary.

k. **Reporting Requirements.** Hospital's failure to comply with Health Plan's requirements regarding Hospital's identification and reporting of institutional and outpatient services, admissions, and/or related services to Health Plan or to obtain authorization as required may result in non-payment to Hospital for all days and charges until the day that notification is received and services are authorized.

l. **Payments which are the Responsibility of a Capitated Provider.** Hospital agrees that if Hospital provides Covered Services that are the financial responsibility of a Capitated Provider, Hospital will look solely to the Capitated Provider, and not Health Plan, for payment of such Covered Services. Pursuant to the terms in the agreement between the Capitated Provider and the Health Plan, if Hospital provides Covered Services that are the financial responsibility of the Capitated Provider, Capitated Provider will compensate the Hospital at the rate set forth in the Agreement between the Hospital and the Capitated Provider. In the event there is not an agreement between the Capitated Provider and Hospital, or where the Capitated Provider and Hospital have not agreed to compensation terms, Hospital will be reimbursed, as determined by the Hospital and the Capitated Provider, at: (i) one hundred percent (100%) of the governing rates provided by applicable Law specific to the Member's enrolled benefit plan (i.e. Medicaid or Medicare, etc.) in place at the time services are rendered; or (ii) at the rates set forth in this Agreement. Except as specifically stated in this section, Hospital agrees that the other compensation terms of the Agreement will continue to be binding upon Hospital. Furthermore, for the avoidance of doubt, Hospital will abide by all provisions of this Agreement relating to non-billing of Members with respect to all services and treatment.

m. **Timely Submission of Encounter Data**. Hospital understands that Health Plan may have certain contractual reporting obligations which require timely submission of encounter data. Therefore, as applicable, Hospital shall submit Encounter Data to Health Plan within thirty (30) days of the Date of Service.

DRAFT

2.13 **Compliance with Law.** Hospital will comply with all applicable Laws governing the delivery of Hospital Services to Members including, but not limited to, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Balanced Budget Act of 1997; and the Americans with Disabilities Act. In addition, Hospital shall comply with the program specific requirements set forth in the attachments to this Agreement as they apply to each product and region.

2.14 **Hospital Non-solicitation Obligations.** Hospital will not unilaterally assign or transfer patients served under this Agreement to another hospital without the prior written approval of Health Plan. Nor will Hospital solicit or encourage Members to select another health plan. Nothing in this provision is intended to limit Hospital's ability to fully inform Members of all available health care treatment options or modalities.

2.15 **Fraud and Abuse Reporting.** Hospital will report to Health Plan's compliance officer all cases of suspected fraud or abuse, as defined in 42 CFR 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) days of the date when Hospital first becomes aware of, or is on notice of, such activity. Hospital will establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and abuse in the provision of health care services under the Medicaid program. Upon the request of Health Plan and/or the state, Hospital will consult with the appropriate state agency prior to and during the course of any such investigations.

2.16 **Advance Directive.** Hospital will document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other applicable Law.

2.17 **Reassignment of Members.** Health Plan reserves the right to reassign Members from Hospital to another provider or to limit or deny the assignment or selection of new Members to Hospital during any termination notice period or if Health Plan determines that assignment of Members to Hospital poses a threat to the Members' health and safety. If Hospital requests reassignment of a Member, Health Plan, in its sole discretion, will make the determination regarding reassignment based upon good cause shown by the Hospital. When the Health Plan reassigns Member(s), Hospital will forward copies of the Member's medical records to the new provider within ten (10) business days of receipt of the Health Plan's or the Member's request to transfer the records.

2.18 **Reciprocity Agreements.** Hospital will cooperate with Affiliates of Health Plan and agrees to provide Hospital Services to Members enrolled in the various products and programs offered by any Affiliate and to assure reciprocity of such health care services. Hospital will comply with the procedures established by Health Plan or its Affiliates and this Agreement for reimbursement of such services or treatment. Hospital will not encourage Members to receive Hospital Services from non-Participating Providers. Hospital will abide by all provisions of this Agreement relating to non-billing of Members with respect to all services and treatment subject to this reciprocity arrangement.

2.19 **Notification of Network Change.** Where Hospital operates a network of facilities, Hospital will provide Health Plan and Members with timely prior written notification in the event a constituent provider terminates its contract with Hospital. Said written notification will be in compliance with applicable Law or Government Program requirements.

2.20 **Members Condition Changes or Deaths.** Upon becoming aware of or suspecting: (i) a significant change in a Member's health or functional status that could affect Member's level of care determination; (ii) a Member is being abused or neglected; or (iii) a Member death, Hospital will notify Health Plan's Member Services Department as soon as possible but not later than seven (7) days.

ARTICLE THREE – HEALTH PLAN'S OBLIGATIONS

3.1 **Compensation.** Health Plan will pay Hospital in accordance with the terms and conditions of this Agreement.

3.2 **Member Eligibility Determination.** Health Plan will maintain data on Member eligibility and enrollment. Health Plan will promptly verify Member eligibility at the request of Hospital.

3.3 **Prior Authorization Review.** Health Plan will timely respond to requests for prior authorization and/or determination of Hospital Services.

3.4 **Medical Necessity Determination.** Health Plan's determination with regard to Medically Necessary services and scope of Hospital Services, including determinations of level of care and length of stay benefits available under the Member's health program will govern. The primary concern with respect to all medical determinations will be in the interest of the Member.

3.5 **Member Services.** Health Plan will provide services to Members including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health

Plan, and providing Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan Participating Providers.

3.6 **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Hospital Services, limitations and exclusions, and coordination of benefits information. Health Plan will make available a Hospital Services Department that, among other Health Plan duties, will be available to educate Hospital regarding Health Plan's policies and procedures.

3.7 **Medical Director.** Health Plan will retain a physician as medical director who will be responsible for the management of the scientific, technical, medical and behavioral health aspects of Health Plan.

ARTICLE FOUR – TERM AND TERMINATION

4.1 **Term.** This Agreement will commence on the Effective Date indicated by Health Plan and will continue in effect for one (1) year; thereafter, it will automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with the provisions of this Agreement or in accordance with applicable state and federal provisions set forth in the Attachments hereto.

4.2 **Termination without Cause.** At any time during this Agreement, this Agreement, a product/program provided pursuant to this Agreement, or an individual Hospital under this Agreement may be terminated without cause by either party on at least one hundred twenty (120) days written notice to the other party.

4.3 **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach may give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination will have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this thirty (30) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the party who provided the notice of termination will have the right to immediately terminate this Agreement, a product/program provided pursuant to this Agreement, or an individual Hospital under this Agreement. Notwithstanding the forgoing, either party may immediately terminate this Agreement, a product/program provided pursuant to this Agreement, or an individual Hospital under this Agreement without providing the other party the opportunity to cure a material breach should the terminating party reasonably believe the material breach of this Agreement to be non-curable.

4.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, or unless otherwise mutually agreed to in writing by both parties, this Agreement, a product/program provider pursuant to this Agreement, or an individual Hospital under this Agreement, may immediately be terminated upon written notice to the other party in the event of any of the below. Upon termination, Health Plan may transfer Member(s) to another provider.

a. Hospital's license or certificate to render health care services is limited, suspended or revoked, or disciplinary proceedings are commenced against Hospital by the state licensing authority;

b. Either party fails to maintain insurance required by this Agreement;

c. Hospital has not or is unable to comply with Health Plan's credentialing requirements, including but not limited to, having or maintaining credentialing status;

d. Either party becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Hospital or Health Plan is appointed by appropriate authority;

e. If Hospital is capitated and Health Plan determines Hospital is financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;

f. Health Plan reasonably determines that Hospital's facility or equipment is insufficient to render Hospital Services;

g. Either party is excluded from participation in Medicare or state health care programs pursuant to Section 1128;

h. Hospital is terminated as a provider by any state or federal health care program;

i. Either party engages in fraud or deception, or permits fraud or deception by another in connection with each party's obligations under this Agreement;

j. Health Plan reasonably determines that health care services are not being properly provided, or arranged for by Hospital and that such failure poses a threat to Members' health and safety;

k. Hospital violates any state or federal law, statute, rule, regulation or executive order; or

l. Hospital fails to satisfy the terms of a corrective action plan.

4.5 **Notice of Nonrenewal or Termination**. Health Plan will provide written notice of nonrenewal or termination of Hospital to the Members served by Hospital as soon as practicable, but in no event later than fifteen (15) days following termination. Hospital will not contact Health Plan's Members upon termination of this Agreement, a product/program provided pursuant to this Agreement, or an individual Hospital under this Agreement. Immediate written notice will be provided without sixty (60) days' notice in the event Hospital's license has been disciplined by a state licensing board.

ARTICLE FIVE – GENERAL PROVISIONS

5.1 **Indemnification.** Each party will indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

5.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor will it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained will prevent any of the parties from entering into similar arrangements with other parties. Each of the parties will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will be construed to create, any right in any third party, including but not limited to, Members. Nor will any third party have any right to enforce the terms of this Agreement.

5.3 **Governing Law.** The laws of the State of Iowa will govern this Agreement.

5.4 **Entire Agreement.** This Agreement, including attachments, addenda, amendments, and incorporated documents or materials, contains the entire agreement between Health Plan and Hospital relating to the rights granted and obligations imposed by this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, between the parties and relating to the subject matter of this Agreement are of no force or effect. Additionally, as to the Medicaid products offered by Health Plan, the State Contract is incorporated herein by reference and shall be the guiding and controlling document when interpreting the terms of this Agreement.

5.5 **Severability.** If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.

5.6 **Headings and Construction.** The headings in this Agreement are for reference purposes only and shall not be considered a part of this Agreement in construing or interpreting any of its provisions. It is the parties' desire that if any provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is to be construed against its drafter shall not apply to the interpretation of the ambiguous provision.

5.7 **Non-exclusivity.** This Agreement will not be construed to be an exclusive Agreement between Health Plan and Hospital. Nor will it be deemed to be an Agreement requiring Health Plan to refer Members to Hospital for health care services.

5.8 **Amendment.** Health Plan may, without Hospital's consent, immediately amend this Agreement to maintain consistency and/or compliance with any applicable Law, policy, directive, or Government Program requirement. Health Plan may otherwise amend this Agreement upon thirty (30) days prior written notice to Hospital. If Hospital does not deliver to Health Plan a written notice of rejection of the amendment within that thirty (30) day period, the amendment will be deemed accepted by and will be binding upon Hospital.

5.9 **Delegation or Subcontract.** Hospital will not delegate or enter into any subcontract agreement for the provision of Covered Services without the prior written consent of Health Plan. Any subcontract agreement entered into by Hospital for the delivery of Covered Services will be in writing and will bind the subcontractor to the terms and conditions of this Agreement including, but not limited to, licensure, insurance, and billing of Members for Covered Services.

5.10 **Assignment.** Hospital may not assign or transfer, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Health Plan and Hospital and their respective successors in interest and assigns.

5.11 **Arbitration.** Any claim or controversy arising out of or in connection with this Agreement will first try to be resolved through the Grievance Program and Health Plan's internal appeals process. In the event that the claim or controversy cannot be resolved through the Grievance Program or Health Plan's internal appeal process, Hospital and Health Plan will engage in mandatory good faith meetings and discussions, which can include multiple writings, telephonic meetings or in person meetings, but will at least include one written communication by each party setting forth their position and one in person meeting, with decision makers present to try and resolve the claim or controversy. Any remaining claim or controversy will be resolved through binding arbitration administered by JAMS pursuant to its Comprehensive

Arbitration Rules and Procedures, then in effect, in Des Moines, Iowa; provided, however, matters that primarily involve Hospital's professional competence or conduct will not be eligible for arbitration. A panel of three (3) arbitrators will be appointed unless the parties agree to utilize a single arbitrator. In the event a panel of three (3) arbitrators will be used, the claimant will select one (1) arbitrator; the respondent will select one (1) arbitrator; and the two (2) arbitrators selected by the claimant and respondent will select the third arbitrator. If possible, each arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care. The arbitration will be conducted in English. Arbitration must be initiated within one (1) year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise, it will be deemed waived. The use of binding arbitration will not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

The parties will conduct a mandatory settlement conference at the initiation of arbitration, to be administered by JAMS. The arbitrator(s) will have no authority to provide a remedy or award damages that would not be available to such prevailing party in a court of law, nor will the arbitrator(s) have the authority to award punitive damages. Each party will bear its own costs and expenses, including its own attorneys' fees, and will bear an equal share of the arbitrator's and administrative fees of arbitration. Furthermore, the parties agree that either party may request a court reporter transcribe the entire proceeding, in which case the parties will divide the cost of the court reporter; however, each party may elect to purchase or forego purchasing a transcript.

The parties agree that any decision made by the arbitrator(s) must provide a reasoned decision as to the facts and law in writing. Furthermore, the parties agree that any arbitration decision must be grounded in applicable law, and any failure to make a decision grounded in law will give any party the right to appeal the decision in addition to those rights of vacatur or appeal already existing pursuant to the Federal Arbitration Act and/or applicable state arbitration laws. Such appeal may be made to a court having jurisdiction over the parties and/or the dispute. If the court having jurisdiction over the parties and/or the dispute for appeal purposes does not permit appeal of an arbitration award to a court, for any reason, the parties agree to submit such appeal to arbitration pursuant to the JAMS rules regarding Optional Arbitration Appeal Procedure (requiring three arbitrators), and any appeal will be held in the same city in which the arbitration occurred. Notice of intent to appeal based on failure to provide a decision grounded in law must be given within fifteen (15) days after the decision is communicated to the parties; and the appeal must be formally initiated by filing in court or commencing arbitration by sending a notice of appeal to JAMS within thirty (30) days after the decision is communicated to the parties. If a court decides it will not hear an appeal because it deems appeals from arbitration not subject to appeal these timelines are tolled until such order is issued, at which time the parties will have thirty (30) days to submit a notice of intent to appeal to JAMS. If a court generally permits appeals from arbitrations, but deems the particular issue not appealable, there is no right for an additional appeal to arbitration. Judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction, after receiving the arbitrator's written reasoned decision and after confirming neither party intends to appeal.

5.12 **Notice.** All notices required or permitted by this Agreement will be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, by Federal Express or other overnight courier that guarantees next day delivery, by facsimile transmission, or by electronic mail or other means of electronic delivery, including but not limited to, Health Plans website and interactive web portal. All notices will be deemed sufficiently given if served in the manner specified in this section. The mailing names and addresses set forth under the Signature Authorization section of this Agreement will be the particular party's address for delivery or mailing of notice purposes. Each party may change their name and address through written notice in compliance with this section. Any notice sent by registered or certified mail, return receipt requested, will be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery will be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice will be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

5.13 **Waiver.** A failure or delay of any party to exercise or enforce any provision of this Agreement shall not be deemed a waiver of any right of that party. Any waiver must be specific, in writing and executed by both the Health Plan and Hospital.

5.14 **Execution in Counterparts and Duplicates**. This Agreement shall be executed in duplicate and each duplicate may also be executed in counterparts, each of which shall be deemed a duplicate original, but all of which together shall constitute one and the same instrument. It is further agreed that facsimile signatures, electronic signature, pdf signatures, or a signature scanned and sent via e-mail shall have the same effect as original signatures.

5.15 **Conflict with Health Plan Product**. Nothing in this Agreement modifies any benefits, terms or conditions contained in the Member's Health Plan product. In the event of a conflict between this Agreement and the benefits, terms, and conditions of the Health Plan product, the benefits, terms or conditions contained in the Member's Health Plan product will govern.

5.16 **Force Majeure.** Neither party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either party's employees, or any other similar cause beyond the reasonable control of such party.

5.17 **Confidentiality.** Any information maintained or generated by either party in fulfillment of its obligations under this Agreement, including healthcare information, shall be kept confidential in accordance with and to the extent required by applicable Laws. Further, all information provided to Hospital, including, but not limited to, Member lists, QI Program, credentialing criteria, compensation methodologies and rates, and any other administrative protocols or procedures of Health Plan, is the proprietary property of Health Plan. Hospital shall not disclose or release such material to any third party without the written consent of Health Plan.

DRAFT

ATTACHMENT A
DEFINITIONS

Capitalized words or phrases in this Agreement mean the following:

1.1 **Accreditation Organization** means any organization, including, without limitation, the National Committee for Quality Assurance ("NCQA"), engaged in accrediting or certifying Health Plan or Hospital.

1.2 **Advance Directive** means a Member's written instructions, recognized under Law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under Law. Examples of Advance Directives are living wills and durable powers of attorney for health care.

1.3 **Affiliate** means an entity owned or controlled by Health Plan or Molina Healthcare, Inc. ("Molina").

1.4 **Agreement** means this Hospital Services Agreement, including all attachments addenda, amendments, and incorporated documents or materials.

1.5 **Authorized Representative** means the person with legal authority to agree to and execute this Agreement.

1.6 **Capitated Provider** shall mean a provider that has accepted financial responsibility for certain Covered Services and Members, which can be demonstrated through the agreement the Capitated Provider has with Health Plan.

1.7 **Centers for Medicare and Medicaid Services** ("CMS") means an administrative agency of the United States Government, responsible for administering the Medicare program.

1.8 **C.F.R** means Code of Federal Regulations.

1.9 **Claim** means an invoice for Hospital Services rendered to a Member by Hospital, submitted in a format approved by Health Plan and with all service and Encounter information required by Health Plan.

1.10 **Clean Claim** means a Claim for Hospital Services that is submitted on an industry standard form (e.g. CMS-1500, UB-04), and has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the Claim.

1.11 **Completion of Audit** means the completion of audit by the Department of Health and Human Services ("DHHS"), the Government Accountability Office ("GAO"), or their designees of Health Plan, Medicare and Medicaid Plan contractor or related entity.

1.12 **Covered Services** means those health care services, supplies and benefits that are (i) Medically Necessary, (ii) benefits of the applicable Health Plan Product(s)/Program(s), and (iii) required to be provided by Health Plan pursuant to the Government Contract(s) as applicable, which covers the Member(s).

1.13 **Cultural Competency Plan** means a plan that ensures Covered Services are provided to Members in a manner that takes into account, but is not limited to, developmental disabilities, physical disabilities, differential abilities, cultural and ethnic backgrounds and limited English proficiency.

1.14 **Date of Service** means the date on which Hospital renders services to a Member, or for inpatient services, the date the Member is discharged.

1.15 **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between a health plan (or applicant) and a First Tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.16 **Emergency Services** are health care services furnished in the emergency department of a hospital for the treatment of a medical emergency; ancillary services routinely available to the emergency department of a hospital for the treatment of a medical emergency; and emergency medical services transportation.

1.17 **Encounter** means a distinct set of services provided to a Member enrolled by Health Plan on the dates that the services were delivered.

1.18 **Encounter Data** means: (i) all data captured during the course of a single health care Encounter that specify the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative) pharmaceuticals, medical devices and equipment associated with a Member receiving services during the Encounter; (ii) the identification of the Member receiving and the provider delivering the health care services during the single Encounter; and (iii) a unique, i.e. unduplicated, identifier for the single Encounter.

1.19 **Final Contract Period** means the final term of the contract between CMS and the Health Plan.

1.20 **First Tier Entity** means any Party that enters into a written arrangement, acceptable to CMS, with Health Plan to provide administrative services or health care services for a Medicare eligible Member under the Medicare Advantage program.

1.21 **Iowa Department of Human Services ("DHS")** means the agency within the State of Iowa that is responsible for the oversight and administration of the Medicaid and CHIP programs.

1.22 **Government Contracts** means those contracts between Health Plan and state and federal agencies for the arrangement of health care service for Members through Government Programs, including but not limited to, the State Contract(s).

1.23 **Grievance Program** means the procedures established by Health Plan to timely address Member and Hospital complaints or grievances.

1.24 **Health Plan** means Molina Healthcare of Iowa, Inc., a Iowa Corporation.

1.25 **Hospital** means the person(s) and/or entity(ies), any constituent physicians, allied health professionals, staff persons, and any employed, subcontracted and/or affiliated entities, and are all bound by the terms and conditions of this Agreement.

1.26 **Hospital Providers** are hospital-based physicians and independent licensed non-physician health care professionals who are employed by, contract with, or on the medical staff of Hospital to provide Covered Services to Members.

1.27 **Hospital Services** are those Covered Services that are within the normal scope of practice and licensure of Hospital and its Hospital Providers, and which includes, but are not limited to, short term inpatient or outpatient general hospital services including room with customary furnishings and equipment, meals (including special diets as medically necessary), general nursing care, use of operating room and related facilities, intensive care unit and services, emergency services, drugs, including drugs to be dispensed at time of emergency room visit in amount sufficient to last until such time Member can reasonably be expected to fill a prescription, medications, biological, anesthesia and oxygen services, ambulatory care services, diagnostic laboratory and x-ray services, special duty nursing as medically necessary, physical therapy, respiratory therapy, administration of blood and blood products, and diagnostic, therapeutic and rehabilitative services as appropriate, and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

1.28 **Law(s)** mean all federal and state statutes and regulations applicable to the subject matter of this Agreement or the parties' performance of their duties and obligations hereunder).

1.29 **Medicaid** means the joint federal-state program provided for under Title XIX of the Social Security Act, as amended.

1.30 **Medically Necessary** means care that is based upon generally accepted medical practices in light of conditions at the time of treatment, and are services that are: (i) appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible Member's medical condition; (ii) compatible with the standards of acceptable medical practice in the community; (iii) provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms; (iv) not provided solely for the convenience of the Member or the convenience of the provider; and (v) not primarily custodial care unless custodial care is a covered service or benefit under the Member's evidence of coverage.

1.31 **Medicare** means the various insurance health plans provided under Title XVIII of the Social Security Act, as amended.

1.32 **Medicare Advantage ("MA")** means an alternative to the traditional Medicare program in which private plans, run by health insurance companies, provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

1.33 **Medicare Advantage Special Needs Plan ("MA-SNP")** means an alternative to the traditional Medicare program in which private plans, run by health insurance companies, provide health care benefits to beneficiaries who are eligible for both Medicare and Medicaid.

1.34 **Medicare-Medicaid Program ("MMP")** means an integrated delivery system, payment model, and alternative to the traditional Medicare and Medicaid programs, aimed at improving the quality, coordination, and cost-effectiveness of services, in which private health plans, run by health insurance companies, provide health care benefits to beneficiaries who are dually eligible for both Medicare and Medicaid.

1.35 **Member** means a person enrolled in one of Health Plan's benefit products or a Health Plan Affiliate's benefit product and who is eligible to receive Covered Services.

1.36 **Overpayments** means any payment Hospital receives or retains in which Hospital, after applicable reconciliation, is not entitled to receive such payment pursuant to Law or the terms of this Agreement.

1.37 **Participating Provider(s)** means those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan.

1.38 **Provider Manual** means Health Plan's, procedures, standards and specimen documents that have been compiled by Health Plan for the use and instruction of Hospital.

1.39 **Quality Improvement Program ("QI Program")** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.

1.40 **Related Entity** means any entity that is related to the Health Plan by common ownership or control and: (i) performs some of the Health Plan's management functions under contract or delegation; (ii) furnishes services to Medicare Members under an oral or written agreement; or (iii) leases real property or sells materials to the Health Plan at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.

1.41 **State Children's Health Insurance Program ("CHIP")** means the program established pursuant to Title XXI of the Social Security Act, as amended.

1.42 **State Contract** means the contract(s) between DHS and Health Plan that govern the provision of Covered Services to Members, as may be amended.

1.43 **Utilization Review and Management Program ("UM Program")** means the policies, procedures and systems developed by Health Plan for evaluating and monitoring the medical necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective reviews, including but not limited to under-utilization and over-utilization.

DRAFT

ATTACHMENT B
PRODUCTS/PROGRAMS

Hospital agrees to participate as a Participating Provider for the following products/programs and successor(s).

1.1 **Medicaid** - including but not limited to the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa (hawk-i) programs.
1.2 **Medicare** – including but not limited to Molina Medicare Options (Medicare Advantage), Molina Medicare Options Plus ("MA-SNP").
1.3 **Medicare-Medicaid Program –** including, but not limited to, Dual Options (Capitated Financial Alignment Demonstration ("CFAD").

Comment [MM1]: Ben did not note this in his email but I left it in.

DRAFT

ATTACHMENT C
COMPENSATION SCHEDULE

1.1 **Medicaid**

a. **Hospital Services Payments.** Health Plan agrees to compensate Hospital for Hospital Services rendered to Members, in accordance with the products/programs specified in Attachment B, that are determined by Health Plan to be payable and submitted on a Clean Claim, on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of: (i) Hospital's billed charges; or (ii) at an allowable amount equivalent to the payable rate under the applicable Medicaid Fee-For-Service Program fee schedule set forth by the State of Iowa, in effect on the Date(s) of Service. Notwithstanding the foregoing, payment for Hospital Services, including, but not limited to, certain Hospital Services where there is no payment rate in the Iowa Medicaid Fee-For-Service Program fee schedule as of the Date(s) of Service, will not exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the Date(s) of Service.

1.2 **Medicare**

a. **Hospital Services Payments**. Health Plan agrees to compensate Hospital for Hospital Services rendered to Members, in accordance with Medicare products/programs as specified in Attachment C, that are determined by Health Plan to be payable and submitted on a Clean Claim, on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of; (i) Hospital's billed charges, or (ii) at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography), as of the date(s) of service.

DRAFT

ATTACHMENT D
DHS PROGRAM REQUIREMENTS

This attachment sets forth the applicable requirements that are required by the State Contract to be included in agreements between Health Plan and Participating Providers or other provisions necessary to reflect compliance with the Law. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments to the State Contract or changes or modifications to Law or Government Program requirements. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1.1 The parties acknowledge that State Contract has not been completed and that upon completion, this attachment will immediately be amended to conform to any requirement set forth therein.

DRAFT

ATTACHMENT E
Medicare Program Requirements – Healthcare Services

This attachment sets forth the applicable Government Program requirements, covering the provision of health care and related services, that are required by CMS to be included in contracts and/or agreements between; (i) health plans/health maintenance organizations, and (ii) clients or providers of health care or related services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1.1 Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(ies) that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein. (42 CFR 422.504(i)(3)(iii)).

1.2 Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information, including books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under Health Plan's contract with CMS, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period between Health Plan and CMS or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 42 CFR 422.504(e)(3), 42 CFR 422.504(e)(4) and 42 CFR422.504(i)(2)(ii).).

1.3 Confidentiality. Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13).)

1.4 Hold Harmless/Cost Sharing. Provider agrees it may not under any circumstances, including nonpayment of moneys due to the providers by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Member, or any persons other than the Health Plan acting on their behalf, for services provided in accordance with this Agreement. The Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. (42 CFR 422.504(g)(1)(i)) and (42 CFR 422.504(g)(1)(iii).) In addition, for Members who are dually eligible for Medicare and Medicaid and enrolled in a Medicare Advantage Special Needs Plan will not be held liable for Medicare Part A and B cost sharing when the State or another payor such as a Medicaid Managed Care Plan is responsible for paying such amounts. Health Plan will inform providers of applicable Medicare and Medicaid benefits and rules for eligible Members. Provider agrees to accept payment from Health Plan as payment in full, or bill the appropriate State source, for any Medicare Part A and B cost sharing that is covered by Medicaid. Collection from the Member of copayments or supplemental charges in accordance with the terms of the Member's contract with the Health Plan, or charges for services not covered under the Member's contract, may be excluded from this provision.

1.5 Accountability. Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions set forth in Attachment E-1 of this Agreement. (42 CFR 422.504(i)(3)(ii).)

1.6 Delegation. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(3)(iii) and 42 CFR 422.504(i)(4).)

1.7 Prompt Payment. Health Plan and Provider agree that Health Plan will pay all Clean Claims for services that are covered by Medicare within sixty (60) days of the date such Claim is delivered by Provider to Health Plan and Health Plan determines such Claim is complete/clean. Any Claims for services that are covered by Medicare that are not submitted to Health Plan within six (6) months of providing the services that are subject of the Claim will not be eligible for payment, and Provider hereby waives any right to payment therefore. Health Plan reserves the right to deny any Claims that are not in accordance with the Medicare Claims Processing Manual and Medicare rules for billing. (42 CFR 422.520(b).)

1.8 Reporting. Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310. (42 CFR 504(a)(8).)

1.9 Compliance with Medicare Laws and Regulations. Provider will comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v).)

1.10 Benefit Continuation. Provider agrees to provide for continuation of Member health care benefits (i) for all Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Members who are hospitalized on the date Health Plan's contract with CMS terminates, or, in the event of insolvency, through discharge. (42 CFR 422.504(g)(2)(i), 42 CFR 422.504(g)(2)(ii) and 42 CFR 422.504(g)(3).)

1.11 Cultural Considerations. Provider agrees that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. (42 CFR 422.112(a)(8).)

DRAFT

ATTACHMENT E-1
Medicare Program Requirements – Delegated Services

This attachment sets forth the applicable Government Program requirements, covering the delegation to Hospital of any management responsibilities or administrative services if any, that are required by CMS to be included in contracts and/or agreements between; (i) health plans/health maintenance organizations, and (ii) clients or providers of health care or related services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1.1 Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(s) that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein. (42 CFR 422.504(i)(3)(iii))

1.2 Medicare Compliance. Provider agrees to require all of its downstream, related entity(s) and transferees to comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v).)

1.3 Confidentiality. Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13).)

1.4 Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 42 CFR 422.504(e)(3), 42 CFR 422.504(e)(4) and 42 CFR 422.504(i)(2)(ii).)

1.5 Responsibilities and Reporting Arrangements. The Agreement specifies the delegated activities and reporting responsibilities if any. To the extent applicable, Provider will support Health Plan in complying with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 310 by providing relevant data. (42 CFR 422.504(i)(4)(i) and 42 CFR 422.504(a)(8).)

1.6 Revocation of Delegated Activities. In the event CMS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities will be revoked. (42 CFR 422.504(i)(4)(ii).)

1.7 Accountability. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(1) and 42 CFR 422.504(i)(3)(iii).)

1.8 Credentialing. If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. Health Plan retains the right to approve, suspend, or terminate any credentialing delegation arrangement. (42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5).)

1.9 Monitoring. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contractual obligations. Health Plan will monitor the performance of first tier, downstream, and related entities. (42 CFR 422.504(i)(1) and 42 CFR 422.504(i)(4).)

1.10 Further Requirements. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with Health Plan's contractual obligations. If Health Plan delegates selection of the providers, contractors, or subcontractor to another organization, Health Plan retains the right to approve, suspend, or terminate any such arrangement. (42 CFR 422.504(i)(3)(iii), 42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5).

DRAFT

Performance Evaluation Report

Molina Healthcare of California Partner Plan, Inc.

July 1, 2012–June 30, 2013

Medi-Cal Managed Care Division
California Department of
Health Care Services

April 2014

Performance Evaluation Report – Molina Healthcare of California Partner Plan, Inc.
July 1, 2012 – June 30, 2013

TABLE OF CONTENTS

1. INTRODUCTION 1
Purpose of Report 1
Managed Care Plan Overview 2
2. MANAGED CARE PLAN STRUCTURE AND OPERATIONS 3
Conducting the EQRO Review 3
Assessing the State's Compliance Review Activities 3
Readiness Reviews 3
Medical Performance Audits and Member Rights Reviews 4
Strengths 5
Opportunities for Improvement 5
3. PERFORMANCE MEASURES 6
Conducting the EQRO Review 6
Validating Performance Measures and Assessing Results 6
Performance Measure Validation 7
Performance Measure Validation Findings 7
Performance Measure Results 8
Seniors and Persons with Disabilities Performance Measure Results 14
Performance Measure Result Findings 19
Improvement Plans 19
Strengths 27
Opportunities for Improvement 27
4. QUALITY IMPROVEMENT PROJECTS 28
Conducting the EQRO Review 28
Validating Quality Improvement Projects and Assessing Results 28
Quality Improvement Project Objectives 29
Quality Improvement Project Validation Findings 30
Quality Improvement Project Outcomes and Interventions 32
Strengths 33
Opportunities for Improvement 33
5. MEMBER SATISFACTION SURVEY 34
Conducting the EQRO Review 34
Findings 34
National Comparisons 36
Strengths 37
Opportunities for Improvement 38
6. ENCOUNTER DATA VALIDATION 39
Conducting the EQRO Review 39
Methodology 39
Encounter Data Validation Findings 40
Review of Encounter Systems and Processes 40
Record Completeness 41

Data Element Completeness 41
Data Element Accuracy 41
Recommendations 42

7. OVERALL FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS 44

Overall Findings Regarding Health Care Quality, Access, and Timeliness 44
Quality 44
Access 47
Timeliness 48
Follow-Up on Prior Year Recommendations 49
Recommendations 49

APPENDIX A. SCORING PROCESS FOR THE DOMAINS OF CARE A-1

APPENDIX B. MCP'S SELF-REPORTED FOLLOW-UP ON EXTERNAL QUALITY REVIEW RECOMMENDATIONS FROM THE JULY 1, 2011–JUNE 30, 2012 PERFORMANCE EVALUATION REPORT B-1

Performance Evaluation Report
Molina Healthcare of California Partner Plan, Inc.
July 1, 2012 – June 30, 2013

1. INTRODUCTION

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services provided by the states' Medicaid MCPs. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on the Medi-Cal Managed Care program (MCMC). Due to the large number of contracted MCPs and evaluative text, HSAG produced an aggregate technical report and MCP-specific reports separately. The reports are issued in tandem as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It

[1] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

includes an aggregate assessment of MCPs' performance through organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2012–June 30, 2013). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, Molina Healthcare of California Partner Plan, Inc. ("Molina" or "the MCP"), for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Plan Overview

In Riverside and San Bernardino counties, Molina is a full-scope MCP delivering services to its MCMC members as a "commercial plan" (CP) under the Two-Plan Model (TPM). In most TPM counties, there is a CP and a "Local Initiative" (LI). DHCS contracts with both plans. The LI is designed—with the input of local government, community groups, and health care providers—to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. MCMC beneficiaries in Riverside and San Bernardino counties may enroll in Molina; the CP; or in Inland Empire Health Plan, the alternative LI.

In Sacramento and San Diego counties, Molina delivers services to its MCMC members under a Geographic Managed Care (GMC) model. In the GMC model, DHCS allows MCMC beneficiaries to select from several commercial MCPs within a specified geographic area.

Molina became operational in Riverside and San Bernardino counties to provide MCMC services effective December 1997. The MCP expanded to Sacramento County in 2000 and San Diego County in 2005. As of June 30, 2013, Molina had 47,962 MCMC members in Riverside County, 61,670 in San Bernardino County, 38,481 in Sacramento County, and 90,375 in San Diego County—for a total of 238,488 MCMC members.[3]

[3] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP's compliance with standards established by the state related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's compliance monitoring reviews to draw conclusions about Molina's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

For this report, HSAG reviewed the most current member rights reviews, medical performance audits, and monitoring reports available as of June 30, 2013. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes in these areas prior to the commencement of MCP operations, during

MCP expansion into new counties, upon contract renewal, and upon the MCP's changes in policies and procedures.

Medical Performance Audits and Member Rights Reviews

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical performance audits of Medi-Cal MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical performance audits assess MCPs' compliance with contract requirements and State and federal regulations. These audits were conducted for each Medi-Cal MCP approximately once every three years.

During this review period, DHCS began a transition of medical performance monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical performance audit frequency from once every three years to once each year. The second change, which occurred late in this report's review period (March 2013), was the phasing out of DHCS's biennial member rights/program integrity on-site reviews.[4] The biennial member rights/program integrity on-site reviews were replaced with an expanded continuous review process.

Under DHCS's new monitoring protocols, findings identified in annual A&I Medical Audits, DMHC Seniors and Persons with Disabilities (SPD) Enrollment Surveys, and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under these new protocols include follow-up communications and meetings with MCPs, augmented by DHCS technical assistance for MCPs to develop meaningful corrective action plans (CAPs) that address findings.

Since DHCS was transitioning to new monitoring protocols during this reporting period, HSAG reviewed the most recent monitoring reports available as of June 30, 2013. In some cases, the most recent monitoring report available was the earlier DHCS or DMHC medical audit report (once every three-years) and/or the biennial member rights/program integrity review report. For some of the MCP-specific evaluation reports, HSAG assessed the MCP using materials produced under the new monitoring protocols.

The most recent routine monitoring review for Molina was conducted by DHCS's Member Rights/Program Integrity Unit (MR/PIU) January 24, 2011, through January 27, 2011, covering the review period of January 1, 2009, through March 31, 2010. HSAG reported on the detailed findings from this review in Molina's previous MCP-specific evaluation reports. MR/PIU conducted a follow-up review for Molina in October 2012. In addition to following up on the

[4] These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

findings identified during the January 2011 review, MR/PIU evaluated Molina's level of progress in performing cultural awareness and sensitivity training required to meet the needs of the SPD population and physical accessibility review surveys.

In a letter dated May 21, 2013, DHCS summarized the results of the October 2012 review. DHCS indicated that Molina had taken appropriate actions to correct the findings from the January 2011 review in the areas of Member Grievances and Prior Authorization Notification. Additionally, the letter indicated that MR/PIU found the MCP's progress on providing SPD sensitivity, facility site review tool, and physical accessibility trainings satisfactory.

Strengths

Molina took actions to fully address the findings from the January 2011 MR/PIU Routine Monitoring Review and has made satisfactory progress on providing SPD sensitivity, facility site review tool, and physical accessibility trainings.

Opportunities for Improvement

Since Molina resolved all areas of concern identified through the January 2011 MR/PIU survey, HSAG does not have any recommendations for opportunities for improvement related to compliance reviews.

Conducting the EQRO Review

DHCS annually selects a set of performance measures for the Medi-Cal full-scope MCPs to evaluate the quality of care delivered by the contracted MCPs to Medi-Cal Managed Care program (MCMC) beneficiaries. DHCS consults with contracted MCPs, the EQRO, and stakeholders to determine what measures the MCPs will be required to report. The DHCS-selected measures are referred to as the External Accountability Set. DHCS requires that MCPs collect and report External Accountability Set rates, which provides a standardized method for objectively evaluating MCPs' delivery of services.

HSAG conducts validation of the External Accountability Set performance measures as required by DHCS to evaluate the accuracy of the MCPs' reported results. Validation determines the extent to which MCPs followed specifications established by DHCS for its External Accountability Set-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

The Centers for Medicare & Medicaid Services (CMS) requires that states conduct performance measure validation of their contracted health plans to ensure that plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the plans' information systems (IS) provide accurate and complete information.

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[5] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

[5] The CMS EQR Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Performance Measure Validation

DHCS's 2013 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 31. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits™[7] of all Medi-Cal MCPs in 2013 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2013 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for Molina Healthcare of California Partner Plan, Inc.,* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that Molina followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A review of the MCP's HEDIS audit report revealed the following observations:

- As in prior years, Molina demonstrated a sound process for ensuring accurate provider demographic information and audited its provider network files weekly and monthly throughout the year.
- Molina had a robust disaster recovery plan, and the components of the plan met or exceeded HEDIS reporting expectations.

[6] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[7] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 displays a performance measure name key with abbreviations for reporting year 2013.

Table 3.1—Name Key for Performance Measures in External Accountability Set

Performance Measure Abbreviation	Full Name of 2013 Reporting Year† Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ACR	*All-Cause Readmissions* ‡
AMB–ED	*Ambulatory Care—Emergency Department (ED) Visits*
AMB–OP	*Ambulatory Care—Outpatient Visits*
CAP–1224	*Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
CAP–256	*Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
CAP–711	*Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
CAP–1219	*Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
CBP	*Controlling High Blood Pressure*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
IMA–1	*Immunizations for Adolescents—Combination 1*
LBP	*Use of Imaging Studies for Low Back Pain*
MMA–50	*Medication Management for People with Asthma—Medication Compliance 50% Total*
MMA–75	*Medication Management for People with Asthma—Medication Compliance 75% Total*
MPM–ACE	*Annual Monitoring for Patients on Persistent Medications—ACE*
MPM–DIG	*Annual Monitoring for Patients on Persistent Medications—Digoxin*
MPM–DIU	*Annual Monitoring for Patients on Persistent Medications—Diuretics*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
W-34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

† The reporting year represents the year the measure rate is reported and generally represents the previous calendar year's data.
‡ The ACR measure is a DHCS-developed measure for use in the All-Cause Readmissions Statewide Collaborative Quality Improvement Project.

Table 3.2 through Table 3.4 present a summary of Molina's 2013 performance measure results (based on calendar year 2012 data) compared to 2012 performance measure results (based on calendar year 2011 data).

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. Table 3.2 through Table 3.4 show the MCP's 2013 performance compared to the DHCS-established MPLs and HPLs.

DHCS based the MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the CDC–H9 (>9.0 percent) measure. For the CDC–H9 (>9.0 percent) measure, a low rate indicates better performance, and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile and the HPL is based on the national Medicaid 10th percentile.

While DHCS requires MCPs to report county-level data, DHCS made an exception and allowed Molina to continue to report Riverside and San Bernardino counties as one combined rate.

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
Molina—Riverside/San Bernardino Counties

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	20.13%	30.23%	★★	↑	18.98%	33.33%
ACR	Q, A	--	14.65%	--	Not Comparable	--	--
AMB–ED	‡	43.22	43.60	‡	Not Comparable	‡	‡
AMB–OP	‡	285.69	260.50	‡	Not Comparable	‡	‡
CAP–1224	A	94.88%	93.65%	★	↓	95.56%	98.39%
CAP–256	A	83.76%	83.03%	★	↔	86.62%	92.63%
CAP–711	A	82.68%	81.96%	★	↔	87.56%	94.51%
CAP–1219	A	84.19%	84.51%	★	↔	86.04%	93.01%
CBP	Q	--	53.83%	--	Not Comparable	--	--
CCS	Q,A	62.00%	52.75%	★	↓	61.81%	78.51%
CDC–BP	Q	59.33%	56.52%	★★	↔	54.48%	75.44%
CDC–E	Q,A	54.83%	46.68%	★★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	40.00%	43.48%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	48.76%	43.71%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	78.65%	81.92%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	34.83%	35.93%	★★	↔	28.47%	46.44%

Table 3.2—Comparison of 2012 and 2013 Performance Measure Results
Molina—Riverside/San Bernardino Counties

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
CDC–LS	Q,A	77.30%	82.61%	★★	↑	70.34%	83.45%
CDC–N	Q,A	81.80%	83.30%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	59.63%	63.86%	★	↔	64.72%	82.48%
IMA–1	Q,A,T	60.88%	69.10%	★★	↑	50.36%	80.91%
LBP	Q	76.40%	78.21%	★★	↔	72.04%	82.04%
MMA–50	Q	--	31.87%	--	Not Comparable	--	--
MMA–75	Q	--	14.51%	--	Not Comparable	--	--
MPM–ACE	Q	81.55%	86.05%	★★	↑	83.72%	91.33%
MPM–DIG	Q	NA	92.11%	★★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	81.41%	84.41%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	77.17%	64.27%	★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	43.84%	28.99%	★	↓	58.70%	74.73%
W-34	Q,A,T	74.77%	68.39%	★★	↔	65.51%	83.04%
WCC–BMI	Q	44.32%	42.00%	★★	↔	29.20%	77.13%
WCC–N	Q	64.97%	59.40%	★★	↔	42.82%	77.61%
WCC–PA	Q	57.08%	49.42%	★★	↓	31.63%	64.87%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡ This is a utilization measure, which is not assigned a domain of care. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.3—Comparison of 2012 and 2013 Performance Measure Results
Molina—Sacramento County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	28.29%	23.08%	★★	↔	18.98%	33.33%
ACR	Q, A	--	13.20%	--	Not Comparable	--	--
AMB–ED	‡	44.96	47.83	‡	Not Comparable	‡	‡
AMB–OP	‡	238.15	261.22	‡	Not Comparable	‡	‡
CAP–1224	A	95.79%	94.81%	★	↔	95.56%	98.39%
CAP–256	A	84.21%	84.09%	★	↔	86.62%	92.63%
CAP–711	A	83.45%	83.80%	★	↔	87.56%	94.51%
CAP–1219	A	83.38%	84.20%	★	↔	86.04%	93.01%
CBP	Q	--	51.29%	--	Not Comparable	--	--
CCS	Q,A	63.11%	50.51%	★	↓	61.81%	78.51%
CDC–BP	Q	58.22%	54.65%	★★	↔	54.48%	75.44%
CDC–E	Q,A	56.22%	47.91%	★★	↓	45.03%	69.72%
CDC–H8 (<8.0%)	Q	46.89%	46.05%	★★	↔	42.09%	59.37%
CDC–H9 (>9.0%)	Q	40.89%	43.26%	★★	↔	50.31%	28.95%
CDC–HT	Q,A	81.78%	78.60%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	33.78%	31.63%	★★	↔	28.47%	46.44%
CDC–LS	Q,A	69.33%	70.00%	★	↔	70.34%	83.45%
CDC–N	Q,A	83.11%	80.47%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	50.12%	54.06%	★	↔	64.72%	82.48%
IMA–1	Q,A,T	55.32%	66.04%	★★	↑	50.36%	80.91%
LBP	Q	84.03%	83.24%	★★★	↔	72.04%	82.04%
MMA–50	Q	--	31.72%	--	Not Comparable	--	--
MMA–75	Q	--	17.24%	--	Not Comparable	--	--
MPM–ACE	Q	78.84%	73.99%	★	↓	83.72%	91.33%
MPM–DIG	Q	NA	NA	NA	Not Comparable	87.93%	95.56%
MPM–DIU	Q	74.23%	73.63%	★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	81.45%	69.62%	★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	51.36%	37.47%	★	↓	58.70%	74.73%
W-34	Q,A,T	76.10%	73.21%	★★	↔	65.51%	83.04%

Table 3.3—Comparison of 2012 and 2013 Performance Measure Results
Molina—Sacramento County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
WCC–BMI	Q	62.33%	54.61%	★★	↓	29.20%	77.13%
WCC–N	Q	64.65%	59.34%	★★	↔	42.82%	77.61%
WCC–PA	Q	58.37%	49.65%	★★	↓	31.63%	64.87%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡ This is a utilization measure, which is not assigned a domain of care. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Table 3.4—Comparison of 2012 and 2013 Performance Measure Results
Molina—San Diego County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
AAB	Q	18.21%	17.33%	★	↔	18.98%	33.33%
ACR	Q, A	--	14.45%	--	Not Comparable	--	--
AMB–ED	‡	43.30	45.58	‡	Not Comparable	‡	‡
AMB–OP	‡	331.91	305.90	‡	Not Comparable	‡	‡
CAP–1224	A	94.76%	95.93%	★★	↔	95.56%	98.39%
CAP–256	A	88.46%	88.02%	★★	↔	86.62%	92.63%
CAP–711	A	87.55%	88.31%	★★	↔	87.56%	94.51%
CAP–1219	A	83.75%	85.26%	★	↑	86.04%	93.01%
CBP	Q	--	52.76%	--	Not Comparable	--	--
CCS	Q,A	68.91%	59.51%	★	↓	61.81%	78.51%
CDC–BP	Q	62.00%	62.30%	★★	↔	54.48%	75.44%
CDC–E	Q,A	56.44%	58.55%	★★	↔	45.03%	69.72%
CDC–H8 (<8.0%)	Q	46.22%	57.85%	★★	↑	42.09%	59.37%
CDC–H9 (>9.0%)	Q	46.67%	32.55%	★★	▲	50.31%	28.95%
CDC–HT	Q,A	84.44%	88.76%	★★	↔	78.54%	91.13%
CDC–LC (<100)	Q	42.22%	47.54%	★★★	↔	28.47%	46.44%
CDC–LS	Q,A	78.22%	86.42%	★★★	↑	70.34%	83.45%
CDC–N	Q,A	80.22%	84.31%	★★	↔	73.48%	86.93%
CIS–3	Q,A,T	73.19%	75.00%	★★	↔	64.72%	82.48%
IMA–1	Q,A,T	71.30%	80.83%	★★	↑	50.36%	80.91%
LBP	Q	71.98%	72.00%	★	↔	72.04%	82.04%
MMA–50	Q	--	35.33%	--	Not Comparable	--	--
MMA–75	Q	--	18.63%	--	Not Comparable	--	--
MPM–ACE	Q	86.72%	85.15%	★★	↔	83.72%	91.33%
MPM–DIG	Q	NA	94.74%	★★	Not Comparable	87.93%	95.56%
MPM–DIU	Q	85.85%	86.01%	★★	↔	83.19%	91.30%
PPC–Pre	Q,A,T	88.94%	79.72%	★	↓	80.54%	93.33%
PPC–Pst	Q,A,T	61.40%	51.52%	★	↓	58.70%	74.73%
W-34	Q,A,T	78.89%	74.74%	★★	↔	65.51%	83.04%

Table 3.4—Comparison of 2012 and 2013 Performance Measure Results
Molina—San Diego County

Performance Measure[1]	Domain of Care[2]	2012 Rates[3]	2013 Rates[4]	Performance Level for 2013	Performance Comparison[5]	DHCS's Minimum Performance Level[6]	DHCS's High Performance Level (Goal)[7]
WCC–BMI	Q	57.67%	64.79%	★★	↑	29.20%	77.13%
WCC–N	Q	61.86%	65.96%	★★	↔	42.82%	77.61%
WCC–PA	Q	52.33%	55.16%	★★	↔	31.63%	64.87%

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.
[4] 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
[6] DHCS's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] DHCS's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
‡ This is a utilization measure, which is not assigned a domain of care. No MPL or HPL is established for a utilization measure; therefore, there is no performance comparison.
-- Indicates a new measure in 2013; the 2012 rate is not available; and DHCS does not apply MPLs and HPLs to new measures; therefore, there is no performance comparison.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ or ▼ = Statistically significant decline.
↔ = No statistically significant change.
↑ or ▲ = Statistically significant improvement.
NA = A *Not Applicable* audit finding because the MCP's denominator was too small to report (less than 30).

Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),[8] DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures). Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The

[8] Senate Bill 208 (Steinberg et al, Chapter 714, Statutes of 2010) added W&I Code 14182(b)(17), which provides that DHCS shall develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care plan and for the subset of enrollees who are seniors and persons with disabilities. Managed care plan performance measures may include measures from HEDIS; measures indicative of performance in serving special needs populations, such as the NCQA Structure and Process measures; or both.

selection team considered conditions seen frequently in the senior population and reflected in measures such as *All-Cause Readmissions, Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Following the list of measures are Tables 3.5 through 3.10, which present a summary of Molina's 2013 SPD measure results. Tables 3.5, 3.7, and 3.9 present the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,[9] and the total combined rate for all measures except the *Ambulatory Care* measures. Tables 3.6, 3.8, and 3.10 present the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures.

- *All-Cause Readmissions—Statewide Collaborative QIP*
- *Ambulatory Care—Outpatient Visits*
- *Ambulatory Care—Emergency Department (ED) Visits*
- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months)*
- *Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)*
- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

[9] HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Tables 3.5, 3.7, and 3.9.

Table 3.5—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population Molina—Riverside/San Bernardino Counties

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	9.17%	18.15%	▼	14.65%
CAP–1224	93.77%	NA	Not Comparable	93.65%
CAP–256	83.13%	79.18%	↔	83.03%
CAP–711	81.88%	84.52%	↔	81.96%
CAP–1219	84.55%	83.44%	↔	84.51%
CDC–BP	67.63%	56.25%	↓	56.52%
CDC–E	46.89%	46.88%	↔	46.68%
CDC–H8 (<8.0%)	42.32%	47.40%	↔	43.48%
CDC–H9 (>9.0%)	46.06%	44.79%	↔	43.71%
CDC–HT	84.23%	80.21%	↔	81.92%
CDC–LC (<100)	37.76%	42.19%	↔	35.93%
CDC–LS	84.65%	76.56%	↓	82.61%
CDC–N	83.40%	88.02%	↔	83.30%
MPM–ACE	83.14%	87.80%	↑	86.05%
MPM–DIG	NA	90.63%	Not Comparable	92.11%
MPM–DIU	80.14%	87.06%	↑	84.41%

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

(▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

Table 3.6—2013 Non-SPD and SPD Rates for Ambulatory Care Measures Molina—Riverside/San Bernardino Counties

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
247.94	40.14	346.49	67.24

*Member months are a member's "contribution" to the total yearly membership.

Table 3.7—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population Molina—Sacramento County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	9.02%	14.68%	▼	13.20%
CAP–1224	94.90%	NA	Not Comparable	94.81%
CAP–256	84.18%	79.27%	↔	84.09%
CAP–711	83.64%	87.88%	↔	83.80%
CAP–1219	84.55%	79.40%	↓	84.20%
CDC–BP	57.40%	55.80%	↔	54.65%
CDC–E	44.84%	47.83%	↔	47.91%
CDC–H8 (<8.0%)	38.12%	52.17%	↑	46.05%
CDC–H9 (>9.0%)	50.22%	44.20%	↔	43.26%
CDC–HT	74.44%	73.91%	↔	78.60%
CDC–LC (<100)	27.35%	34.06%	↔	31.63%
CDC–LS	64.13%	63.77%	↔	70.00%
CDC–N	71.30%	81.88%	↑	80.47%
MPM–ACE	71.60%	74.59%	↔	73.99%
MPM–DIG	NA	NA	Not Comparable	NA
MPM–DIU	70.51%	74.40%	↔	73.63%

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

(▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

Table 3.8—2013 Non-SPD and SPD Rates for Ambulatory Care Measures Molina—Sacramento County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
218.18	42.97	415.90	65.28

*Member months are a member's "contribution" to the total yearly membership.

Table 3.9—2013 Performance Measure Comparison and Results for Measures Stratified by the SPD Population Molina—San Diego County

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
ACR	9.37%	17.65%	▼	14.45%
CAP–1224	96.16%	80.65%	↓	95.93%
CAP–256	88.11%	84.13%	↔	88.02%
CAP–711	88.25%	89.63%	↔	88.31%
CAP–1219	85.32%	84.01%	↔	85.26%
CDC–BP	60.21%	58.45%	↔	62.30%
CDC–E	45.42%	52.11%	↔	58.55%
CDC–H8 (<8.0%)	46.83%	57.75%	↑	57.85%
CDC–H9 (>9.0%)	42.25%	37.32%	↔	32.55%
CDC–HT	81.69%	85.21%	↔	88.76%
CDC–LC (<100)	33.80%	51.41%	↑	47.54%
CDC–LS	72.18%	83.80%	↑	86.42%
CDC–N	71.13%	90.14%	↑	84.31%
MPM–ACE	83.63%	85.79%	↔	85.15%
MPM–DIG	NA	94.12%	Not Comparable	94.74%
MPM–DIU	81.40%	88.10%	↑	86.01%

* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2013 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2013 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2013 were not significantly different than the non-SPD rates.

(▲▼) are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

Table 3.10—2013 Non-SPD and SPD Rates for Ambulatory Care Measures Molina—San Diego County

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
273.91	43.19	512.86	61.02

*Member months are a member's "contribution" to the total yearly membership.

Performance Measure Result Findings

Molina continues to show below-average performance on its performance measures. All counties had more measures with rates below the MPLs in 2013 than in 2012 and more measures with rates that declined significantly from 2012 to 2013 than from 2011 to 2012. Across all counties, 25 measures had rates below the MPLs—15 more than in 2012—and 16 measures had rates that declined significantly from 2012 to 2013.

Although the MCP continues to show below-average performance, in Sacramento County the rate for the *Use of Imaging Studies for Low Back Pain* measure was above the HPL for the second year in a row, and San Diego County had two *Comprehensive Diabetes Care* measures with rates above the HPLs—*LDL-C Control (<100 mg/dL)* and *LDL-C Screening.* Across all counties, 11 measures had rates with statistically significant improvement from 2012 to 2013.

Seniors and Persons with Disabilities Findings

Across all counties, the SPD rates for nine measures were significantly better than the non-SPD rates. San Diego County had five measures with SPD rates that were significantly better and Riverside/San Bernardino and Sacramento counties each had two measures with SPD rates that were significantly better than the non-SPD rates.

Across all counties, the SPD rates for seven measures were significantly worse than the non-SPD rates. The SPD rate for one of these measures, *All-Cause Readmissions*, was significantly worse than the non-SPD rate across all counties, meaning that in all counties, the SPD population (aged 21 years and older) had more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population.

The *Ambulatory Care* measures are utilization measures, which can be helpful in reviewing patterns of suspected under- and overutilization of services; however, rates should be interpreted with caution as high and low rates do not necessarily indicate better or worse performance. For this reason, DHCS does not establish performance thresholds for these measures, and HSAG does not provide comparative analysis.

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve quality, access, and timeliness associated with the low-performing measure and positively impact the measure's rate. For each rate that falls below

the MPL, the MCP must submit an IP with a detailed description of the steps it will take to improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

For the 2012–13 MCP-specific reports, HSAG reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2012 (measurement year 2011). HSAG then reviewed the HEDIS 2013 rates (measurement year 2012) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. In addition, HSAG assessed the MCP's need to continue existing IPs and/or to develop new IPs.

Molina was required to submit IPs for 10 measures with rates below the MPLs in 2012 (measurement year 2011). Below is a summary of each IP and HSAG's analysis of the progress the MCP made on improving performance on the measures.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

Molina was required to submit an IP for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in San Diego County for the second year in a row. Molina identified several new barriers and challenges to the MCP's success in reaching the MPL for this measure, including:

- Many inappropriate antibiotic prescriptions being written at the time of an emergency room or urgent care visit.
- Emergency room physicians being focused on rapid and immediate care and not being aware of the importance of avoiding antibiotic treatment for acute bronchitis.
- Some prescribers at the federally qualified health center (FQHC) being mid-level physician assistants and nurse practitioners who may be less aware of the importance of avoiding antibiotic treatment for acute bronchitis.

To address the newly-identified barriers and challenges, Molina implemented several new interventions, including:

- Conducting a clinical study to assess practitioner practice pattern variations with acute bronchitis treatment and sending letters with information about the appropriate use of antibiotics to providers identified in the clinical study as prescribing antibiotics for the diagnosis of acute bronchitis.
- Sending educational postcards on the appropriate use of antibiotics to members identified in the clinical study as filling a prescription for an antibiotic for the treatment of acute bronchitis.
- Conducting provider education sessions that include independent practice association and FQHC leadership.

- Including articles in the quality improvement provider newsletters on the avoidance of antibiotics in the treatment of adults with acute bronchitis, with reminders of where to obtain the clinical practice guidelines and member education handouts.

The rate for this measure declined by a little less than 1 percentage point from 2012 to 2013, and the rate remained below the MPL. Molina will be required to continue the IP for this measure for San Diego County.

Cervical Cancer Screening

Molina was required to submit an IP for the *Cervical Cancer Screening* measure in Sacramento County for the second year in a row in 2012, and for Riverside/San Bernardino counties for the first time. The MCP indicated that all barriers identified in the previous IP remained and that no new barriers were identified. Molina indicated that the MCP conducted data and barrier analyses to determine why the 2012 HEDIS rates did not show improvement over the 2011 HEDIS rates. The following reasons were identified:

- An increase in the female membership.
- Younger members not getting screened.
- Members not using the MCP's free transportation services.
- Providers with high membership not performing screenings.

To address the identified challenges, Molina continued several interventions and identified new interventions to implement. New interventions included:

- Implementing a pay-for-performance program that targets high-volume providers who are not performing the screenings.
- Implementing an incentive program for female members that includes a letter being mailed to them with information about needed services, instructions on how to schedule an appointment with their provider, and a form to complete and submit that triggers the MCP sending them a gift.
- Posting information in Molina Medical Group clinics about Molina's free neighborhood shuttles and distributing the information to all members.
- Mailing and faxing information to high-volume providers who are not performing screenings.

Despite the MCP's efforts, the rate for this measure declined significantly in Riverside/San Bernardino and Sacramento counties from 2012 to 2013. Additionally, the rate for this measure in San Diego County declined significantly from 2012 to 2013, which resulted in the rate moving from above the MPL in 2012 to below the MPL in 2013. Although the rates for this measure in Riverside/San Bernardino, Sacramento, and San Diego counties were below the MPLs in 2013,

Molina will not be required to continue its IP for this measure. In August 2013, it was learned that significant changes were made to the specifications for the *Cervical Cancer Screening* measure. NCQA will therefore not publically report this measure for HEDIS 2014, and DHCS made a decision that the MCPs with *Cervical Cancer Screening* rates below the MPLs in 2013 would not be required to submit an IP for the measure. Although this decision was made after the review period for this report, since the decision was made prior to the report being finalized, the information is included.

Comprehensive Diabetes Care—LDL-C Screening

Molina was required to submit an IP for the *Comprehensive Diabetes Care—LDL Screening* measure in Sacramento County because the rate for this measure was below the MPL in 2012. Molina identified several member, provider, and MCP barriers and challenges preventing the rate for this measure being above the MPL, including:

Members

- Lack of knowledge about the relevance of LDL-cholesterol level to overall health and control of diabetes.
- Language barriers with providers.
- Lack of transportation.
- Lack of knowledge regarding health benefits and that the screening is a covered benefit.
- Lack of time to schedule an appointment for the screening.

Providers

- No availability of evening and weekend appointment times.
- Lack of child care services for patients with children.
- Misperceptions about the willingness of minority patients following through on getting screenings.

MCP

- Not having updated addresses and telephone numbers for transient members.
- Members changing their MCP and/or primary care provider and services being interrupted (i.e., care coordination and follow-up).

To address the barriers and challenges, Molina implemented several interventions, including:

- Implementing a pay-for-performance program that rewards physicians for performance that meets or exceeds the MPL.

- Targeting member outreach efforts to members with none or the least amount of physician encounters and health screenings/examinations.
- Mailing a birthday card to members with diabetes that includes a health care screening insert.

Molina's efforts were not successful at improving the rate on this measure to above the MPL in 2013, and the MCP will need to continue this IP in Sacramento County.

Childhood Immunization Status—Combination 3

Molina was required to continue the IP for the *Childhood Immunization Status—Combination 3* measure for Riverside/San Bernardino and Sacramento counties because the rate for this measure was below the MPL in 2012.

Molina indicated that the MCP analyzed the 2012 final sample size administrative and medical record data to determine why the rate for this measure did not improve to above the MPL in Riverside/San Bernardino and Sacramento counties from 2011 to 2012. Despite the MCP's efforts to improve the integrity of the administrative data, the rates in these counties remained below the MPLs in 2012. The MCP conducted additional analyses and identified system, provider, and patient (parent) barriers, including:

System

- Poor access to immunization registry for MCPs or other health care entities.
- Insufficient and incomplete immunizations records in the registry.
- Incomplete, untimely, inconsistent, and underreported immunization encounters/claims data from network entities.

Providers

- Lack of reminder systems.
- Missing immunization opportunities when children visit for other reasons, such as well-child visits.
- Poor utilization of immunization registry to record and document immunizations, resulting in incomplete documentation in the registry.
- Reluctance to administer multiple injections concurrently.

Patients (Parents)

- Lack of recall on which immunizations have been given and not given.
- Difficulty understanding the complex vaccination schedule and the number of required doses.
- Personal barriers, including lack of transportation and scheduling challenges.

Molina implemented the following interventions to address the barriers:

- Paying bonuses to providers who submit complete, accurate, and timely data on wellness services, including immunizations.
- Improving the MCP's Needed Services Report process by upgrading the provider Web portal to allow providers to retrieve information on the services needed by members.
- Calling members to remind them about scheduling immunization appointments and assisting members with making the appointments and arranging transportation.
- Offering incentives to members with missing immunizations.

Although the rate in Riverside/San Bernardino counties improved by more than 4 percentage points and the rate in Sacramento County improved by more than 3 percentage points, the improvement was not statistically significant and did not result in the rates being above the MPLs in 2013. Molina will be required to continue the IP for this measure in these counties, which will be the fourth year the MCP has been required to do so for this measure in these counties. Molina's efforts on this measure appear to be moving performance in a positive direction; however, the MCP will need to continue to assess the factors that are leading to continued poor performance on this measure and modify the MCP's strategies to improve the rates.

Prenatal and Postpartum Care—Timeliness of Prenatal Care

Molina was required to continue its IP for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure in Riverside/San Bernardino counties. The MCP identified the following new member-related barriers that resulted in the rate continuing to be below the MPL:

- Lack of transportation.
- Lack of understanding about the importance of prenatal care.

To improve the rate on this measure, Molina implemented the following new interventions:

- A pay-for-performance program as an incentive for providers to provide all recommended health care services to members.
- Member education on the importance of prenatal care through the MCP's Health and Family Newsletter and through a targeted mailing.

Despite the MCP's efforts, the rate for this measure declined significantly from 2012 to 2013 and remained below the MPL in Riverside/San Bernardino counties. Additionally, although the rate for this measure in Sacramento County improved to above the MPL in 2012, the rate declined significantly from 2012 to 2013, resulting in it being below the MPL in 2013. Finally, San Diego County, which historically has performed above the MPL on this measure, saw a statistically significant decline on the rate for this measure from 2012 to 2013, resulting in the rate being

below the MPL for the first time in this county. Molina will need to continue the IP for this measure in 2013 in Riverside/San Bernardino counties and include Sacramento and San Diego counties. It will be important for the MCP to determine the factors leading to continued decline on the rate for this measure, despite the MCP working for several years on improving the rate.

Prenatal and Postpartum Care—Postpartum Care

Molina was required to continue its IP for the *Prenatal and Postpartum Care—Postpartum Care* measure in Riverside/San Bernardino and Sacramento counties. The MCP focused efforts on the following barriers:

- Member lack of knowledge about the importance of timely postpartum care within the recommended time frame.
- Lack of member motivation to arrange a postpartum care appointment after delivery.
- Member lack of reliable transportation.
- Lack of reinforcement from providers of the importance of scheduling the postpartum care appointment within the recommended time frame.

After conducting data analyses, Molina identified several new interventions, including:

- Conducting outreach calls to pregnant and postpartum members to educate them on the importance of making appointments; assist with transportation; and provide interpreter services, if needed.
- Conducting provider education visits specifically focused on the *Prenatal and Postpartum Care* measures and other measures on which the providers are performing poorly.
- Implementing a pay-for-performance program as an incentive to providers and network groups to submit accurate, timely, and consistent postpartum care data information on Molina's members.

In addition to the information in the MCP's IP for this measure, HSAG reviewed information Molina provided as part of the MCP's response to recommendations included in Molina's 2011–12 MCP-specific evaluation report. Molina's self-report indicates that the MCP is considering selecting a formal quality improvement project (QIP) that focuses on this measure since the MCP has performed poorly on this measure for several years.

Molina's interventions were not successful in bringing the rates in Riverside/San Bernardino and Sacramento counties above the MPLs. Conversely, the rates declined significantly in these counties from 2012 to 2013. Additionally, the rate for this measure in San Diego County declined significantly from 2012 to 2013, and the rate moved from above the MPL to below the MPL for the first time since 2010. Molina will be required to continue the IP in Riverside/San Bernardino and Sacramento counties and include San Diego County. As with the *Timeliness of Prenatal Care*

measure, it will be important for Molina to determine the factors leading to continued decline in the rate on this measure, despite the MCP working for several years on improving the rate.

Use of Imaging Studies for Low Back Pain

In 2012, Molina was required to submit an IP for the *Use of Imaging Studies for Low Back Pain* measure for the first time in San Diego County. The MCP identified several barriers and challenges to the rate on this measure being above the MPL, including:

- Many inappropriate imaging studies being done during an emergency or urgent care visit.
- Emergency room physicians being focused on rapid and immediate care.
- Practitioners being unaware of the importance of avoiding imaging studies during the first 28 days after the initial diagnosis of low back pain.
- Some prescribers at the FQHC being mid-level physician assistants and nurse practitioners who may be unaware of the importance of avoiding imaging studies during the first 28 days after the initial diagnosis of low back pain.
- Members seeking treatment for low back pain at emergency rooms rather than with their primary care physician.
- Lack of member understanding of the importance of avoiding imaging studies during the first 28 days after the initial diagnosis of low back pain.

To address the identified barriers and challenges, Molina implemented several interventions, including:

- Adopting low back pain clinical practice guidelines, posting the guidelines on Molina's provider Web site, and faxing the guidelines to primary care physicians and hospitals.
- Conducting provider education sessions that include independent practice association and FQHC leadership.
- Member education on the appropriate use of imaging studies for low back pain through the MCP's Health and Family Newsletter.

The MCP's rate for this measure in San Diego County was 0.3 percentage points from the MPL in 2012; in 2013, the rate moved to within 0.04 percentage points of the MPL. Unfortunately, since the rate for this measure remained below the MPL in 2013, Molina will be required to continue the IP for this measure in San Diego County.

2013 Improvement Plans

In addition to the IPs above that will need to continue and the new counties that will need to be added to existing IPs, Molina will be required to submit IPs for the following measures in Sacramento County that had rates below the MPLs in 2013:

- *Annual Monitoring for Patients on Persistent Medications—ACE*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

Although Molina's rates on all four *Children and Adolescents' Access to Primary Care Practitioners* measures in Riverside/San Bernardino and Sacramento counties and the *Children and Adolescents' Access to Primary Care Practitioners (12–19 Years)* measure in San Diego County were below the MPLs in 2013, the MCP will not be required to submit IPs for these measures. DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years. This decision was made to prioritize DHCS and MCP efforts on other areas of poor performance that have clear improvement paths and direct population health impact.

Strengths

The rate for the *Use of Imaging Studies for Low Back Pain* measure was above the HPL for the second year in a row in Sacramento County, and San Diego County had two *Comprehensive Diabetes Care* measures with rates above the HPLs—*LDL-C Control (<100 mg/dL)* and *LDL-C Screening*. Across all counties, 11 measures had rates with statistically significant improvement from 2012 to 2013.

Opportunities for Improvement

As in previous years, the opportunities for improvement on performance measures impact all three domains of care—quality, access, and timeliness. MCP will need to submit new IPs for two measures in Sacramento County, continue all IPs from 2012 (except the *Cervical Cancer Screening* IP as noted above), and add counties to three existing IPs. The MCP has the opportunity to continue to have technical assistance calls with DHCS and the EQRO to discuss strategies for addressing Molina continuing to have consecutive years of poor performance on measures, including a decline in performance on some measures, despite efforts to make improvements.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[10] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Full-scope MCPs must conduct a minimum of two QIPs. They must participate in the DHCS-led statewide collaborative QIP and conduct an MCP-specific (internal) QIP or an MCP-led small group collaborative QIP. MCPs that hold multiple MCMC contracts or that have a contract that covers multiple counties must conduct two QIPs for each county.

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of MCPs' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the MCP's QIP objectives (QIP results).

Beginning July 1, 2012, HSAG began using a revised QIP methodology and scoring tool to validate the QIPs. HSAG updated the methodology and tool to place greater emphasis on health care outcomes by ensuring that statistically significant improvement has been achieved before it assesses for sustained improvement. Additionally, HSAG streamlined some aspects of the scoring to make the process more efficient. With greater emphasis on improving QIP outcomes, member health, functional status, and/or satisfaction will be positively affected.

HSAG organized, aggregated, and analyzed Molina's validated QIP data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

[10] The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Quality Improvement Project Objectives

Molina participated in the statewide collaborative QIP and had one internal QIP in progress during the review period of July 1, 2012–June 30, 2013.

Table 4.1 below lists Molina's QIPs and indicates the counties in which the QIP is being conducted, whether the QIP is clinical or nonclinical, and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

Table 4.1—Quality Improvement Projects for Molina
July 1, 2012, through June 30, 2013

QIP	Counties	Clinical/Nonclinical	Domains of Care
All-Cause Readmissions	Riverside/San Bernardino, Sacramento, and San Diego	Clinical	Q, A
Improving Hypertension Control	Riverside/San Bernardino, Sacramento, and San Diego	Clinical	Q, A

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries aged 21 years and older. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members leading to improved health outcomes.

Prior to initiation of the statewide collaborative QIP, Molina had a 30-day readmission rate of 12.5 percent among Medi-Cal beneficiaries. Molina also found that the readmission rate for the SPD population was 16.3 percent, which was higher than the 10.5 percent rate for the non-SPD population.

Molina's *Improving Hypertension Control* QIP evaluated whether members' blood pressure was controlled. Controlled blood pressure in hypertensive members is associated with reductions in stroke, myocardial infarction, and heart failure incidences. At the initiation of the QIP, the percentage of hypertensive members with controlled blood pressure ranged between 56.6 to 66.4 percent for Molina's counties. For this QIP, the rates for Riverside and San Bernardino counties are combined to be consistent with HEDIS reporting since the project outcome is a HEDIS measure; Sacramento and San Diego counties' rates are reported separately.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Validation Activity
Molina—Riverside/San Bernardino, Sacramento, and San Diego Counties
July 1, 2012, through June 30, 2013

Name of Project/Study	Counties	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP					
All-Cause Readmissions	Counties received the same score—Riverside/San Bernardino, Sacramento, and San Diego	Study Design Submission	90%	100%	*Met*
Internal QIPs					
Improving Hypertension Control	Riverside/San Bernardino	Annual Submission	94%	100%	*Met*
	Sacramento	Annual Submission	94%	100%	*Met*
	San Diego	Annual Submission	91%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.
[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that the study design submission by Molina of its *All-Cause Readmissions* QIP received an overall validation status of *Met* with 100 percent of critical elements and 90 percent of evaluation elements met. Molina also received an overall validation status of *Met* for its *Improving Hypertension Control* annual submission with 100 percent of the critical elements and between 91 percent or 94 percent of the evaluation elements being met based on the county.

Table 4.3 summarizes the aggregated validation results for Molina's QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
Molina—Riverside/San Bernardino, Sacramento, and San Diego Counties
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	100%	0%	0%
	VI: Accurate/Complete Data Collection	90%	0%	10%
Design Total		**96%**	**0%**	**4%**
Implementation	VII: Sufficient Data Analysis and Interpretation	100%	0%	0%
	VIII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	IX: Real Improvement Achieved	42%	0%	58%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**42%**	**0%**	**58%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

HSAG validated Activities I through VI for Molina's *All-Cause Readmissions* QIP study design submission and Activities I through IX for the MCP's *Improving Hypertension Control* QIP annual submission.

Molina demonstrated a thorough application of the Design stage, meeting 96 percent of the requirements for all applicable evaluation elements within the study stage for both QIPs. Molina did not describe the MCP's data analysis plan for the *All-Cause Readmissions* QIP, resulting in a lower score for Activity VI. Molina met 100 percent of the requirements for all applicable evaluation elements for the *Improving Hypertension Control* QIP for the Design stage.

Only the *Improving Hypertension Control* QIP progressed to the Implementation and Outcomes stages during the reporting period. Molina demonstrated a thorough application of the Implementation stage, meeting 100 percent of the requirements for all applicable evaluation elements within the study stage. The QIP received a lower score for San Diego County in Activity IX because there was no improvement in the study indicator's rate from Remeasurement 1 to

Remeasurement 2. The QIP received a lower score in all counties for Activity IX because the study indicator did not demonstrate statistically significant improvement over baseline. Activity X was not assessed for this QIP since sustained improvement cannot be assessed until the study indicator has achieved statistically significant improvement over baseline and reported a rate in a subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

Table 4.4 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

The *All-Cause Readmissions* QIP did not progress to the implementation or outcomes stage during the reporting period; therefore, no intervention or outcome information is included in this report for this QIP.

Table 4.4—Quality Improvement Project Outcomes for Molina—Riverside/San Bernardino, Sacramento, and San Diego Counties July 1, 2012, through June 30, 2013

QIP #1—Improving Hypertension Control				
Study Indicator: Percentage of members 18 to 85 years of age who had both a systolic and diastolic blood pressure of <140/90				
County	**Baseline Period 1/1/09–12/31/09**	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
Riverside/San Bernardino	59.6%	42.6%*	53.7%*	‡
Sacramento	56.6%	50.8%	53.1%	‡
San Diego	66.4%	58.3%*	55.0%	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.
* A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).
‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Improving Hypertension Control QIP

In 2012, Molina submitted Remeasurement 2 results for the *Improving Hypertension Control* QIP. The study indicator rates in Riverside/San Bernardino counties significantly improved from Remeasurement 1 to Remeasurement 2; however, the rates were still below the baseline rate. Although not statistically significant, the study indicator rate in Sacramento County improved by more than 2 percentage points. The study indicator rate in San Diego County significantly declined

from Remeasurement 1 to Remeasurement 2. A review of the MCP's QIP Summary Form and QIP Validation Tools revealed the following observations:

- For Riverside/San Bernardino and Sacramento counties, the interventions were successful, and the MCP documented the need to continue the interventions in order to evaluate the overall effectiveness of the interventions.
- Although the interventions were not successful in San Diego County, Molina documented the need to continue the interventions to enable the MCP to evaluate the overall effectiveness of the interventions.
- For San Diego County, Molina described problem-solving techniques using data analysis to identify possible causes and solutions; however, the MCP did not determine if county-specific interventions are needed based on subgroup analysis results for each county.

Strengths

Molina demonstrated an excellent application of the QIP process for the Design and Implementation stages. The MCP achieved an overall *Met* validation status on both QIP submissions without having to resubmit, indicating proficiency with the QIP validation process.

In Molina's 2011–12 MCP-specific evaluation report, HSAG recommended that the MCP perform barrier analyses to identify barriers to making improvements on QIP study indicators. As part of the QIP validation process for the MCP's 2012 QIP submissions, HSAG determined that for its *Improving Hypertension Control* QIP, Molina completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process. Additionally, in the documentation provided by Molina for HSAG to review when producing this report, the MCP provided documentation from the causal/barrier analysis conducted for the *All-Cause Readmissions* QIP.

Opportunities for Improvement

Although Molina understands the QIP process, Molina has not achieved statistically significant improvement over baseline for the *Improving Hypertension Control* QIP study indicator in any of the counties. Although the rate is moving in a positive direction in Riverside/San Bernardino and Sacramento counties, the rate in San Diego County continues to decline. Molina has the opportunity to build on the successes from the interventions being implemented in Riverside/San Bernardino and Sacramento counties and apply applicable strategies in San Diego County that will hopefully result in the rate for the study indicator achieving statistically significant and sustained improvement over baseline.

Conducting the EQRO Review

In addition to conducting mandatory federal activities, CMS provides for the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] survey as an optional Medicaid external quality review activity to assess MCMC beneficiaries' satisfaction with their health care services. DHCS periodically assesses the perceptions and experiences of MCMC beneficiaries as part of its process for evaluating the quality of health care services.

To assist with this assessment, DHCS contracted with HSAG to administer the CAHPS Health Plan Surveys in 2013. DHCS requires that the CAHPS survey be administered to both adult beneficiaries and the parents or caretakers of child beneficiaries at the MCP level. In 2013, HSAG administered standardized survey instruments, CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with HEDIS supplemental item sets, to members of all full-scope MCPs.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Molina's 2013 CAHPS MCP-Specific Report contains the detailed findings and recommendations from the 2013 survey. A brief summary of the findings, strengths, and opportunities for improvement is included below.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about Molina's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures. The global measures (also referred to as global ratings) reflect overall member satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., getting needed care, getting care quickly).

[11] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

CAHPS Global Rating Measures:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

CAHPS Composite Measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

Table 5.1 shows the domains of care (quality, access, timeliness) for each of the CAHPS measures.

Table 5.1—CAHPS Measures Domains of Care

Measure	Domains of Care
Rating of Health Plan	Q
Rating of All Health Care	Q
Rating of Personal Doctor	Q
Rating of Specialist Seen Most Often	Q
Getting Needed Care	Q, A
Getting Care Quickly	Q, T
How Well Doctors Communicate	Q
Customer Service	Q
Shared Decision Making	Q

National Comparisons

To assess the overall performance of the MCPs, HSAG calculated MCP-level results with county-level analysis, when the MCP provided services in more than one county, and compared the results to the NCQA HEDIS Benchmarks and Thresholds for Accreditation.[12] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).[13]

Star ratings were determined for each CAHPS measure (except the *Shared Decision Making* measure)[14] using the following percentile distributions in Table 5.2.

Table 5.2—Star Ratings Crosswalk Used for CAHPS Measures

Star Rating	Adult and Child Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or above the 75th and below the 90th percentiles
★★★ Good	At or above the 50th and below the 75th percentiles
★★ Fair	At or above the 25th and below the 50th percentiles
★ Poor	Below the 25th percentile

Table 5.3 through Table 5.6 present the star ratings for the global ratings and composite measures for Molina's adult and child Medicaid populations.[15]

Table 5.3—Medi-Cal Managed Care Adult County-Level Global Ratings
Molina—Sacramento, San Bernardino/Riverside, and San Diego Counties

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Sacramento	★+	★+	★+	★★★+
Riverside/San Bernardino	★	★+	★+	★+
San Diego	★	★+	★★★+	★+
+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.				

[12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.
[13] NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.
[14] Since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating.
[15] Due to the changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure.

Table 5.4—Medi-Cal Managed Care Child County-Level Global Ratings
Molina—Sacramento, San Bernardino/Riverside, and San Diego Counties

County	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Sacramento	★+	★+	★+	★+
Riverside/San Bernardino	★	★	★	★★★★★+
San Diego	★★	★	★★★	★★★★★+

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Table 5.5—Medi-Cal Managed Care Adult County-Level Composite Measures
Molina—Sacramento, San Bernardino/Riverside, and San Diego Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Sacramento	★+	★+	★+	★★+
Riverside/San Bernardino	★+	★+	★+	★★★★+
San Diego	★+	★+	★★+	★+

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Table 5.6—Medi-Cal Managed Care Child County-Level Composite Measures
Molina—Sacramento, San Bernardino/Riverside, and San Diego Counties

County	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Sacramento	★+	★+	★+	★★+
Riverside/San Bernardino	★+	★+	★	★★★+
San Diego	★	★	★	★★★★★+

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating these results.

Strengths

For the child population, San Diego County received an *Excellent* rating for the *Rating of Specialist Seen Most Often* and *Customer Service* measures, and Riverside/San Bernardino counties received an *Excellent* rating on the *Rating of Specialist Seen Most Often* measure for the child population. Additionally, Riverside/San Bernardino counties received a *Very Good* rating for the adult *Customer Service* measure. Please note that across all counties, Molina had fewer than 100 respondents for most measures so caution should be exercised when evaluating these results.

The following measures received a *Good* rating:

- *Rating of Personal Doctor*—San Diego County for both the adult and child populations
- *Rating of Specialist Seen Most Often*—Sacramento County for the adult population
- *Customer Service*—Riverside/San Bernardino counties for the child population

Molina improved its ratings in Sacramento County on the following measures from 2010 to 2013:

- *Rating of Specialist Seen Most Often*—adult population
- *Customer Service*—adult and child populations

Molina improved its ratings in Riverside/San Bernardino counties on the following measures from 2010 to 2013:

- *Rating of Specialist Seen Most Often*—child population
- *Customer Service*—adult and child populations

Molina improved its ratings in San Diego County on the following measures from 2010 to 2013:

- *Rating of Personal Doctor*—adult population
- *Rating of Specialist Seen Most Often*—child population
- *How Well Doctors Communicate*—adult population
- *Customer Service*—child population

Opportunities for Improvement

Molina's CAHPS results showed below-average performance for the majority of the child and adult global ratings and composite measures. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the MCP's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as Molina's highest priorities: *Rating of Health Plan, Rating of Personal Doctor,* and *Rating of All Health Care*. The MCP should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2013 Molina CAHPS MCP-Specific Report.* Areas for improvement spanned the quality domain of care.

Conducting the EQRO Review

Accurate and complete encounter data are critical to the success of managed care programs. The completeness and accuracy of these data are essential in DHCS's overall management and oversight of its Medi-Cal MCPs. In order to examine the extent to which encounters submitted to DHCS by MCPs are complete and accurate, DHCS contracted with HSAG to conduct an encounter data validation (EDV) study.

Methodology

During the reporting period, HSAG evaluated two aspects of the encounter data for each MCP. First, HSAG evaluated the information systems and processes of each MCP. Secondly, HSAG performed a comparative analysis between the encounter data housed in the DHCS data warehouse and the encounter data submitted to HSAG from each MCP's data processing system.

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)[16] completed by the MCPs during their NCQA HEDIS Compliance Audit™. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

Concurrent with the review of the MCP information systems and processes, HSAG used the administrative records (claims/encounters) in each MCP's claims processing system to evaluate the extent to which the encounters submitted to DHCS were complete and accurate. HSAG evaluated the encounters submitted to DHCS with a date of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012, for the following four types of encounters:

- Medical/Outpatient
- Hospital/Inpatient
- Pharmacy
- Long-Term Care

[16] The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

All encounters submitted to HSAG by the MCPs underwent a preliminary file review. The preliminary file review determined whether any potential data issues identified in the data files would warrant a resubmission. The comparative analyses evaluated the extent to which specified key data elements in DHCS's data warehouse are matched with the MCP's files in the following categories:

- Record Completeness
- Element-Level Completeness
- Element-Level Accuracy

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Molina's 2012–13 MCP-Specific Encounter Data Validation Study Report contains the detailed findings and recommendations from the EDV study. A brief summary of the findings and opportunities for improvement is included below.

Encounter Data Validation Findings

Review of Encounter Systems and Processes

Overall, the information provided in Molina's Roadmap and questionnaire indicates that the MCP has established operational policies and practices for the creation, validation, correction, and ongoing monitoring of encounter data submission. Approximately 90 percent of Molina's contracted providers are capitated, and approximately 95 percent of claims are received electronically. While providers have 365 days from the date of service to submit new claims, the reimbursement amount for claims received in excess of 180 days from the date of service are reduced. Molina's pharmacy benefit manager (PBM) and vision claims are received monthly and processed for submission to DHCS.

In September 2012, Molina's redesigned its inbound encounter processes to streamline them and increase data quality. The Claims Encounter Management System (CEMS) was developed to provide Molina's staff with improved access to detailed claims and encounter views and support encounter error correction and resubmission to DHCS. Molina reported that fewer than 0.009 percent of encounters are initially rejected by DHCS, although the MCP indicated that error rates have increased due to changes in DHCS's submission requirements and delays and gaps in guidance from DHCS. The submission requirement changes, along with Molina not requiring providers to submit encounters within a specific time frames , may impact the reconciliation of encounters between Molina and DHCS.

Record Completeness

Overall, Molina had fairly low record omission and record surplus rates for the Medical/Outpatient and Hospital/Inpatient claim types, indicating fairly complete Medical/Outpatient and Hospital/Inpatient data when comparing DHCS's data and the encounter data extracted from Molina's system for this study. However, the Pharmacy claim type had relatively incomplete data due to the fairly poor record omission rate of 22.6 percent and record surplus rate of 13.6 percent. For the Pharmacy records omitted from DHCS's data, Molina's records indicated that more than 98 percent were submitted to DHCS on March 4, March 10, or April 11, 2011. The main cause for the surplus Pharmacy records was due to the MCP's data not containing records with dates of service in June 2011. Molina's record omission rate for the Pharmacy claim type was 9.3 percentage points worse than the statewide rate, while all of the remaining record omission and surplus rates were better than the statewide rates. The county-level variation was minimal for both record omission and surplus rates, with the exception of the record omission rates for the Pharmacy claim type. The difference between the highest Pharmacy record omission rate (29.0 percent) from San Diego County and the lowest omission rate (10.5 percent) from Sacramento County was 18.5 percentage points.

Data Element Completeness

Molina had fairly good performance for data element completeness, with element omission and element surplus rates of 2.1 percent or less for all key data elements across the three claim types. Molina's element omission rates and surplus rates were generally similar to or better than the respective statewide rates. The data elements *Provider Specialty* and *Procedure Code Modifier* in the Medical/Outpatient claim type were the only data elements that had element surplus rates slightly worse than the statewide rates by 0.8 percentage points and 1.6 percentage points, respectively. There was minimal county variation for the element omission and surplus rates.

Data Element Accuracy

Molina had element accuracy rates that were greater than 95 percent for all key data elements across the three claim types except the three elements listed below.

- For the Medical/Outpatient claim type, the *Provider Type* had an element accuracy rate of 76.9 percent, which was below the statewide rate by 17.6 percentage points. Approximately 86 percent of the inaccuracies for this data element were attributed to a value of "27" (Podiatrists) in the MCP's data and a value of "10" (Group Certified Pediatric Nurse Practitioner and Certified Family Nurse Practitioner) in DHCS's data file. At the county level, the data element *Provider Type* had a 24.3 percentage point spread between the highest element accuracy rate (93.2 percent for Sacramento County) and the lowest rate (68.9 percent for Riverside County).

- For the Medical/Outpatient claim type, the *Rendering Provider Number* had an element accuracy rate of 83.4 percent, which was below the statewide rate by 12.1 percentage points. Approximately 56 percent of the inaccuracies for the *Rendering Provider Number* were from the records with a provider type of "15" (Community Hospital Outpatient Departments).
- For the Hospital/Inpatient claim type, the *Revenue Code* had an element accuracy rate of 94.7 percent, which was slightly below the statewide rate by 0.4 percentage points. More than 98 percent of the records with mismatched revenue code values had the first two digits of the revenue codes in the MCP's data matching the last two digits of the revenue codes in DHCS's data. At the county level, Sacramento County had the highest accuracy rate of 100 percent, while San Diego County had the lowest rate of 91.2 percent.

The remaining element accuracy rates met or exceeded the statewide rates and did not have notable county-level variation.

The all-element accuracy rates for the Hospital/Inpatient and Pharmacy claim types were above the statewide rate by 25.4 percentage points and 21.2 percentage points, respectively. However, due to the low element accuracy rates for a few data elements, the Medical/Outpatient claim type underperformed the statewide rate by 4.7 percentage points. There was no county variation for the Pharmacy claim type. For the Medical/Outpatient claim type, Sacramento County had an all-element accuracy rate of 77.4 percent, which was more than 18 percentage points higher than the rates for the other three counties. For the Hospital/Inpatient claim type, San Diego County had the lowest rate of 81.5 percent, which was more than 12 percentage points below the other counties' all-element accuracy rates.

Recommendations

Based on its review, HSAG recommends the following:

- Molina should investigate the reasons for the relatively poor record omission rate and record surplus rate for the Pharmacy claim type and create strategies for improvement.
- Nearly all Medical/Outpatient records in the MCP's data and DHCS's data were missing values for the data element *Referring/Prescribing/Admitting Provider Number*. The percentage of records without values for this data element was high compared to the other MCPs in the study. Molina should consult with DHCS about whether the *Referring/Prescribing/Admitting Provider Number* is a data element for which Molina should be collecting values for the Medical/Outpatient records. If so, Molina should modify its processes and procedures so that the values for the data element *Referring/Prescribing/Admitting Provider Number* can be submitted to DHCS in the future.

- Molina should investigate the low element accuracy rates for the data elements *Provider Type* and *Rendering Provider Number* in the Medical/Outpatient claim type so that it can improve the accuracy rates for these two data elements.
- Despite having a fairly high element accuracy rate of 94.7 percent for the *Revenue Code* in the Hospital/Inpatient claim type, Molina should work with DHCS to investigate the reasons(s) and take necessary actions for improvement.

7. Overall Findings, Conclusions, and Recommendations

for **Molina Healthcare of California Partner Plan, Inc.**

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each MCP in the three domains of care—quality, access, and timeliness. A numerical score is calculated for each domain of care for performance measure rates, CAHPS survey measure ratings, QIP validation, and QIP outcomes (measured by statistical significance and sustained improvement). A final numeric score, combining the performance measures scores, CAHPS survey measure ratings scores, and QIP performance scores, is then calculated for each domain of care and converted to a rating of above average, average, or below average. In addition to the performance score derived from performance measures, CAHPS survey measures, and QIPs, HSAG uses results from the MCPs' medical performance and Medi-Cal Managed Care Division reviews and assessment of the accuracy and completeness of encounter data to determine overall performance within each domain of care, as applicable. A more detailed description of HSAG's scoring process is included in Appendix A.

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[17]

DHCS uses the results of performance measures and QIPs to assess care delivered to beneficiaries by an MCP in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, DHCS monitors aspects of an MCP's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems. DHCS also uses the results

[17] This definition of quality is included in Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction: An Introduction to the External Quality Review (EQR) Protocols*, Version 1.0, September 2012. The definition is in the context of Medicaid/Children's Health Insurance Program MCOs, and was adapted from the IOM definition of quality. The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

HSAG reviewed Molina's quality improvement program documents, which describe the processes the MCP uses and the organizational structure the MCP has in place to ensure quality services are provided to the MCP's Medi-Cal members.

The rates for 10 quality measures improved significantly from 2012 to 2013, and the following three quality measures had rates above the HPLs in 2013:

- *Use of Imaging Studies for Low Back Pain* in Sacramento County
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* in San Diego County
- *Comprehensive Diabetes Care—LDL-C Screening* in San Diego County

Across all counties, 16 quality measures had rates below the MPLs, and 15 quality measures had rates that declined significantly from 2012 to 2013. The MCP implemented IPs for 10 quality measures with rates below the MPLs in 2012, and none of the IPs were successful at bringing the rates above the MPLs in 2013. The MCP will be required to add counties to two of the IPs for 2013 and submit new IPs for two quality measures in 2013. Note: As indicated in the Improvement Plans section of this report, although the IP for the *Cervical Cancer Screening* measure was not successful at bringing the rate above the MPLs in Riverside/San Bernardino and Sacramento counties in 2013 and the rate for this measure was below the MPL in San Diego County, the MCP will not be required to continue the IP for this measure.

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care. The following quality measures had SPD rates that were significantly better than the non-SPD rates:

- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0 Percent)* in Sacramento and San Diego counties
- *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)* in San Diego County
- *Comprehensive Diabetes Care—LDL-C Screening* in San Diego County
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Sacramento and San Diego counties
- *Annual Monitoring for Patients on Persistent Medications—ACE* in Riverside/San Bernardino counties
- *Annual Monitoring for Patients on Persistent Medications—Diuretics* in Riverside/San Bernardino and San Diego counties

The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to better monitoring of care.

Across all counties, the SPD rates for the following quality measures were significantly worse than the non-SPD rates:

- *All-Cause Readmissions* in Riverside/San Bernardino, Sacramento, and San Diego counties
- *Children and Adolescents' Access to Primary Care Physicians (12–24 Months)* in San Diego County
- *Children and Adolescents' Access to Primary Care Physicians (12–19 Years)* in Sacramento County
- *Comprehensive Diabetes Care (CDC)—Blood Pressure Control (<140/90 mm Hg)* in Riverside/San Bernardino counties
- *Comprehensive Diabetes Care—LDL-C Screening* in Riverside/San Bernardino counties

The SPD rates in all counties for the *All-Cause Readmissions* measure being significantly higher than the non-SPD rates means that in all counties, the SPD population (aged 21 years and older) had more readmissions due to all causes within 30 days of an inpatient discharge than the non-SPD population.

All CAHPS measures fall into the quality domain of care. Across all counties most of the measures had a *Poor* rating. The following measures received an *Excellent* rating:

- *Rating of Specialist Seen Most Often* in Riverside/San Bernardino and San Diego counties for the child population
- *Customer Service* in San Diego County for the child population

Riverside/San Bernardino County received a *Very Good* rating for the CAHPS *Customer Service* measure for the adult population, and the following CAHPS measures received a *Good* rating:

- *Rating of Personal Doctor* in San Diego County for both the adult and child populations
- *Rating of Specialist Seen Most Often* in Sacramento County for the adult population
- *Customer Service* in Riverside/San Bernardino counties for the child population

Both of Molina's QIPs fall into the quality domain of care. The *All-Cause Readmissions* QIP did not progress to the Outcomes stage, so HSAG was not able to assess the QIP's success at improving the quality of care delivered to the MCP's members. Although the *Improving Hypertension Control* QIP is showing some positive results in Riverside/San Bernardino and Sacramento counties, the QIP study indicator has not yet achieved statistically significant improvement over baseline. Additionally, the study indicator rate declined in San Diego County at Remeasurements 1 and 2.

Overall, Molina showed below-average performance related to the quality domain of care.

Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

HSAG reviewed Molina's quality improvement program documents and found descriptions of several activities focused on ensuring member access to services. The MCP's 2012 program evaluation describes results of all quality improvement activities and shows that Molina met or exceeded most access-related goals.

Although Molina reports meeting or exceeding access-related quality improvement goals, the MCP continues to struggle with performance on access measures. While the rate for one access measure in San Diego County, *Comprehensive Diabetes Care—LDL-C Screening*, improved significantly from 2012 to 2013, resulting in the rate for this measure being above the HPL in 2013, across all counties 21 access measures had rates below the MPLs. Across all counties, the rates for six access measures improved significantly from 2012 to 2013; however, the rates for nine access measures declined significantly from 2012 to 2013.

The MCP implemented IPs for eight access measures with rates below the MPLs in 2012, and none of the IPs were successful at bringing the rates above the MPLs in 2013. Additionally, the MCP will be required to add counties to two of the IPs for 2013. Note: As indicated in the Improvement Plans section of this report, although the IP for the *Cervical Cancer Screening* measure was not successful at bringing the rate above the MPLs in Riverside/San Bernardino and Sacramento counties in 2013 and the rate for this measure was below the MPL in San Diego County, the MCP will not be required to continue the IP for this measure.

Nine of the performance measures stratified for the SPD population fall into the access domain of care. The SPD rates for the following access measures were significantly better than the non-SPD rates:

- *Comprehensive Diabetes Care—LDL-C Screening* in San Diego County

- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* in Sacramento and San Diego counties

The SPD rates for the following access measures were significantly worse than the non-SPD rates:

- *All-Cause Readmissions* in Riverside/San Bernardino, Sacramento, and San Diego counties
- *Children and Adolescents' Access to Primary Care Physicians (12–24 Months)* in San Diego County
- *Children and Adolescents' Access to Primary Care Physicians (12–19 Years)* in Sacramento County
- *Comprehensive Diabetes Care—LDL-C Screening* in Riverside/San Bernardino counties

Molina performed below average on the access-related CAHPS measure, *Getting Needed Care*, receiving a *Poor* rating in all counties for both the adult and child populations.

Both of Molina's QIPs fall into the access domain of care. As indicated above, the *All-Cause Readmissions* QIP did not progress to the Outcomes stage; therefore, HSAG was not able to assess the QIP's success at improving access to care for the MCP's Medi-Cal members. Also, as indicated above, although the *Improving Hypertension Control* QIP is showing some positive results in Riverside/San Bernardino and Sacramento counties, the QIP study indicator has not yet achieved statistically significant improvement over baseline. Additionally, the study indicator rate declined in San Diego County at Remeasurements 1 and 2.

Overall, Molina showed below-average performance related to the access domain of care.

Timeliness

The timeliness domain of care relates to an MCP's ability to make timely utilization decisions based on the clinical urgency of the situation, to minimize any disruptions to care, and to provide a health care service quickly after a need is identified.

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

Molina's quality improvement program description includes descriptions of activities related to member rights, grievances, continuity and coordination of care, and utilization management, which all impact the timeliness of care delivered to members.

Molina had no timeliness measures with rates above the HPLs. The rate for the *Immunizations for Adolescents—Combination 1* measure, which falls into the timeliness domain of care, had statistically significant improvement from 2012 to 2013 in all counties. Eight timeliness measures had rates below the MPLs in 2013, and six timeliness measures had rates that declined significantly from 2012 to 2013.

The MCP implemented IPs for five timeliness measures with rates below the MPLs in 2012, and none of the IPs were successful at bringing the rates above the MPLs in 2013. Additionally, the MCP will be required to add counties to two of the IPs for 2013.

One CAHPS measure, *Getting Care Quickly*, falls into the timeliness domain of care. This measure received a *Poor* rating in all counties for both the adult and child populations.

Overall, Molina showed below-average performance in the timeliness domain of care.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2011–12 MCP-specific evaluation report. Molina's self-reported responses are included in Appendix B.

Recommendations

Based on the overall assessment of Molina in the areas of quality, timeliness, and accessibility of care, HSAG recommends the following to the MCP:

- Since Molina had 25 measures with rates below the MPLs in 2013 and 16 measures with rates that were significantly lower in 2013 when compared to 2012, HSAG recommends that the MCP work with DHCS to identify priority areas for improvement and focus efforts on the priority areas rather than attempting to improve performance on all measures at once.
- Since the SPD rate for the *All-Cause Readmissions* measure was significantly higher than the non-SPD rate in all counties, assess the factors that are leading to a higher rate of readmissions for the SPD population and identify strategies to ensure the MCP is meeting the needs of the SPD population.
- For its *Improving Hypertension Control* QIP, build on the successes from the interventions being implemented in Riverside/San Bernardino and Sacramento counties and apply applicable strategies in San Diego County that will hopefully result in the rate for the QIP study indicator achieving statistically significant and sustained improvement over baseline.
- Review the 2013 MCP-specific CAHPS results report and develop strategies to address the *Rating of Health Plan, Rating of Personal Doctor,* and *Rating of All Health Care* priority areas.

- Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.

In the next annual review, HSAG will evaluate Molina's progress with these recommendations along with its continued successes.

Appendix A. Scoring Process for the Domains of Care

for **Molina Healthcare of California Partner Plan, Inc.**

Quality, Access, and Timeliness Scoring Process

Scale
2.5–3.0 = Above Average
1.5–2.4 = Average
1.0–1.4 = Below Average

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.[18] This process allows HSAG to evaluate each MCP's performance measure rates (including CAHPS survey measures) and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

Performance Measure Rates

(Refer to Tables 3.2 through 3.4)

Quality Domain

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than three.
   - If there are **three or more** measures below the MPLs, the number of measures below the MPLs minus the number of measures above the HPLs must be less than three.

[18] The CMS protocols specify that the EQRO must include an assessment of each MCP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients in its detailed technical report. The report must also document procedures used by the EQRO to analyze the data collected and how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

Access and Timeliness Domains

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
   - If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than two.
   - If there are **three or more** measures below the MPLs, then the number of measures below the MPLs minus the number of measures above the HPLs must be less than two.
3. To be considered **Below Average**, the MCP will have two or more measures below the MPLs than it has above the HPLs.

CAHPS Survey Measures

(Refer to Tables 5.3 through 5.6)

1. A score of 3 is given for each measure receiving an Excellent or Very Good Star rating.
2. A score of 2 is given for each measure receiving a Good Star rating.
3. A score of 1 is given for each measure receiving a Fair or Poor Star rating.

Quality Domain

(Note: Although the *Shared Decision Making* measure falls into the quality domain of care, since NCQA does not publish accreditation benchmarks and thresholds for this measure, it does not receive a Star rating and is therefore not included in this calculation.)

1. To be considered **Above Average**, the average score for all quality measures must be 2.5–3.0.
2. To be considered **Average**, the average score for all quality measures must be 1.5–2.4.
3. To be considered **Below Average**, the average score for all quality measures must be 1.0–1.4.

Access Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Needed Care* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Needed Care* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Needed Care* measure.

Timeliness Domain

1. To be considered **Above Average**, the MCP must receive an Excellent or Very Good Star rating on the *Getting Care Quickly* measure.
2. To be considered **Average**, the MCP must receive a Good Star rating on the *Getting Care Quickly* measure.
3. To be considered **Below Average**, the MCP must receive a Fair or Poor Star rating on the *Getting Care Quickly* measure.

Quality Improvement Projects (QIPs)

Validation *(Table 4.2)*: For each QIP submission and subsequent resubmission(s), if applicable.

1. **Above Average** is not applicable.
2. **Average** = *Met* validation status.
3. **Below Average** = *Partially Met* or *Not Met* validation status.

Outcomes *(Table 4.4)*: Activity IX, Element 4—Real Improvement

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Not all study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

Sustained Improvement *(Table 4.4)*: Activity X—Achieved Sustained Improvement

1. **Above Average =** All study indicators achieved sustained improvement.
2. **Average =** Not all study indicators achieved sustained improvement.
3. **Below Average =** No study indicators achieved sustained improvement.

Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care.

For each **QIP**, the Validation score (1 or 2), the Outcomes score (1, 2, or 3), and the Sustained Improvement score (1, 2, or 3) are entered for each applicable domain of care (Q, A, T). The scores are automatically calculated by adding the scores under each domain of care and dividing by the number of applicable elements.

For each **CAHPS** measure, a score of 3 is given for each measure receiving a Star rating of Excellent or Very Good and the total score is entered for each domain of care (Q, A, T). A score of 2 is given for each measure receiving a Star rating of Good, and the total score is entered for each domain of care (Q, A, T). A score of 1 is given for each measure receiving a Star rating of Fair or Poor, and the total score is entered for each domain of care (Q, A, T). The average score for each domain of care is used to determine the CAHPS measure performance for each domain of care.

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical performance and Medi-Cal Managed Care Division reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures, CAHPS measures, and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the encounter data validation (EDV) study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

Appendix B. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

for **Molina Healthcare of California Partner Plan, Inc.**

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with Molina's self-reported actions taken through June 30, 2013, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

Table B.1—Molina's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
To ensure successful improvement plans (IPs) for measures that performed below the MPLs in 2012:	
1. Participate in technical assistance calls with the EQRO to discuss the plan's barrier analysis and interventions for measures that have consecutive years of performance below the MPLs without improvement to increase the likelihood of future success.	Molina Healthcare of California Partner Plan, Inc., arranged and participated in Technical Assistance calls with Health Services Advisory Group (HSAG), DHCS' external quality review organization, to discuss Improvement Plans for HEDIS measures that performed below the MPLs in 2012. • Meeting: Technical Assistance call with HSAG and DHCS for all plans required to submit IPs Date: January 23, 2013 Meeting & Discussion Topics: 2012 HEDIS IP Submission Form (updated form since 2011); HEDIS IP Evaluation Checklist to understand the criteria that will be applied to each IP. Molina Attendees: Shirley Kim, Rick VanGorder, Carol Pranis, Camille Morris, Deborah Clancy, and Erlinda Castillo • Meeting: Technical Assistance call requested by Molina held with DHCS and HSAG Date: February 6, 2013 Meeting & Discussion Topics: Discussed Molina's barrier analysis and interventions for HEDIS measures that have consecutive years of performance below the MPLs without improvement, CIS-3, PPC, and CDC. Discussed in detailed analysis of the negative numerators and positive numerators to identify differences in the sample population. Discussed targeting primary causal barriers with data information to support the findings, instead of anecdotal barriers that are theoretical in nature. Molina Attendees: Shirley Kim, Rick VanGorder, Erlinda Castillo, Carol Pranis, Camille Morris, Deborah Clancy • Meeting: 30 Day All-Cause Readmission Statewide

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	Collaborative technical assistance calls Dates: August 2, 2012, October 18, 2012, November 8, 2012, and February 7, 2013 Meeting & Discussion Topics: appropriate analyses, including causal barrier, data analysis, and intervention evaluation analysis to implement effective interventions for improvement. Molina Attendees: Rick VanGorder, Carol Pranis, Camille Morris, Deborah Clancy, Erlinda Castillo and Shirley Kim
2. Consider selecting a performance measure with poor performance as a formal QIP topic for future studies to focus resources on the areas in greatest need of improvement.	Among the HEDIS measures that performed below the MPLs in 2012 for Molina, postpartum care (PPC-Pst) measure has the greatest need of improvement based on continued performances below the MPL in the past years. Molina is considering selecting PPC-Pst measure as the topic for a formal QIP. PPC-Pst QIP will be implemented to assess root causal barriers with data information; to identify and prioritize barriers and opportunities for improvement; to plan, design, and implement effective intervention; and to evaluate and validate the effectiveness of implemented interventions through process and outcome evaluations.
3. Evaluate whether the interventions implemented leading to a slight increase in the rate on the *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* measure in San Diego County are effective. If they are not effective, consider whether to modify or replace these interventions to bring the rate above the MPL in 2013.	As delineated in Molina's 2012 HEDIS *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* (AAB) Improvement Plan (IP) document for San Diego County, appropriate interventions were prioritized and implemented based on detailed analysis of causal barriers. Implementation of interventions in late 2012 and during 2013 did not impact the HEDIS 2013 rates (measurement period from 1/1/12–12/31/12). However, existing interventions are evaluated to either modify or add new interventions to bring the rate above the MPL in the subsequent year. YTD 2014 HEDIS rate for *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* (AAB) in San Diego as of June 2013 is 29.71 percent, above the MPL of 18.98 percent. • **9/24/12–10/8/12:** Molina Provider Service representatives received training on A "Provider's Guide to HEDIS and Star" prior to their distribution to PCPs. This guide contains specific criteria and coding information for all critical HEDIS measures, *including Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*, to assist providers with meeting HEDIS requirements. • **10/8/12–12/31/12:** A "Provider's Guide to HEDIS and Star" was distributed to PCPs by Molina Provider Service representatives during provider office visits. • **2/8/13:** Analysis of HEDIS 2012 AAB measure findings for numerator negative cases identified FQHC and ER practitioners as most common prescribers of antibiotics for a diagnosis of acute bronchitis. Few PCPs were prescribing inappropriately. • **2/12/13:** San Diego MHC medical director and chief medical

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	officer (CMO) notified of HEDIS 2012 AA findings—intervention developed to educate FQHC practitioners about the HEDIS AAB specifications and HEDIS 2012 findings. • **4/2/13:** San Diego MHC medical director presented FQHC-specific HEDIS results/scorecards and a review of HEDIS specifications to FQHC leadership at quarterly Health Plan-FQHC meeting. • **4/10/13:** Monthly monitoring of HEDIS 2014 administrative rates initiated. • **5/3/13:** First quarterly analysis of claims and pharmacy data for a diagnosis of acute bronchitis where prescriptions were filled for an antibiotic. • **5/10/13:** Monitoring of May HEDIS 2014 data identified ER MDs as high prescribers of antibiotics for acute bronchitis. • **5/13/13:** 89 Letters sent to PCP, Clinic, and FQHC practitioners who prescribed antibiotics for the diagnosis of acute bronchitis. Letters indicated if the prescription was related to an ER or urgent care center (UCC) visit. Letter provided a link to the Acute Bronchitis Clinical practice guidelines and to the AWARE (Alliance Working for Antibiotic Resistance Education) Web site for patient education materials to support practitioners' efforts to educate members about appropriate antibiotic use. • **5/14/13:** Just the Fax (JTF) provider bulletin notice sent to all contracted hospital ER medical directors with HEDIS 2012 rates and reminder of HEDIS AAB requirements. • **6/5/13:** First quarterly educational postcard mailing to 89 members who filled an antibiotic prescription as treatment of acute bronchitis. The postcard included the messages that antibiotics will not cure a virus, most bronchitis is caused by a virus, and the risk of antibiotic resistance from inappropriate use of antibiotics. • **6/10/13:** Molina San Diego-based medical director conducted educational sessions about antibiotic avoidance for treatment of acute bronchitis in adults during meetings with independent practice associations (IPAs) and FQHC leadership, including medical directors. • **6/10/13:** Emergency physicians identified from the 2012 HEDIS data analysis added to the 2013 AWARE annual toolkit mailing to remind them of the current guidelines. • **6/14/13:** Monitoring of June HEDIS 2014 AAB data showed San Diego rate YTD to be 29.71 percent (MPL 18.98 percent). Interventions will continue as planned.

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
4. Repeat barrier analysis and modify or implement new interventions for the *Cervical Cancer Screening* measure to help bring the rate for this measure to above the MPL in Sacramento and Riverside/San Bernardino counties in 2013.	As delineated in Molina's 2012 HEDIS *Cervical Cancer Screening* (CCS) Improvement Plan (IP) document for Riverside/San Bernardino and Sacramento counties, appropriate interventions were prioritized and implemented based on detailed analysis of causal barriers. Barriers are prioritized based on the magnitude of challenge, and appropriate interventions that address the identified barriers are also prioritized based on available resources and the impact for improvement. Although, Sacramento failed to meet the MPL of 64.0 percent, Sacramento County demonstrated an increase in the rate for 2012 (63.1 percent) when compared to 2011 rate of 60.1 percent, an increase of 3 percentage points. BARRIERS • Increase in female membership which may result in higher demand of female practitioners for women's health. • Providers with high membership not performing screening • Members are not aware of and/or utilizing the free transportation services • Younger members are not getting the screening • Burden on providers' staff for on-site chart review processes and collections of medical records INTERVENTIONS • **CONTINUOUS—Quarterly 2012–2013 and ongoing**—Needed Services Reports listing providers' assigned members that are in need of HEDIS-related measures, preventive health provider informational mailings and faxes (i.e., JTF provider bulletins, Clinical Practice Guidelines, Preventive Health Guidelines) are disseminated. The Member Services Department, when speaking to a member, will also see alerts that identify missing preventive services for members and are trained to educate the members about their needed services. Member information mailings (i.e., member newsletters, brochures, reminder postcards, Evidence of Coverage, CCS bracelet) are sent to applicable members. • **NEW—2012–2013**—Implementation of electronic document storage in some of the Molina Medical Group clinics in Sacramento and Riverside/San Bernardino County to catalogue paper documents that are exchanged between Molina and the clinics. Information will be readily available as needed for hybrid abstractions. • **NEW—9/24/12–10/8/12**—A "Provider's Guide to HEDIS & STAR": written by MHC's Quality Improvement (QI) Department. The QI Department nurses trained all of the Provider Services field staff in its use with guidance on how to present the book to primary and specialty care physicians in each county. The book includes CCS guidelines and requirements. • **NEW—10/8/12–12/31/12**—A "Provider's Guide to HEDIS and STAR" was distributed to PCPs by MHC's Provider Service representatives during provider office visits.

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	• **NEW—Quarter 1 2013**—Hiring of more female nurse practitioners and female physician assistants to perform female invasive screenings and help with patient overload in Molina Medical Group clinics located in Riverside/San Bernardino County. • **NEW—Quarter 1 2013**—Kids Corner: a free child care on-site service at MMG sites in Sacramento and Riverside/San Bernardino counties for patients who have medical appointments at the clinics. Now, instead of missing or cancelling appointments, parents can have peace of mind their child is safe while they attend to their own health. • **NEW—Quarter 1 2013**—Neighborhood Shuttle, a free Van Service: The Molina Healthcare Neighborhood Shuttle is a free transportation service that travels on a designated route stopping at Molina Medical clinics, grocery stores, Laundromats and at other convenient stops. The Neighborhood Shuttle is offered in North Long Beach, San Bernardino, Fontana, and North Sacramento. No need to contact the health plan to set up an appointment. The Neighborhood Shuttle travels a designated route five days a week, from 8:30 a.m.–5:00 p.m. to and from a variety of both medical and non-medical locations. • **NEW—4/11/13**—MHC member incentive program targeting Sacramento County members to aid in obtaining their cervical cancer screenings. The members' PCP completes the form once services are rendered and returns the form to the health plan for gift incentive distribution to the member.
5. Identify the factors that led to a decline in performance on the *Comprehensive Diabetes Care—LDL-C Screening* measure in Sacramento County from above the MPL in 2011 to below the MPL in 2012 and identify interventions that will lead to an improvement in the rate to above the MPL in 2013.	Below are identified causal/barriers factors that are attributable to declined performance on the *Comprehensive Diabetes Care, LDL-C Screening* measure in Sacramento County. MEMBER BARRIERS: Require child care services, distrust health care providers, only seeks care when ill, has no time to see health care providers due to work, school, family obligations, fear of pain from health care procedures, unable to schedule appointments due to provider time constraints, misperceptions about various health care topics, lack of knowledge about test parameter, lack of privacy and comfort at health care site, discourteous staff at health care site, language and cultural barriers at health care site, needs transportation to health care, testing is inconvenient due to preparation, depression hinders acquisition of health care. PROVIDER BARRIERS: Lacks convenient appointment times/hours, no child care services, less likely to recommend testing to minority patients due to misperceptions and biases, forgets to tell patients they need testing, discourteous staff, long wait times for patients, heavy workload impedes optimal health care practice, does not use translator service for non-English-speaking patients,

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	provider overwhelmed by multiple treatment guidelines and protocols, sends patients to lab for tests to be performed. HEALTHPLAN BARRIERS: Members move frequently and cannot be located; health plan members are allowed to change plans frequently, which interrupts continuity of care and service; plan does not continually remind members and providers of availability of translator and transport services. INTERVENTIONS: A "Needed Services Report" for each provider's patients is sent to PCPs three times a year that highlights recommended HEDIS testing. Soft interventions of provider and member informational mailings and notices continue: JUST THE FAX (JTF) provider bulletin regarding county diabetes data to respective physicians and physician specific 2012 diabetes performance data; HEAD TO TOE postcards sent to members. MHC initiated a new member telephone outreach program that informs the member of services available and recommended plus performs an initial assessment for case management services. Interventions were implemented for calendar year 2012, and the CDC LDL-Cholesterol testing rate for Sacramento increased from 69.3 percent to 70.33 percent, 0.01 percent less than the MPL of 70.34 percent.
6. Thoroughly assess factors that have led to continued poor performance on the *Childhood Immunization Status—Combination 3* measure and modify the IP interventions, as appropriate, to move performance to above the MPL.	As delineated in Molina's 2012 HEDIS *Childhood Immunization Status—Combination 3* (CIS-3) Improvement Plan (IP) document, a detailed causal/barrier analyses were conducted using data mining activities. The positive and negative numerators of the CIS-3 sample size population (subgroups) were analyzed to compare and contrast the differences and characteristics of the groups. Furthermore, an intensive analysis of the seven types of immunizations in CIS Combination 3 resulted in identification of new barriers. Findings interpret that PCV, DTaP, and HepB are highly accountable for the overall negative numerator proportion and ultimately weigh down the potential positive hits in the final sample size. Findings also interpret that when individual immunization rate is observed, the completion rate is relatively higher than the final CIS-3 rate. This is due to CIS-3 measure's high sensitivity, specificity, and inclusive criteria that require members who completed the entire seven different types of immunizations within two years. Detailed analysis by county and by type of immunizations inferred the following barriers. Although particular barriers that were previously identified are still existing, intensive analysis and diverse segmentation analysis of the positive and negative numerators of the final sample size in each county have identified new barriers. System-driven barriers:

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	• Sensitivity and specificity to data exchange format and processes between the health plan and immunization registry. • Poor access to immunization registry for health plans or other health care entities. • Insufficient and incomplete records of immunization in the registry. • Incomplete, untimely, inconsistent, and underreported immunization encounters/claims data from network entities. Provider-related Barriers: • Practitioners'/providers' lack of incorporating system in their offices to record, remind, and recall patients for vaccinations. • Practitioners/providers may miss immunization opportunities when children visit for other reasons, such as well-child visits. • Poor utilization of immunization registry to record and document, resulting in incomplete documentation. • Incomplete, untimely, inconsistent, and under-submission of immunization encounter data from providers who are on capitation payment arrangement. • Reluctance to administer multiple injections concurrently. Patient (Parent) Barriers: • Lack of recall on what immunizations are given and not given. • Difficulty understanding the complex vaccination schedule and the number of required doses. • Personal barriers (no transportation, inconvenient clinic hours or locations). • Fear of side effects. Interventions implemented: • Internal investigation to validate completeness and accuracy of data receipt and extraction: Immunization data collected in the encounter system, interface and transfer of data between Molina system and the immunization registry and electronic health record system. • Needed Service Reports via provider e-portal. • Immunization Incentives for Members. Comparison between HEDIS 2012 and 2013 rates interpret that implemented interventions are being effective, since the CIS-3 rates for Riverside/San Bernardino increased from 59.6 percent to 63.86 percent and Sacramento increased form 50.1 percent to 54.06 percent.

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
7. Apply lessons learned in Sacramento County that led to improvement on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure from below the MPL in 2011 to above the MPL in 2012 to Riverside/San Bernardino counties, which continue to perform below the MPL on this measure.	The causes/barriers must be accurately identified and defined with data information, and interventions must be planned to specifically address and target the identified barriers. Effective interventions cannot be designed and planned if the causes/barriers are not objectively identified through data. Moreover, intermittent monitoring and analysis are needed to evaluate the effectiveness of the implemented intervention in addition to the outcome evaluation. It is critical to continuously analyze the findings with data. Our members in general do not realize the importance of the visit and simply forgo prenatal and postpartum care visit appointments unless they find it necessary. Molina's improvement plan and interventions will target patient education and provider engagement to reinforce patient compliance. Since member's health perception is highly influenced by providers, engaging physicians and clinicians to be accountable in providing optimized evidence-based quality care is equally important.
8. Evaluate effectiveness of existing interventions for the *Prenatal and Postpartum Care—Postpartum Care* measure in Sacramento County and Riverside/San Bernardino counties.	All interventions are monitored and evaluated intermittently to determine effectiveness of each intervention implemented. Process measure indicators are collected and monitored to evaluate the work progress and to evaluate the effectiveness of intervention against the outcome measure. 1. Pregnancy Notification Report (PNR) Outreach Calls (this is an ongoing intervention through postpartum)—assess and track the number of PNR that received monthly, monitor the outcome of each call such as the number of members successfully contacted, confirmed appointments, members who had seen an obstetrician (OB), volume of medical records collected, unable to contact letters sent, and call-back received). A scorecard is used to track and demonstrate the effectiveness of the intervention. 2. Molina Medical Group Prenatal and Postpartum Pilot Project—review outcomes, monitor patient volume seen for prenatal and postpartum care visits, provider claims, and encounter data. 3. Provider Education Strategy Visit (FSR)—review process and outcomes, monitor volume of provider offices who received HEDIS postpartum care measure education, medical records received, provider claims and encounter data of providers who were educated. A scorecard is used to assess performance level and track quarterly progress. 4. Review of transportation services for availability, timeliness, and member satisfaction.

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
9. Identify the factors that led to a decline in performance in San Diego County on the *Use of Imaging Studies for Low Back Pain* measure from above the MPL in 2011 to below the MPL in 2012. Develop interventions to address the identified factors to bring the rate above the MPL.	Implementation of interventions in late 2012 and during 2013 did not impact the HEDIS 2013 rates (measurement year 1/1/12–12/31/12). Factors that lead to the decline in rates in 2012 included high inappropriate ordering of x-rays for a new diagnosis of low back pain by FQHC and ER providers. The YTD 2014 HEDIS rate for *Use of Imaging Studies for Low Back Pain* (LBP) in San Diego as of June 2013 is 68.35 percent, below the MPL of 72.04 percent. Along with the interventions completed though June 30, 2013, additional interventions targeting ER physicians, including San Diego-based medical director meetings with hospital-based ER groups will be developed for the latter half of 2013. • **9/24/12–10/8/12:** Molina Provider Service representatives received training on A "Provider's Guide to HEDIS and Star" prior to their distribution to PCPs. This guide contains specific criteria and coding information for all critical HEDIS measures, including *Use of Imaging Studies for Low Back Pain*, to assist providers with meeting HEDIS requirements. • **10/8/12–12/31/12:** A "Provider's Guide to HEDIS and Star" was distributed to PCPs by Molina Provider Service representatives during provider office visits. • **2/8/13:** Analysis of HEDIS 2012 LBP measure findings for numerator negative cases identified FQHC and ER practitioners as most common prescribers of x-rays during the first 28 days after diagnosis of low back pain. Few PCPs were ordering x-rays inappropriately. • **2/12/13:** San Diego MHC medical director and CMO notified of HEDIS 2012 LBP findings—intervention developed to educate FQHC practitioners about the HEDIS LBP specifications and HEDIS 2012 findings. • **4/2/13:** San Diego MHC medical director presented FQHC-specific HEDIS results/scorecards and a review of HEDIS specifications to FQHC leadership at quarterly Health Plan-FQHC meeting. • **4/10/13:** Monthly monitoring of HEDIS 2014 administrative rates initiated. • **5/3/13:** First quarterly analysis of claims data for a diagnosis of low back pain where x-rays were prescribed during the first 28 days after diagnosis. • **5/10/13:** Monitoring of May HEDIS 2014 data identified FQHC and ER MDs as high prescribers of x-rays for a diagnosis of low back pain. • **5/13/13:** Eighty-nine letters sent to San Diego PCP, Clinic, and FQHC practitioners who ordered x-rays for the diagnosis of lower back pain. Letters indicated if the x-rays were related to an ER visit. Letter provided a link to the low back pain clinical practice guidelines. • **5/14/13:** Just the Fax (JTF) provider bulletin notice sent to all contracted hospital ER medical directors with HEDIS 2012 rates and reminder of HEDIS LBP requirements.

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	• **6/10/13:** Molina San Diego-based medical director conducted educational sessions about avoidance of x-rays during the first 28 days after diagnosis of low back pain during meetings with IPAs and FQHC leadership, including medical directors. • **6/14/13:** Monitoring of June HEDIS 2014 LBP data showed San Diego rate YTD to be 68.35 percent (MPL 72.04 percent). • **6/25/13:** Discussion with San Diego- based Molina medical director regarding the development of stronger interventions targeting Emergency physicians identified as prescribing x-rays for the diagnosis of lower back pain during the first 28 days after diagnosis.
To ensure successful QIPs:	
1. Perform barrier analyses to identify and prioritize barriers for each measurement period. More frequent analyses may allow the plan to identify changes or trends that are not evident from annual analyses alone. Barrier analyses should not be considered interventions.	**Statewide Collaborative QIP: All-Cause Readmission** Prioritized barriers to improving 30 Day All-Cause Readmissions include: 1. Failed or unsafe discharges 2. Inadequate discharge plan from hospital 3. Poor medication reconciliation 4. Member/caregiver unaware of discharge instructions from hospital Health Plan Barriers: 1. Finite funding 2. Emphasis on short inpatient length of stay with member discharged before condition is stable 3. Inadequate care coordination 4. Inadequate follow-up of member once discharged from inpatient setting 5. Inadequate discharge planning 6. Workforce shortage 7. Late assignment of discharged members to case managers 8. PCP unaware of patient issues and case management care plan Hospital Barriers: 1. Workforce shortage: Inadequate discharge planning staff in numbers and quality 2. Finite funding 3. No consequences for readmissions: Medi-Cal & Medicare pay for unlimited inpatient stays 4. Discharge planning not a hospital priority 5. Hospital does not notify the PCP of patient's admissions & discharge 6. Inadequate health teaching of patient prior to inpatient discharge 7. Patient has no pharmacist contact for medication education prior to discharge 8. Lack of communication between hospital and health plan

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	regarding discharge plan 9. Weekend discharge of patient without health plan involvement PCP Barriers: 1. Unable to see discharged patients in a timely manner 2. Unable to devote sufficient time to members during post-discharge visits Member Barriers: 1. Lack of funds to afford medications and/or costs of services 2. Lack of caregiver and/or social support in home 3. Lack of transportation for health care purposes: Members don't realize service is a covered benefit 4. Member non-compliance: Lack of knowledge, cultural barriers, language barrier, member preferences. Community Barrier: 1. Lack of or inadequate community support resources. **Internal QIP: Improving Hypertension Control** In order to identify specific factors and steps from the two external types of audiences (practitioners and members) that are attributable to controlling high blood pressure, a brainstorming process by the QI team was first used to list the factors, followed by the fishbone diagram. Upon identification of the factors derived from practitioner- and member-related barriers to improving hypertension control, interventions were developed. Barriers were prioritized based on the level of impact and the likelihood of achieving positive results, if targeted. Appropriate interventions were prioritized based on data accessibility, data availability, and feasibility with given resource to implement. Year 2013 is the Remeasurement 3 submission with 2012 measurement year. Prioritization of the practitioner-related barriers: 1. Ineffective or lack of pharmacological regimen to control high blood pressure 2. Failure to increase or change therapy to achieve BP goals 3. Disagreement with clinical practice guidelines 4. Lack of knowledge about clinical practice guidelines 5. Inadequate or no patient education Prioritization of the member-related barriers: 1. Noncompliance with medication therapy 2. Complicated medication regimen, side effects of medication, and inconvenient dosing schedule that further lead to noncompliance 3. Lack of awareness to hypertension, including the blood pressure measure and its category 4. Clinical instruction on how to control and manage high blood pressures is not clear and/or not given to the

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	patients in writing 5. Individual lifestyle and diet that affect blood pressure
2. Ensure interventions address the high-priority barriers. Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing Medi-Cal population and finite resources.	**Statewide Collaborative QIP: All-Cause Readmission** For the 30 Day All-Cause Readmission Statewide Collaborative, we identified these two high-priority hospital barriers with the respective interventions: BARRIER: Workforce Shortage: Inadequate discharge planning staff in numbers and quality to affect efficient, thorough, and safe patient discharges with patient's lacking knowledge and their physicians not receiving adequate hospitalization information. INTERVENTION: The MHC Transition of Care Coach assumes responsibility for communication and collaboration with inpatient and community-based providers as well as the patient and caregiver to ensure adequate knowledge of matters related to the hospital stay and post-hospital care needs. BARRIER: Finite Funding: Limited hospital budgets result in inadequate staffing to ensure safe, efficient, and thorough patient discharges. INTERVENTION: Renegotiate hospital contracts at time of renewal with emphasis on bundled payments and value-based purchasing. **Internal QIP: Improving Hypertension Control** Below are the prioritized barriers and their corresponding interventions to address those barriers: Prioritized barriers: 1. Insufficient antihypertensive treatment to improve BP control through appropriate and effective pharmacological regimen and to reduce drug-related barriers. 2. Lack of PCP awareness of their assigned members' hypertension diagnosis and their need for an annual visit and appropriate treatments. 3. Lack of patient/member understanding of the importance of controlling hypertension and taking prescribed medications. Prioritized Interventions: • Hypertension Pharmacy Profile (quarterly report) Date Implemented: 04/10; 07/10; 10/10; 01/11; 04/11; 10/11; 12/11; 4/12; 7/12; 10/12 Category of the Intervention: Provider Targeted population: Direct target to providers and indirect target to members through providers. Targeted Barrier: Ineffective or lack of pharmacological regimen to control high blood pressure; failure to increase or change therapy to achieve BP goals; inadequate or no patient education.

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	• Member Postcards: Date Implemented: 04/10; 07/10; 10/10; 01/11; 04/11; 10/11; 12/11; 4/12; 7/12; 10/12 Category of the Intervention: Member Targeted population: Member Targeted Barrier: Lack of patient/member understanding of the importance of controlling hypertension and taking prescribed medications; patient noncompliance to prescribed medication therapy. • Member Outreach Calls: Date Implemented: Monthly member calls with start date of 10/11 and end date of 11/12 during the QIP period Category of the Intervention: Member Targeted population: Member Targeted Barrier: Lack of patient/member understanding of the importance of controlling hypertension and taking prescribed medications; patient noncompliance to prescribed medication therapy. • Needed Services Report: Date Implemented: 1/11; 7/11; 10/11; 1/12; 7/12; 11/12 Category of the Intervention: Provider Targeted population: Direct target to providers and indirect target to members through providers. Targeted Barrier: Lack of PCP awareness of their assigned members' hypertension diagnosis and their need for an annual visit and appropriate treatments.
3. Ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance.	**Statewide Collaborative QIP: All-Cause Readmission** For the 30 Day All-Cause Readmission Statewide Collaborative QIP, MHC proposed the following evaluation methods to determine the effectiveness of the Case Management and Transition of Care program for Riverside, San Bernardino, Sacramento, and San Diego counties and by payer type (Medi-Cal, SPD, Non-SPD): • For Complex Case Management staff, evaluate performance by: • Total number of members managed by each case manager • Total number of members with emergency room encounters. Differentiate those sent home vs. those with hospital admissions • Total number of members per case manager hospitalized: Differentiate planned vs. unplanned encounters • Total number of members per case manager with planned and unplanned 30 day readmissions.

2011–12 External Quality Review Recommendation	Molina's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	• For Transition of Care staff evaluate performance by: • Total number of hospitalized members managed • Total number of hospitalized and discharged members with phone vs. face-to-face contact • Total number of discharged members with planned and unplanned 30 day readmissions and further differentiated by phone contact only vs. phone and face-to-face contact • Total number of discharged members referred to the Case Management program for the first time vs. the number previously in the program and returning to it vs. those that no longer require case management. **Internal QIP: Improving Hypertension Control** During the period of July 1, 2012, through June 30, 213, Molina's internal QIP (IQIP) has completed its project cycle with Remeasurement 3 period of 1/1/2012–12/31/2012. During the IQIP lifecycle, the baseline and subsequent remeasurements were analyzed and evaluated by the study outcome indicator, HEDIS Controlling High Blood Pressure (CBP). Moreover, implemented interventions were observed and evaluated in conjunction to the result of the statistical analysis and finding of the study outcome: The number of members who did not fill any type of antihypertensive class medications; the number of distinct PCPs who received quarterly data reports on their assigned hypertensive members without indication of filling an antihypertensive medication were observed and evaluated