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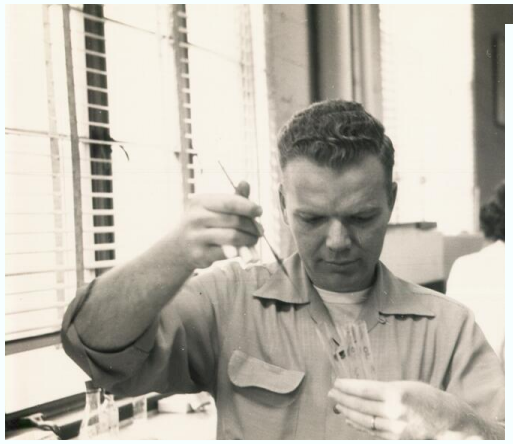
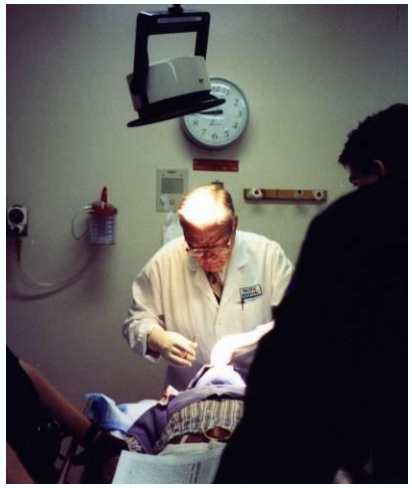
Provider Orientation – Integral Transition

Molina Healthcare





Founded in 1980 by Dr. C. David Molina

Single clinic

Commitment to provide quality healthcare those most in need and least able to afford it

Fortune 400 company that touches over 4.3 million Medicaid beneficiaries

15 states

Molina Story 2.0 Core v2014.2b-HD.mp4

Recognition

- Molina Healthcare currently has nine NCQA accredited health plans, and is among the national leaders in quality Medicaid accreditations.
- Molina Healthcare plans have been ranked among America's top Medicaid plans by U.S. News & World Report and NCQA.
- Hispanic Business magazine ranked Molina Healthcare as the nation's largest Hispanic owned company in 2009.
- Ranked #301 on 2015 Fortune 500.
- Time Magazine recognized Dr. J. Mario Molina, CEO of Molina Healthcare, as one of the 25 most influential Hispanics in America.

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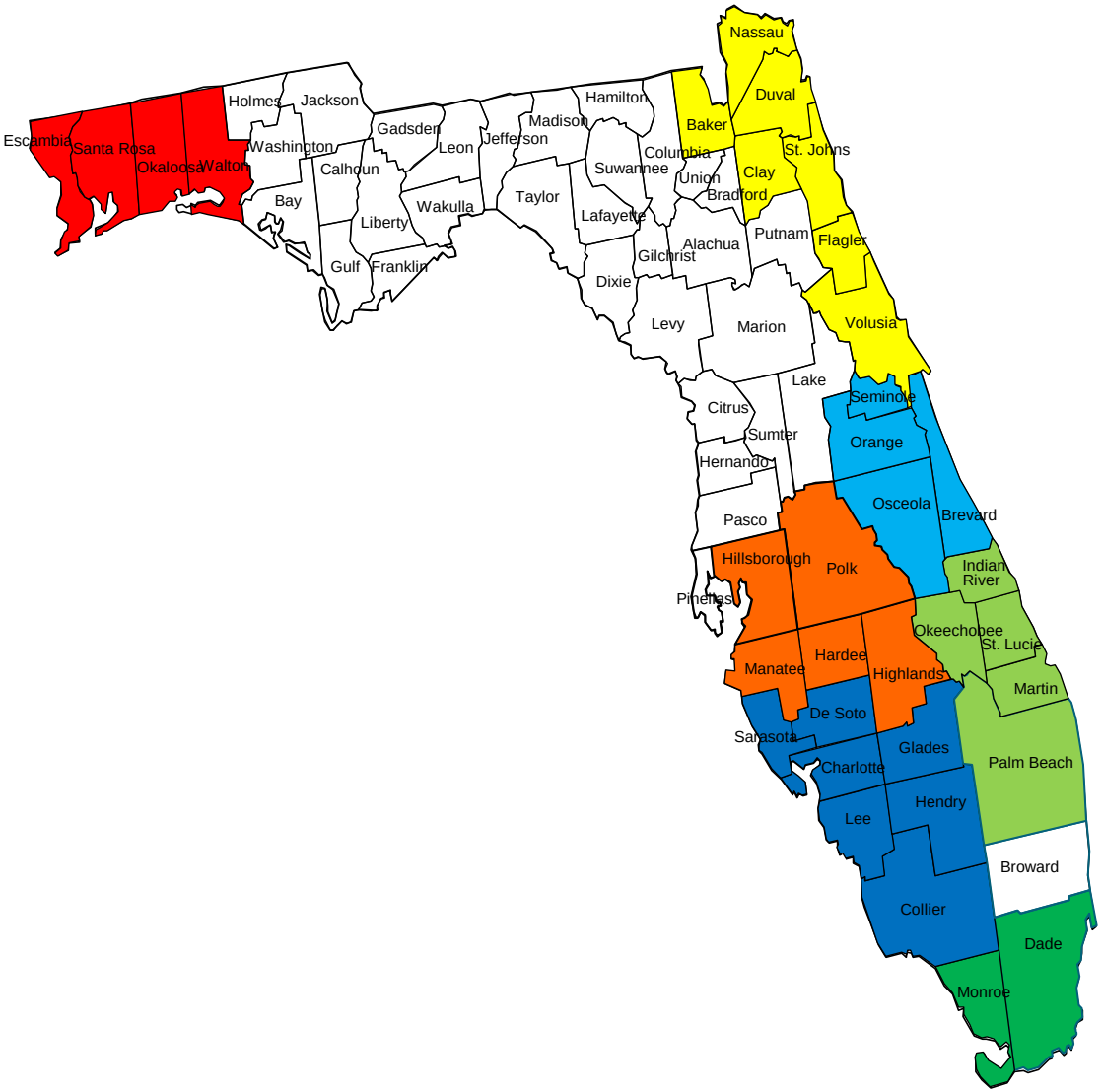
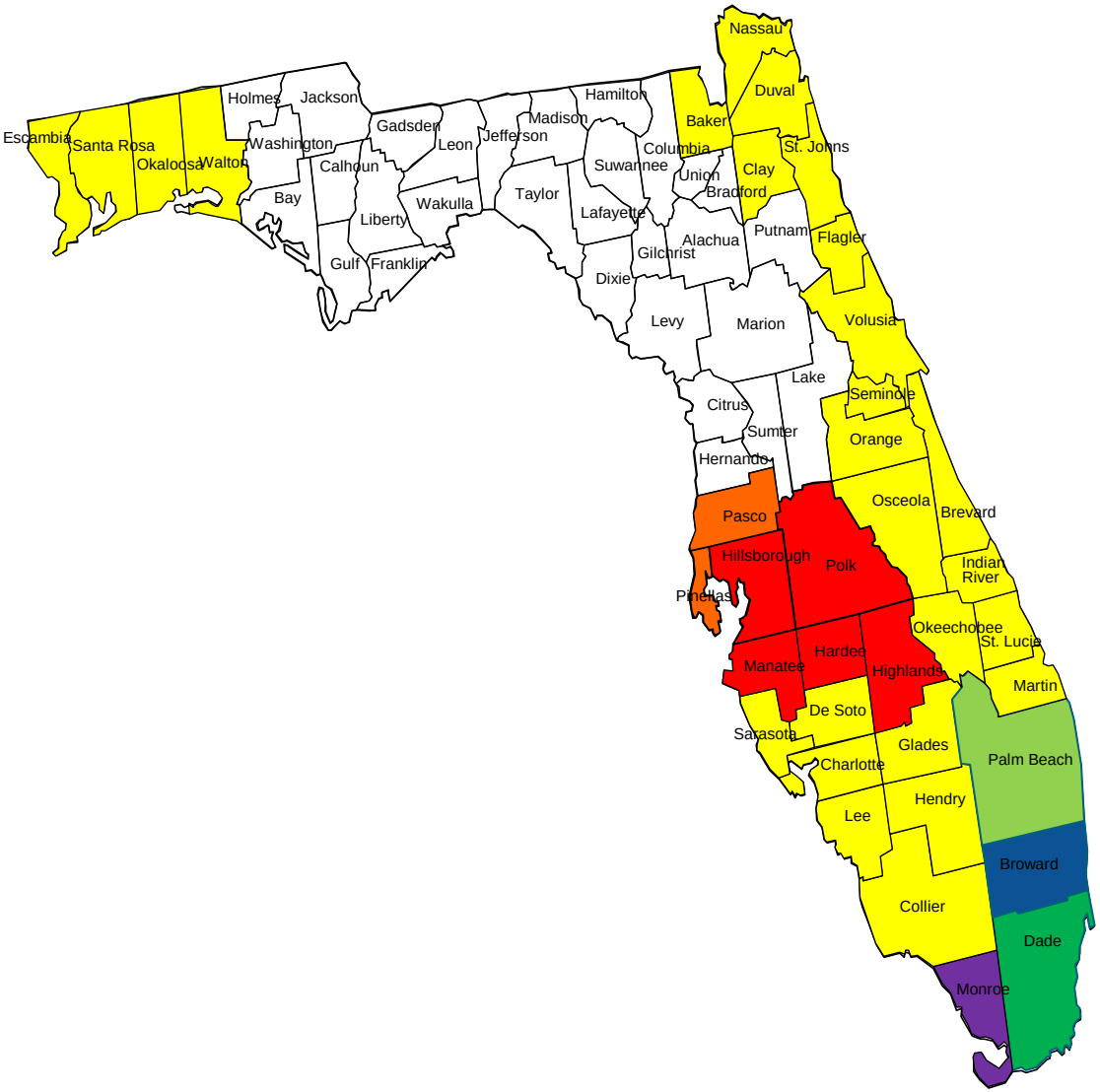
MMA Service Area – November 2015



Region	Color
Region 1	Red
Region 4	Yellow
Region 6	Orange
Region 7	Light Blue
Region 8	Blue
Region 9	Light Green
Region 11	Green

34 Counties

All Product Service Areas – November 2015



MFL Product	Color
ALL Products	Green
Medicaid & LTC	Purple
Medicare & Marketplace	Blue
MCD/MCR/ Marketplace	Light Green
Medicaid	Yellow
Medicare and LTC	Orange
MCD/MCR/LTC	Red

37 Counties
7 different combinations

Continuity of Care

- No disruption of care for transitioning members
- Providers should continue to provide care for covered services regardless of authorization requirements during the continuity of care period
- Molina will cover the continued course of treatment of covered services without authorization throughout the continuity of care period
- Authorization will be required as defined in Molina's Prior Authorization Guide for new covered services and continued care after the 60 day continuity of care period

Implementation Date	Continuity of Care Period End Date
11/1/2015	12/31/2015

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Continuity of Care

MMA Plan shall provide continuation of MMA services (Covered Services) until the enrollee's PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the enrollee's treatment plan, which shall be no more than sixty (60) days after the effective date of enrollment. The following services may extend beyond sixty (60) day continuity of care period, and the Managed Care Plan shall continue the entire course of treatment with the recipient's current provider as described below:

- Prenatal and postpartum care – The Plan shall continue to pay for services provided by a pregnant woman's current provider for the entire course of her pregnancy, including the completion of her postpartum care (six weeks after birth), regardless of whether the provider is in the Managed Care Plan's network.
- Transplant services (through the first year post-transplant) – the Managed Care Plan shall continue to pay for services provided by the current provider for one year post - transplant, regardless of whether the provider is in the Managed Care Plan's network.
- Oncology (Radiation and/or Chemotherapy services from the current round of treatment) – The Managed Care Plan shall continue to pay for services provided by the current provider for the duration of the current round of treatment, regardless of whether the provider is in the Managed Care Plan's network.
- Full course of therapy Hepatitis C treatment drugs

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Continuity of Care

The Managed Care Plan shall honor any written documentation of prior authorization of ongoing covered services for a period of sixty (60) days after the effective date of enrollment, or until the enrollee's PCP or behavioral health provider (as applicable to medical care of behavioral health care services, respectively) reviews the enrollee's treatment plan, whichever comes first.

For all enrollees, written documentation of prior authorization of ongoing medical and behavioral health services includes the following, provided that the services were prearranged prior to enrollment with the Managed Care Plan:

- Prior existing orders
- Provider appointments, e.g. dental appointment, surgeries, etc.
- Prescriptions (including prescriptions at non-participating pharmacies); and
- Behavioral health services.

The Managed Care Plan shall not delay service authorization if written documentation is not available in a timely manner. However, the Managed Care Plan is not required to approve claims for which it has received no written documentation.

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Provider Contracts

- Integral provider contracts have been assigned to Molina, effective 11/1/2015
- Molina will not take assignments of existing Integral contracts if the provider already has an existing Molina agreement.
- Molina may contact you to evaluate your contract at a later date.

Integral contract only	Integral & Molina contract
Integral rates	Molina rates

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Credentialing

- Providers' credentialed status with Integral is valid with Molina for 6 months after the 11/1/2015 implementation date
- Providers must credential directly with Molina within the 6 month period – by 4/30/2016
- Some providers may have already credentialed with Molina
  - No action is needed until provider is due for Re-credentialing
  - If you believe you are a credentialed Molina provider, contact Provider Services at (866)472-4585 to confirm
- Molina will reach out to providers to initiate the credentialing process within the next 30 days
- Providers can initiate the credentialing process today
  - Applications can be obtained from your Provider Services Representative

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Covered Services

- Managed care plans are required to provide services at a level equivalent to the Medicaid state plan. The Medicaid Covered Services are outlined in the State's Medicaid Coverage and Limitation Handbooks.

- The Handbooks are located on the Agency's Fiscal website.

- Medicaid Coverage & Limitation Handbooks – http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx

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Covered Services

Advanced Registered Nurse Practitioner Services	Medical Supplies, Equipment, Prosthetics and Orthotics
Ambulatory Surgical Treatment Center Services	Mental Health Services
Birthing Center Services	Nursing Care
Chiropractor Services	Optical Services and Supplies
Dental Services	Optometrist Services
Early Periodic Screening Diagnosis and Treatment Services for Recipients Under Age 21	Physical, Occupational, Respiratory, and Speech Therapy
Emergency Services	Physician Services, including physician assistant services
Family Planning Services and Supplies (some exceptions)	Podiatric Services
Healthy Start Services (some exceptions)	Prescription Drugs
Hearing Services	Renal Dialysis Services
Home Health Agency Services	Respiratory Equipment and Supplies
Hospice Services	Rural Health Clinic Services
Hospital Inpatient Services	Substance Abuse Treatment Services
Hospital Outpatient Services	Transportation to Access Covered Services
Laboratory and Imaging Services	

Transportation

For all MMA regions, Molina Healthcare offers its members access to non-emergency transportation though Logisticare.

To make an appointment for a transportation service, contact Logisticare's reservation line at (866)528-0454.

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Translation Services

Molina Healthcare offers oral and written translations services to assist members in communicating with providers, Molina Member Services representatives, and case managers.

These services include:

- Oral and written translation services for members with low English proficiency
- Sign language interpretation services for the hearing impaired
- Member materials in Spanish, Braille, or in audio format.

Providers may request interpreter services for any Molina Healthcare Member, at no cost to the provider or the Member.

If you require translation services for a Molina Member, please contact Member Services at (866) 472-4585 or for the hearing impaired, (800)955-8771, to make an appointment with a qualified interpreter.

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Expanded Benefits

- PCP Visits (non-pregnant adults) - Unlimited visits
- Home Health Care (non-pregnant adults) – Unlimited visits; subject to prior authorization
- Physician Home Visits – Unlimited visits; subject to prior authorization
- Prenatal/Perinatal Visits – Unlimited visits; subject to prior authorization
- Outpatient Services – Mammograms & OB ultrasounds are excluded from accruing toward the Medicaid Outpatient Services Limitations
- OTC - $25 per head of household per month
- Adult Dental Services
- Waived Copayments
- Vision Services (including polycarbonate lenses for members <21 years old)
- Hearing Services - $500 every 3 years for an inner-ear hearing aid
- Newborn Circumcision - upon request during initial hospitalization
- Adult Pneumonia Vaccine – 1 per lifetime; available through participating CVS Pharmacies
- Adult Influenza – 1 per year; available through participating CVS Pharmacies
- Adult Shingles Vaccine – 1 per lifetime; available through participating CVS Pharmacies
- Post Discharge Meals – 3 per day for 7 days
- Nutritional Counseling - Unlimited visits; subject to prior authorization
- Pet Therapy & Art Therapy
- Medically Related Lodging and Food

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Networks – MMA

Region	Dental	Vision	Behavioral Health	DME, Home Health Services, Home Infusion Services	Laboratory
Region 1	Dentaquest	iCare Solutions	Access Behavioral Health	Please Contact Molina	Quest Diagnostics
Region 6	Dentaquest	iCare Solutions	PsychCare	Please Contact Molina	Quest Diagnostics
Region 8	Dentaquest	iCare Solutions	PsychCare	Please Contact Molina	Quest Diagnostics

Networks – Contact Info

- **Access Behavioral Health –**
  www.abhfl.org
  Telephone: 866-477-6725
- **DentaQuest –**
  www.dentaquest.com
  Telephone: 888-696-9541
- **Quest Diagnostics –**
  www.questdiagnostics.com
  Telephone: 866-MYQUEST (866-697-8378)
- **PsychCare –**
  www.psychcare.com
  Telephone: 855-371-3945
- **CVS Caremark –**
  www.caremark.com/wps/portal
  Telephone: 800-237-2767
- **iCare Solutions –**
  www.myicarehealth.com
  Telephone: 855-373-7627

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Medicaid Preferred Drug List (PDL)

Molina covers those drugs and dosage forms listed in the Agency For Healthcare Administration's Medicaid Preferred Drug List (PDL), located at:

http://www.fdhc.state.fl.us/Medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml

Preferred Drug List - Florida Medicaid Preferred Drug list

Changes Summary Report - Lists only changes made to the Preferred Drug List as a result of the P&T Committee meeting.

Summary of Drug Limitations - Important information regarding quantity and/or age limits for various drugs.

Each page of the PDL contains six sections:

- Class: Defines the medications therapeutic class
- Medication Drug Name: Defines the medication name
- Generic Name: Defines the medications generic name
- Medicaid Minimum Age: Defines the minimum age for the medication listed
- Medicaid Maximum Age: Defines the maximum age for the medication listed
- **Clinical PA Required: Defines whether or not the drug requires an authorization**
  - **Molina requires PA**

Molina Healthcare's Pharmacy Prior Authorization form is located on Molina Healthcare's website at:

http://www.molinahealthcare.com/providers/fl/PDF/Medicaid/forms_FL_PARequestForm.pdf

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Provider Handbook

Molina Healthcare of Florida's Provider Handbook is written specifically to address the requirements of delivering healthcare services to Molina Healthcare members, including your responsibilities as a participating provider. Providers may request printed copies of the Provider Handbook, at no cost, by contacting Provider Services at (866) 472-4585, or view the handbook on our website, at:

http://www.molinahealthcare.com/providers/fl/PDF/Medicaid/provider-handbook.pdf

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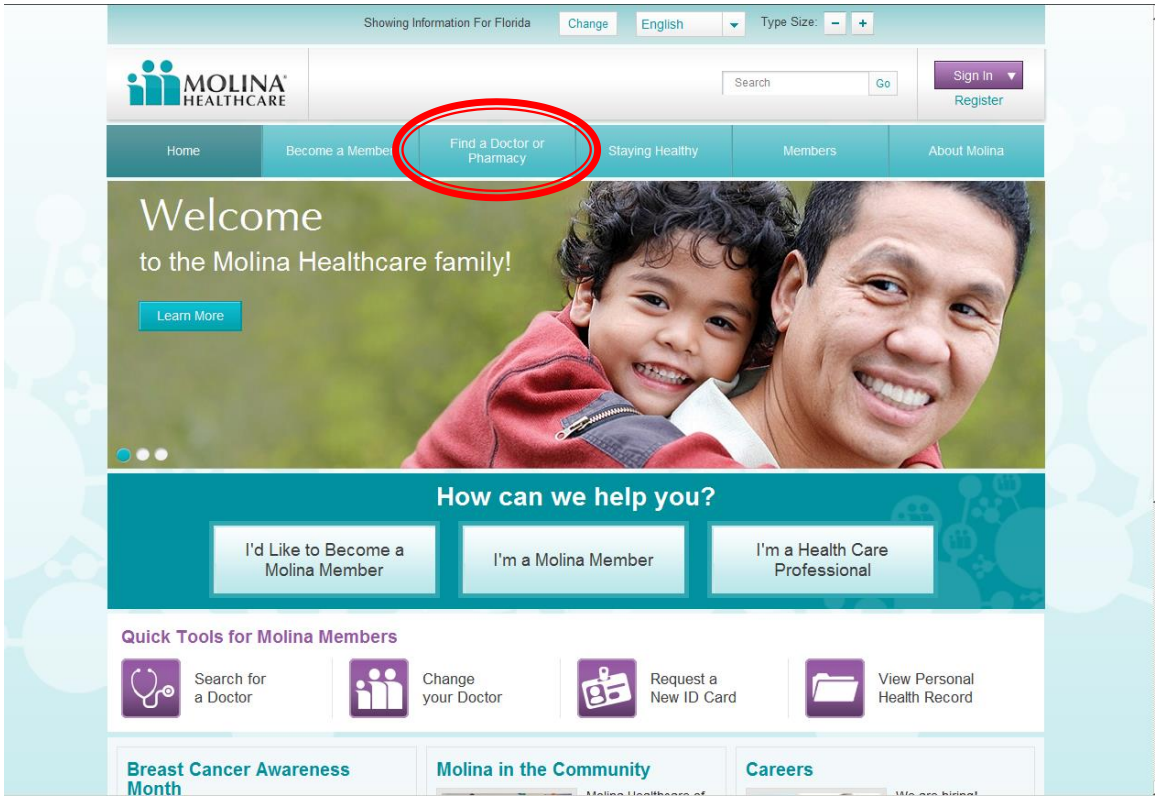
Provider Directory

Molina Healthcare providers may request a copy of our Provider Directory from their Provider Services Representative, or may use the Online Directory on our website.

To find a Medicaid provider, visit us at www.molinahealthcare.com, and click Find a Doctor or Pharmacy.



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Verifying Eligibility

Molina Healthcare offers various tools for verifying member eligibility. Providers may use our online self-service Web Portal, integrated voice response system (IVR), or speak with a live Customer Service Representative.

Web Portal : https://eportal.molinahealthcare.com/Provider/login

Customer Service: (866) 472-4585 (M-F 8:00 am – 7:00 pm)

IVR Automated System: (866) 472-4585 (24 Hours)

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Molina Model of Care

The Model of Care confirms & reestablishes the member's connection to their interdisciplinary care team and ensures appropriate use of services and facilities.

- High touch
- Focus on care transitions
- Prevention of hospital admissions/readmissions
- Appropriate ER utilization

Utilization Management

Integrated Care Management & Coordination Model

Concurrent Review
- Inpatient Admission / Continued Stay Review
- Discharge Planning

Transition of Care
- Discharge Support & Coordination
- Post-Discharge Home Visit / Telephonic Contact
- Hospital Readmission Prevention

Case Management
- Initial Health Risk Assessment
- Comprehensive Needs Assessment
- Individualized Care Planning

Community Connectors
- Supportive Care Coordination
- Member Liaison

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Utilization Management

Health Care Services at Molina consists of four (4) teams. Our teams work together in an integrated approach to provide quality care & excellent customer service to our members & providers

Care Access & Monitoring	Care Management
▪ Care Access (Prior Authorization) ▪ Monitoring (Concurrent Review)	▪ Case Management ▪ Community Connectors ▪ Transition of Care

Member / Medical Appeals	Central Programs
▪ Appeals Review ▪ Post-Service Review ▪ Claims Review	▪ NICU & High Risk OB ▪ Transplants ▪ Nurse Advice Line

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Utilization Management

Care Access & Monitoring (CAM)

Basic CAM Guidelines	
Referrals to network (par) Specialists	Do Not Need Authorization
Imaging, Diagnostic testing, etc.	Most do not need authorization. Refer to website or portal for codes that require authorization.
Expanded Benefits: ▪ Pet Therapy ▪ Art Therapy ▪ Physician Home Visits ▪ Post-Discharge Meals	Require Authorization
Refer to the Molina PA Guide and Service Request Form (SRF) for more details.	
How To Get An Authorization	
Molina Provider Web Portal	https://eportal.molinahealthcare.com/Provider/Login
Fax	Medicaid – (866)440-9791

Case Management

Case Management – Current Programs

- Complex Case Management Program
  - Level 3 & 4 members
  - High Cost
  - Frequent Flyers
- Oncology Case Management Program
  - Telephonic & Face-to-Face Visits
  - ICT Meetings with Dr. Brito (Oncology Consultant)
- Post-natal/Baby HEDIS Program
  - Post-partum visit
  - Six Well-child visits
  - Vaccinations
  - Lead Screening

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Community Connectors

Success Stories:

- ✓ Paid rent and electricity for 6 months for free
- ✓ Delivered blind cane for free from the Lighthouse Association for the Blind
- ✓ Collaborated with provider office to obtain a score of 100% of annual evaluation forms completed for the year
- ✓ Re-connected members back to their support groups.
- ✓ Found housing for members
- ✓ Empowered member to visit the sickle cell assistance clinic for the first time

<u>True Molina Stories:</u>

True_Molina_Stories_-_Cliff_(General)-HD.mp4

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Transition of Care - Stats and Staff

Transitions of Care

- Medicare (All)
- Medicaid (All except OB/Peds)
- Market Place (All except OB/Peds)

Program

- Telephonic Hospital Contact
  - Introduction of program
  - Contact information verification
- Post-Discharge Telephonic Contact
- Post-Discharge Face-to-Face Contact
- Transition of Care Follow-up Telephonic contacts – Days 7, 14, 21, 30

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Transition of Care – Current/Future

Current

ER Diversion

- Medicare (All)
- Medicaid (All)
- Market Place (All)

Program

- Telephonic Contact
- ER Visit Assessment
- Enrolled in Case Management

Future

- Behavioral Health Transitions of Care Program
- OB/Peds Transitions of Care Program

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Referrals & Authorizations

Referrals are made when medically necessary services are beyond the scope of the PCPs practice. **Visits to in-network specialists do not require a PCP referral or authorization from Molina Healthcare.** Information should be exchanged between the PCP and Specialist to coordinate care of the patient.

Prior Authorization is a request for prospective review. It is designed to:

- Assist in benefit determination
- Prevent unanticipated denials of coverage
- Create a collaborative approach to determining the appropriate level of care for Members receiving services
- Identify Case Management and Disease Management opportunities
- Improve coordination of care

Requests for services on the Molina Healthcare Prior Authorization Guide are evaluated by licensed nurses and trained staff that have authority to approve services.

Molina Healthcare's Prior Authorization Guide is included in your Welcome Kit, and also available on our website, at: http://www.molinahealthcare.com/medicaid/providers/fl/forms/Pages/fuf.aspx

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Requests for Authorization

Authorization for elective services should be requested with supporting clinical documentation at least 14 days prior to the date of the requested service. Authorization for emergent services should be requested within one business day. Information generally required to support decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services
- Physical examination that addresses the problem
- Lab or radiology results to support the request (Including previous MRI, CT, Lab or X-ray report/results)
- PCP or Specialist progress notes or consultations
- Any other information or data specific to the request

Molina Healthcare of Florida will process all "non-urgent" requests in no more than 14 calendar days of the initial request. "Urgent" requests will be processed within 72 hours of the initial request.

Providers who request prior authorization approval for patient services and/or procedures can request to review the criteria used to make the final decision.

Providers may request to speak to the Medical Director who made the determination to approve or deny the service request.

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Requests for Authorization

Providers may submit requests for prior authorization to the Utilization Management Department in the following ways:

Web Portal : https://eportal.molinahealthcare.com/Provider/Login

Medicaid Fax: (866)-440-9791

If submitting via fax, please use the Service Request Form included in your Welcome Kit and available online, at:

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

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Web Portal Authorization Tools

- Submit Requests for Authorization
- Verify Authorization Status
- Create Authorization Templates
- View Recent Authorizations
- Access Prior Authorization Guide

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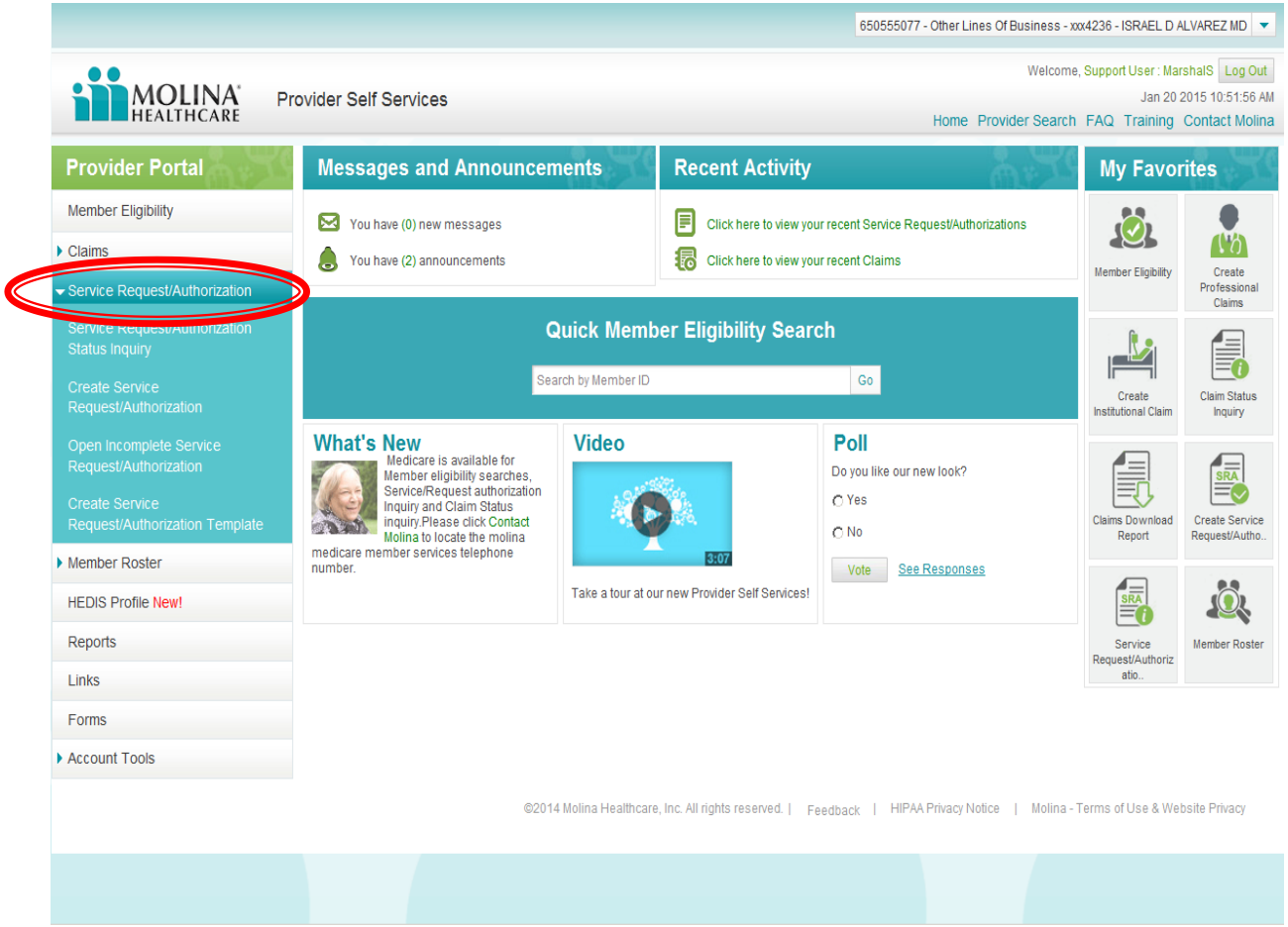
Submitting Authorizations via the Web Portal



- Web Portal Quick Reference Guide is included in your Welcome Kit
- Training materials are available in the Web Portal

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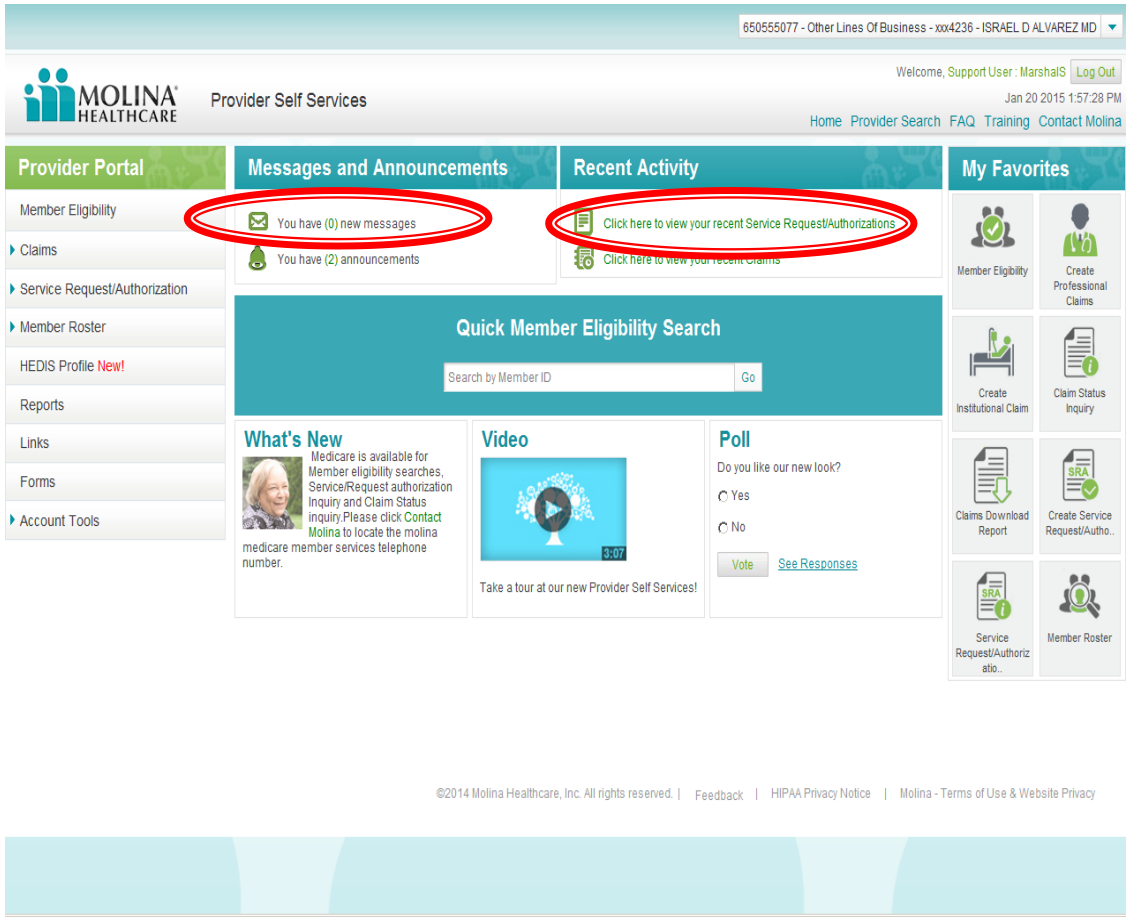
Submitting Authorizations via the Web Portal



- View recent authorizations on the Home Page
- Receive messages when authorization status changes
- Prompter turnaround time

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Web Portal Tools

Member Eligibility	• Verify effective dates • Verify patient demographics • Download member roster (PCPs only)
Claims	• Check claim status • Submit claims • Correct claims • Void claims
Authorizations	• Check status of an authorization • Request authorization
HEDIS	• View HEDIS rates by provider & measure • View member details by measure

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Web Portal Tools - HEDIS

650555077 - Other Lines Of Business - xxx4236 - [redacted]

MOLINA HEALTHCARE Provider Self Services

Welcome, Support User : MarshalS Log Out

Jan 21 2015 11:29:14 AM

Home Provider Search FAQ Training Contact Molina

HEDIS Profile

FAQ Help

The performance rates are based on claims/encounters data received as of 11/30/2014

My Rates | Members

Group Name: [redacted]

Provider Name: [redacted]

Select a Service location: All

Show Data For: All Members

Medicaid Measure	Your Current 2015 Measurement Year Performance: Total # Patients in Measure	# Patients Completed Services	# Patients Still Needing Services	% of Patients who Received Services	2013 Measurement Year Performance[4]: Your Performance	Health Plan Performance[1,2]	2015 NCQA Nat'l Medicaid Percentiles[3]: NCQA benchmarks 50th Percentile	NCQA benchmarks 75th Percentile	NCQA benchmarks 90th Percentile
Adolescent Well Care Visit (AWC)	31	14	17	45.16%	61.11%	48.79%	48.51%	59.21%	65.56%
Annual Dentist Visit 2-21 Years (ADV)	79	52	27	65.82%	55.49%	34.38%	52.65%	61.13%	66.80%
Childhood Immunizations * (CIS) CO2	4	3	1	75.00%	77.78%	67.33%	75.18%	79.72%	83.33%
Follow-up Care for Children Prescribed ADHD Medication –Initiation(ADD)	1	0	1	0.00%	0.00%	28.85%	41.09%	46.99%	53.03%
Well Child Visits 0-15 Months (W15)	4	1	3	25.00%	28.57%	51.21%	62.86%	69.75%	76.92%
Well Child Visits 3-6 Years (W34)	11	8	3	72.73%	72.34%	74.01%	71.76%	77.26%	82.69%

1 Page 1 of 1 10 per page Showing 1-6 of 6

Your rate is at or above 90% NCQA benchmark

Your rate is at or above 75% NCQA benchmark

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Provider Notifications

Providers must immediately notify Molina Healthcare, if any of the following events occur:

- Provider's business license to practice in any state is suspended, surrendered, revoked, terminated, or subject to terms of probation or other restrictions.
- Provider has any malpractice claim asserted against it by a Molina Healthcare member, or 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
- Provider is the subject of any criminal investigation or proceeding
- Provider is convicted for crimes involving moral turpitude or felonies
- Provider is named in any civil claim that may jeopardize Provider's financial soundness
- There is a change in provider's business address, telephone number, ownership, or Tax Identification Number
- Provider's professional or general liability insurance is reduced or canceled
- Provider becomes incapacitated such that the incapacity may interfere with member care for 24 hours
- Any material change or addition to the information submitted as part of provider's application for participation with Molina Healthcare
- Any other act, event or occurrence which materially affects provider's ability to carry out its duties under the Provider Services Agreement

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PCP Responsibilities

- Coordinate and supervise the delivery and transition of care to and for each assigned Member.
- Ensure newly enrolled Members receive an initial health assessment no later than one-hundred eighty (180) days following the date of enrollment and assignment to the PCP.
- Ensure 24/7/365 availability for members requiring emergency services.
- Ensure appointment access for all Members in accordance with the Access to Care Standards
- Provide Child Health Check-Ups (CHCUP) in accordance with the periodicity schedule referenced in the CHCUP section of this handbook.
- Provide immunizations in accordance with the Recommended Childhood Immunization Schedule for the US, or when necessary for the Member's health.
- Participate in the Vaccines for Children Program (VFC) for Members 18 years old and younger.
- Provide immunization information to the Department of Children and Families (DCF) upon request by DCF and receipt of the Member's written permission, for members requesting temporary cash assistance.
- Provide adult preventive care screenings in accordance with the U.S. Preventive Services Task Force guidelines

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PCP Responsibilities

- Utilize Molina Healthcare network providers whenever possible. If services necessary are not available in network, contact Utilization Management for assistance.
- Maintain a procedure for contacting non-compliant Members.
- Ensure Members are aware of the availability of non-emergency transportation and assist members with transportation scheduling.
- Ensure Members are aware of the availability of free, oral interpretation and translation services, including Members requiring services for the hearing impaired.
- Provide a physical screening within seventy-two (72) hours, or immediately if required, for children taken into protective custody, emergency shelter, or foster care program by DCF.
- Submit timely, complete and accurate encounters for each visit where the PCP sees the Member.
- Submit encounters on a CMS-1500 form/UB-04 form (or electronic equivalent)
- Allow access to Molina Healthcare or its designee to inspect office, records, and/or operations when requested.
- Cooperate in investigations, reviews or audits conducted by Molina Healthcare, AHCA, or any other state or federal agency.

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PCP Changes, Assignments & Dismissals

PCP Assignment – Members have the right to choose their PCP. If the Member or his/her designated representative does not choose a PCP, one will be assigned using the following considerations:

- Reasonable proximity to the Member's home
- Member's last PCP, if known
- Member's covered family members, in an effort to keep family together
- Member's Age

PCP Changes – Members may change their PCP at any time with the change being effective no later than the beginning of the month following the request for the change.

PCP Dismissals – A PCP may find it necessary to dismiss a Member from his/her practice due to member non-compliance with recommended health care, or unruly and disorderly behavior (must ensure that behavior is not related to mental health status). It is recommended that PCPs counsel Members prior to dismissal from the practice and allow sufficient time for the behavior to improve. If the dismissal is inevitable, PCPs must immediately notify both the Member and Molina Healthcare of the dismissal and continue treating the member for a minimum of 60 days following the notification to the Member and Molina Healthcare for non-complaint members , and 30 days (emergency care only) for unruly and disorderly Members.

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Appointment Access

Type of Care	Appointment Wait Time
Preventive Care Appointment	Within 30 days of request
Routine Sick Visit	Within 7 days of request
Urgent Care	Within 24 hours
Emergency Care	Triage and treat immediately Available by phone 24 hours/7 days
After-Hours Care	Available by phone 24 hours/7 days
Office Waiting Time	Should not exceed 30 minutes

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Pregnancy Notification

Molina Healthcare must be notified by the PCP, Specialist or Hospital of a member's pregnancy for an unborn record number to be created by Department of Children and Families and AHCA.

PCP's and Specialists are required to immediately notify Molina Healthcare of Florida of the first prenatal visit and/or positive pregnancy test of any member presenting themselves for healthcare services. Molina Healthcare notifies the appropriate Department of Children and Families Customer Support Center Economic Self-Sufficiency Services of a member's pregnancy.

To notify Molina Healthcare of a member's pregnancy, complete the Pregnancy Notification Form and forward it to us via fax or email to:

Pregnancy Notification Fax: (866) 440-9791

Pregnancy Notification Email: MFLBaby@MolinaHealthcare.com

The Pregnancy Notification Form is included in your Welcome Kit, and available on our website, at: http://www.molinahealthcare.com/medicaid/providers/fl/forms/Pages/fuf.aspx

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Child Health Check-Up

Child Health Check-Up (CHCUP) is a comprehensive, preventive health screening available to every Medicaid eligible child under the age of 21. CHCUP screenings are performed according to a periodicity schedule that ensures children have a health screening on a routine basis.

A CHCUP includes:

- Comprehensive health and developmental history
- Comprehensive unclothed physical examination
- Developmental assessment
- Nutritional assessment
- Appropriate immunizations
- Laboratory testing (including blood lead testing)
- Health education and anticipatory guidance
- Dental screening
- Hearing screening
- Objective testing; diagnosis and treatment; referrals and follow up, as appropriate

When conducting a CHCUP exam, please complete the appropriate AHCA Child Health Check-Up Tracking Form and ensure that it is incorporated in the Member's medical record. The form is located on AHCA's website at: http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Child_Health_Check-UpHB.pdf

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Immunizations

Medicaid eligible recipients from birth through (18) years of age are eligible to receive free vaccines through the federal Vaccines for Children (VFC) Program. Providers are reimbursed only for the administration of the vaccines. The vaccines are free to the provider through the Vaccines for Children (VFC) program, and provided by Department of Health.

Medicaid eligible recipients (19) through (20) years of age may receive vaccines through their health care provider. These vaccines are not free to the provider and are reimbursed by Medicaid. Reimbursement includes the administration fee and the cost of the vaccine.

Medikids recipients are not eligible for VFC. Providers should bill state Medicaid directly, for immunizations provided to Medikids recipients.

Molina covers the following adult immunizations as an expanded benefit, accessible at CVS pharmacies:

- Influenza, once per year
- Pneumococcal, once per lifetime
- Herpes Zoster (shingles), once per lifetime

These vaccines are available for children at the physician's office

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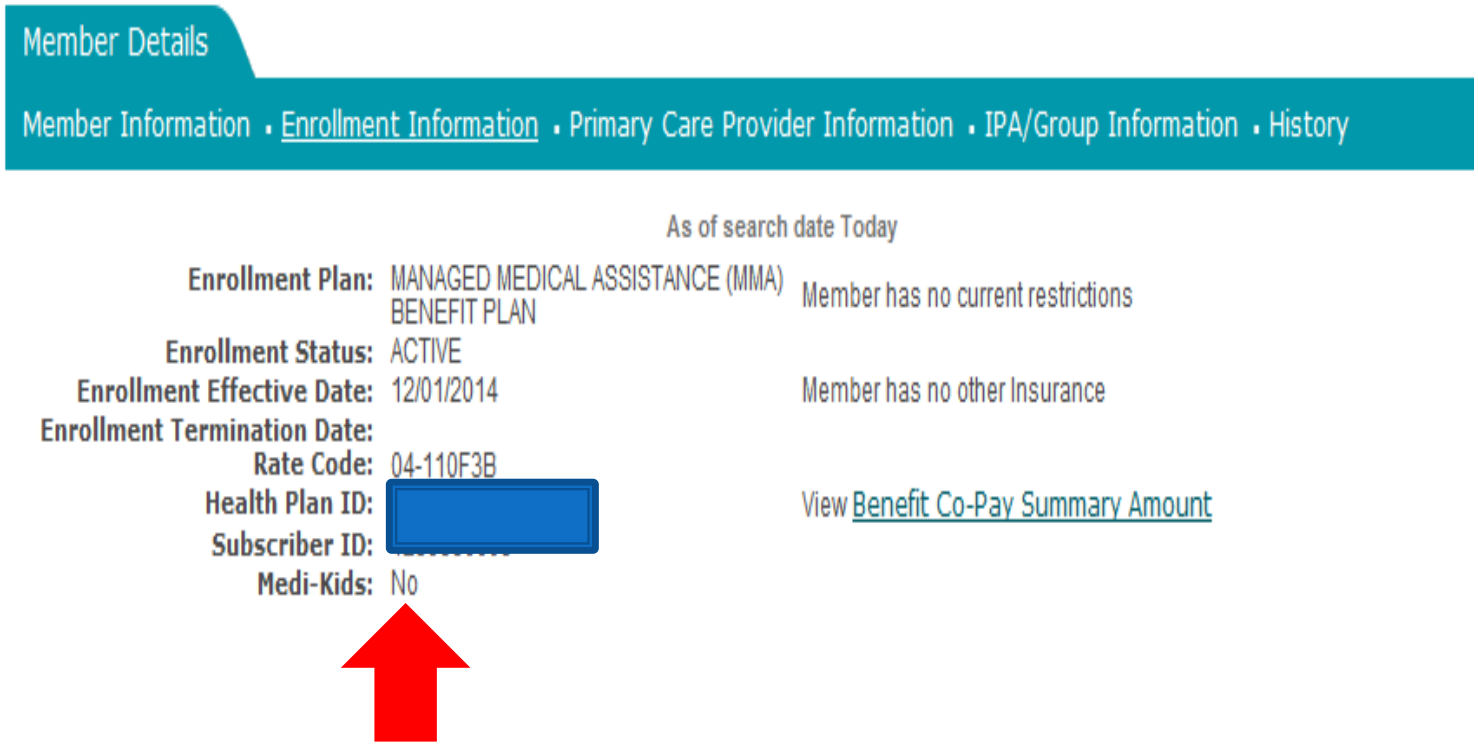
Immunizations

Molina's Web Portal identifies Medikids in its Member Eligibility screen.



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Claims

Providers may submit claims to Molina Healthcare on paper or electronically, using a current version CMS-1500 or the electronic equivalent. Providers may also use our Web Portal to submit claims.

Medicaid Claims Submission Address

Molina Healthcare of Florida
P.O. Box 22812
Long Beach, CA 90801

EDI Claims Submission

Emdeon Payor ID# 51062
Emdeon Telephone (877) 469-3263

Web Portal
https://eportal.molinahealthcare.com/Provider/Login.

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Timely Filing

F.S. 641.3155 requires that Participating providers submit all claims within six (6) months of the date of service. Network providers must make every effort to submit claims for payment in a timely manner, and within the statutory requirement.

Corrected Claims may be submitted at any time during the timely filing period of the provider contract, or within 35 days of the claim processing date (after the filing period has expired).

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Electronic Funds Transfer

Providers are encouraged to enroll in Electronic Funds Transfer (EFT) in order to receive payments promptly.

Molina Healthcare's EFT provider is ProviderNet.

To enroll, visit https://providernet.adminisource.com/Start.aspx

To Register for EFT, providers will need the following:

- Last Molina check
- Name of the Bank Institution
- Bank Routing and Account Number
- Provider NPI
- Provider Tax ID
- Provider Billing Address (pay-to address)
- Voided check

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Electronic Funds Transfer

EFT vs. Paper Check – Turnaround Times

Payment Type	Average TAT from claim paid date
EFT-Direct Deposit	3-4 days
Paper Checks	16 days

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Balance Billing

Participating providers shall accept Molina Healthcare's payments as payment in full for covered services. Providers may not balance bill the Member for any covered benefit, except for applicable copayments and deductibles, if any.

As a Molina Healthcare of Florida participating provider, your office is responsible for verifying eligibility and obtaining approval for those services that require authorization. In the event of a denial of payment, providers shall look solely to Molina Healthcare for compensation for services rendered.

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Provider Disputes

Any disagreement regarding the processing, payment or non-payment of a claim is considered a Provider Dispute. To file a Provider Dispute, providers may contact Customer Service at (866) 472-4585, or send the request for review in writing, along with any supporting documentation to the address below:

Molina Healthcare of Florida
Attn: Provider Disputes
P.O. BOX 527450
Miami, FL 33152-7450
Fax: 877-553-6504

Provider Disputes must be received within one (1) year of the date of payment or denial of the claim. All provider disputes will be reviewed confidentially, and the outcome will be communicated in writing within sixty (60) days or receipt of the Provider Dispute.

If the Provider Dispute results in an unfavorable decision, and the provider has additional documentation supporting their position, the provider may resubmit the Provider Dispute for secondary review. In the alternative, providers may also request a review of their original appeal by the State's independent dispute resolution organization, listed below:

Maximus Federal Services State Appeals Process
50 Square Drive Suite 120
Victor, NY 14564
Tel. (866) 763-6395
Fax (585) 425-5296

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Fraud, Waste & Abuse

Molina Healthcare of Florida seeks to uphold the highest ethical standards for the provision of health care benefits and services to its members. Federal and state resources dedicated to the prevention and detection of health care fraud have increased substantially in the past few years as part of the effort to control federal program expenditures. Molina Healthcare of Florida is committed to working with federal and state regulatory and law enforcement agencies to help prevent and detect fraud, and to recover funds paid for fraudulent claims.

Definitions:

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR §455.2)

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

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Examples of Fraud & Abuse

- Paying or receiving kickbacks for member enrollment or service referrals
- Submitting claims for services not rendered and/or falsifying medical records to increase payment
- Double billing services
- Balance billing members
- Billing services separately that should be billed using a single code (unbundling) or adding modifiers when not appropriate to increase payment
- Use of a medical identification card by someone other than the person identified on the card
- Forgery or alteration of a prescription
- Omitting information or providing misleading or false personal information to obtain health care benefits an individual would not otherwise be entitled to
- Participating in schemes that involve collusion between a provider and a member, such as diverting controlled substance medications for street sales

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Report Fraud & Abuse

You may report suspected cases of fraud and abuse to Molina's Compliance Officer or directly to the Florida Agency for Healthcare Administration (AHCA), Consumer Complaint Hotline toll-free at 1-888-419-3456.

You have the right to report your concerns anonymously to either Molina and/or the Health Care Administration Bureau of Managed Care.

Molina Healthcare of Florida Confidential Compliance Hotline Voice Mail: 866-606-3889

Email: mhfcompliance@molinahealthcare.com

To submit written report to Molina Healthcare of Florida via mail or fax:

Compliance Officer
Molina Healthcare of Florida
8300 NW 33rd St, Suite 400
Doral, Florida 33122
Confidential Fax: 866-440-8591

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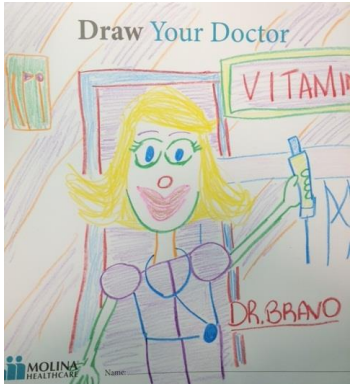
Molina Outreach

The Molina Marketing Team works with our contracted providers by holding state approved events that include;

- Education for the staff on:
  - Benefits Design
  - Lock-in
  - Retention
  - HEDIS Initiatives

- Events for your patients that could include
  - Open House
  - Draw Your Doctor
  - Patient Appreciation Events
  - Baby Showers
  - Birthday Parties
  - Child Obesity
  - Nutrition
  - Senior Aid



There may even be an appearance by our beloved Dr. Cleo!

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Molina Outreach - Marketing Do's & Don'ts

Do's

- Provide the names of the managed care plans with which you participate
- Make available and distribute managed care plan materials *refer to Provider Handbook for additional specifications
- Refer your patients to other sources of information, such as a managed care plan, the enrollment broker or the local Medicaid office
- Share information with patients from the Agency's website or CMS' website
- Announce new or continuing affiliations with managed care plans (radio, TV)
- Make new affiliation announcements within the first 30 days of the new provider agreement
- Make one announcement to patients of a new affiliation that names only the managed care plan, when conveyed by mail, email or phone

Don'ts

- Offer marketing/appointment forms
- Make phone calls, direct or indirect to persuade recipients to enroll in a managed care plan
- Mail marketing materials on behalf of a managed care plan
- Offer anything of value to induce enrollee to select you as their provider
- Conduct health screening as a marketing activity
- Accept compensation from a managed care plan for marketing activities
- Distribute marketing materials within an exam room setting
- Furnish to a managed care plan lists of your Medicaid patients or the membership of any managed care plan

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Questions

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