Provider Orientation

2022 | Molina Healthcare

MOLINA HEALTHCARE

MHO-2465
1221

Agenda

- Provider Resources
- Molina Provider Portal and Availity
- Quality
- Pharmacy
- Health Care Services (Utilization Management/Care Management)
- Billing and Claims
- Appeals and Grievances
- Compliance
- Provider Training
- Contact Molina

Molina Healthcare

Molina Healthcare, Inc., a FORTUNE 500 company, provides managed health care services under the Medicaid and Medicare programs, and through the state insurance marketplaces.

Through its locally operated health plans, Molina served approximately 4.6 million members nationwide as of March 31, 2021.

- **Medicaid:** Provides a wide range of quality health care services to families and individuals who qualify for government-sponsored programs
- **Medicare:** Medicare Advantage plans designed to meet the needs of individuals with Medicare
- **MyCare Ohio:** A member-centered health care approach for people who are eligible for both Medicare and Medicaid
- **Marketplace:** Offers plans that remove financial barriers to quality care and keep members' out-of-pocket expenses to a minimum

Provider Resources

MOLINA HEALTHCARE

Provider Services

Satisfaction

- Provider Services Representatives and Engagement Teams
- Annual Assessment of Provider Satisfaction
- The It Matters to Molina Program that Includes Monthly Forums, surveys, and an Information Page on the Provider Website

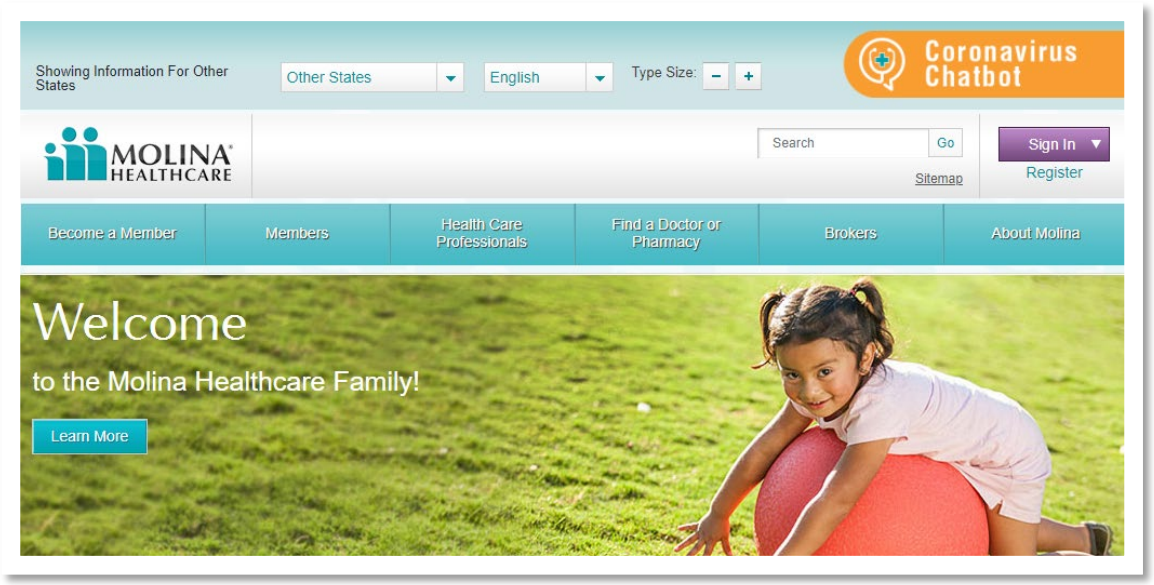
Communication

- Provider Bulletin and Provider Newsletters
- Online Provider Manuals
- Online Trainings, Health Resources, and Provider Resource Guides
- Interactive Voice Response (IVR) Phone System

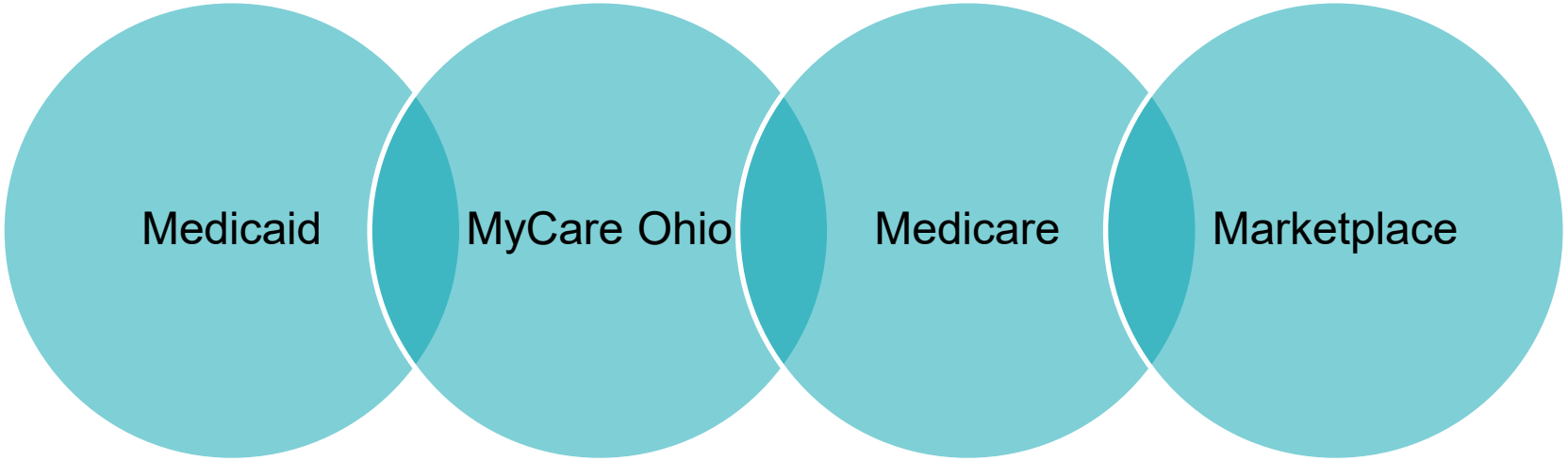
Technology

- 24-hour Provider Portal
- Electronic Funds Transfer and Electronic Remittance Advice
- Online Prior Authorization and Claim Dispute Submission
- Supplemental Prior Authorization Lookup Tool on Provider Portal and Provider Website

Provider Website



Molina has a Provider Website for each line of business



Find the Provider Website at MolinaHealthcare.com.

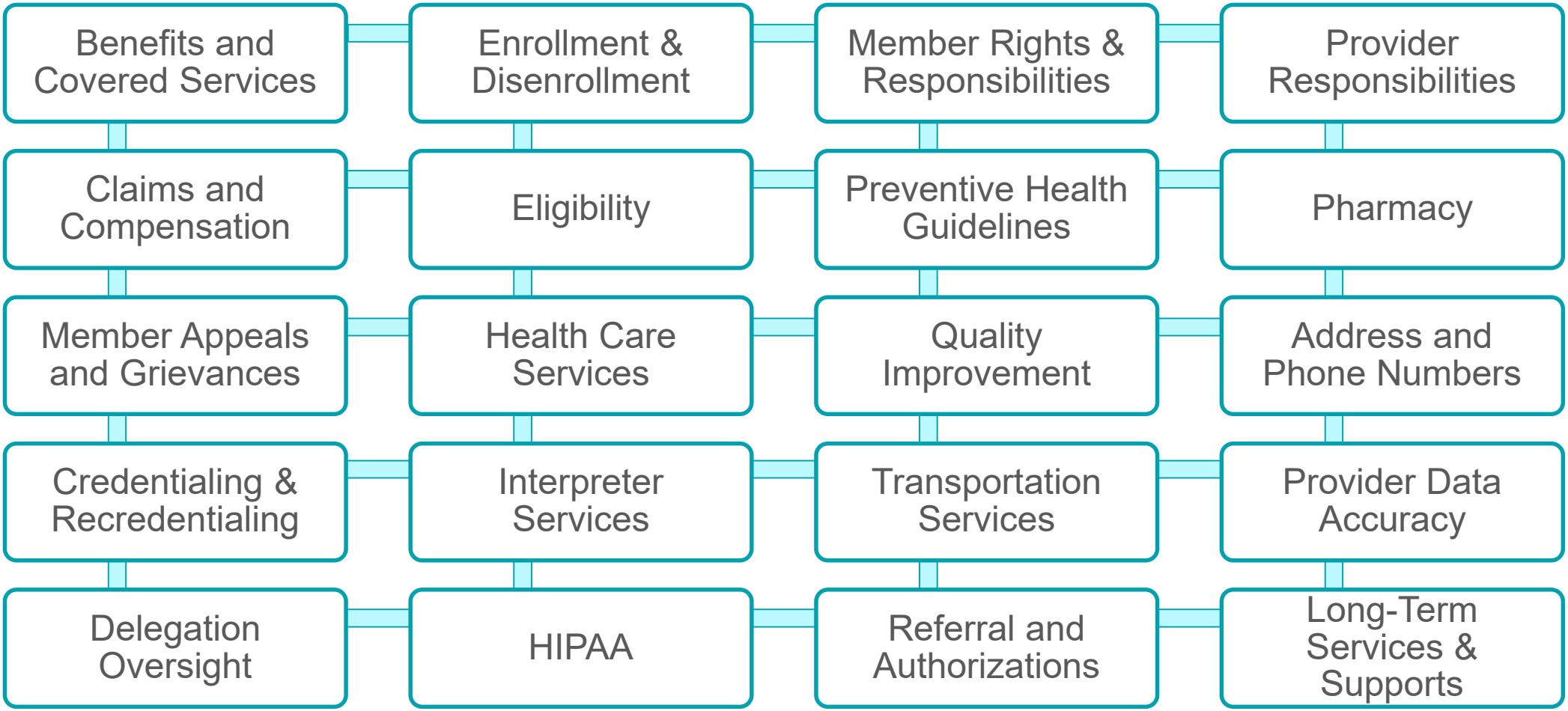
Provider Online Resources

Molina's Provider Website has a variety of online resources:

- Provider Manual
- Dental Manual
- Provider Portal
- It Matters to Molina Page and a Claims Payment Systemic Errors (CPSE) Page
- Provider Online Directory
- Contact Information
- Preventive and Clinical Care Guidelines
- Claims Information
- Health Insurance Portability and Accountability Act (HIPAA)
- Advanced Directives
- Frequently Used Forms
- Pharmacy Information
- Prior Authorization Information
- Claim Reconsiderations
- Provider Communications: Provider Bulletins and Provider Newsletters
- Fraud, Waste and Abuse Information
- Member Rights and Responsibilities
- Molina Policies

Provider Manual Highlights

The Provider Manual is customarily updated annually, but may be updated more frequently. Information in the Provider Manual includes:



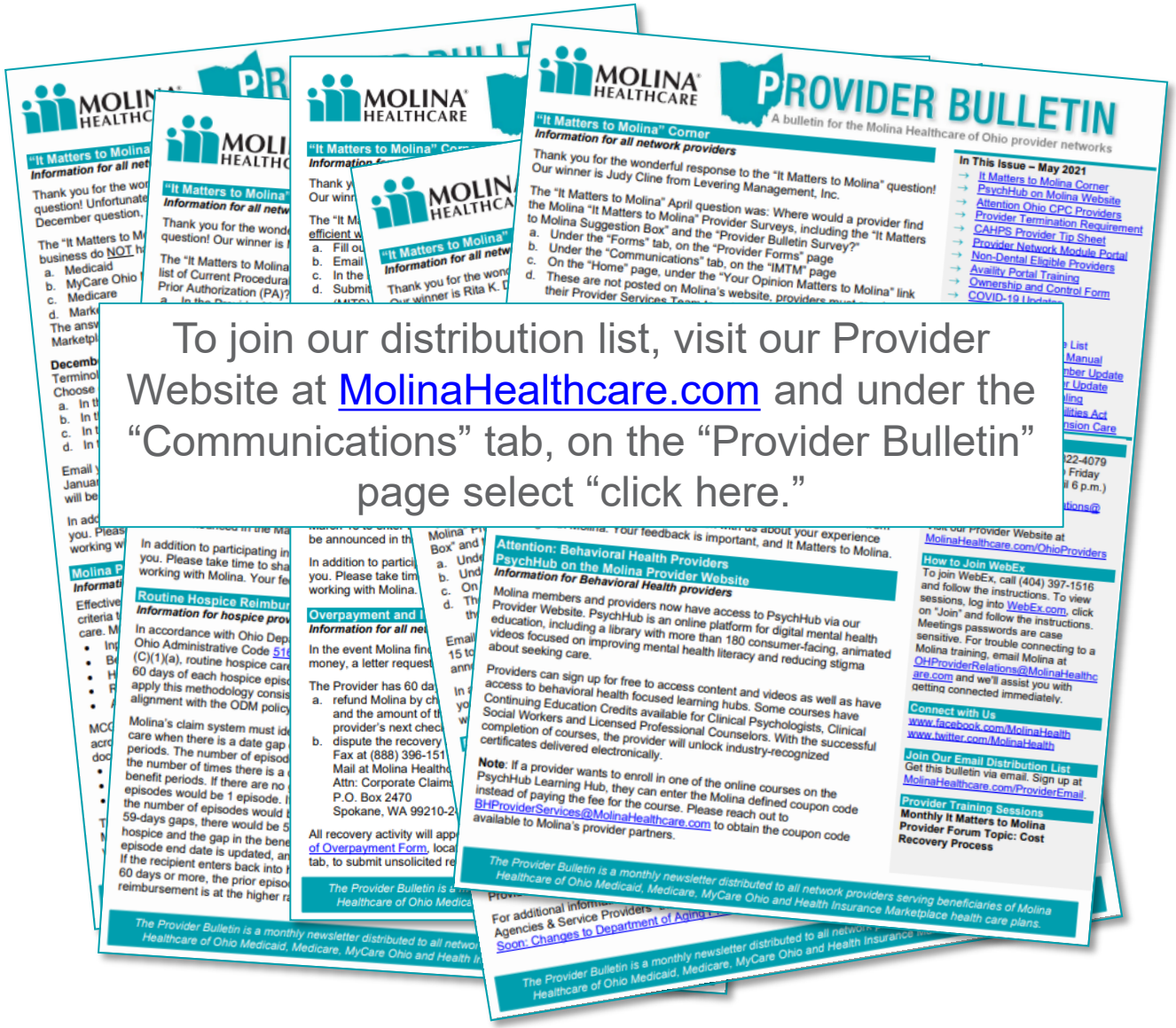
Provider Manuals are specific to each line of business.

Provider Bulletin

A monthly Provider Bulletin is sent to Molina's provider network to report updates.

The Provider Bulletin includes:

- Prior authorization changes
- Training opportunities
- Updates to the Provider Portal
- It Matters to Molina Corner
- Changes in policies that could affect:
  - Claim submissions
  - Billing procedures
  - Payment
  - Appeals



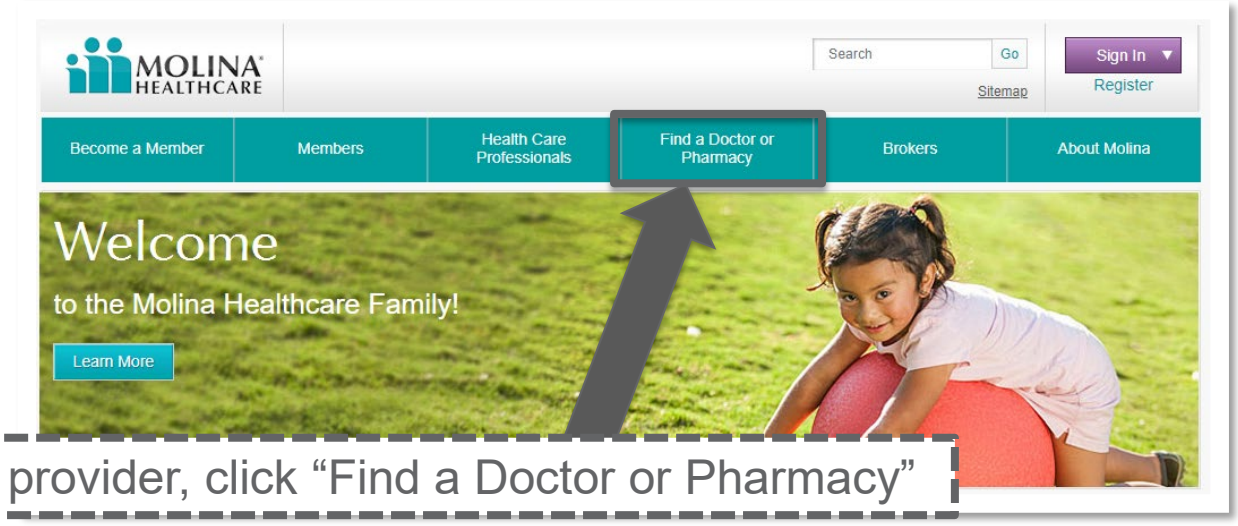
To join our distribution list, visit our Provider Website at MolinaHealthcare.com and under the "Communications" tab, on the "Provider Bulletin" page select "click here."

Provider Online Directory

The Provider Online Directory now offers enhanced search functionality so information is available quickly and easily. Molina providers are encouraged to use the Provider Online Directory linked on our Provider Website to find a network provider or specialist.

Key Benefits Include:				
User-friendly and intuitive navigation	Provider profile cards for quick access to information	Browsing by category, search bar, and common searches	Expanded search options and filtering for narrowing results	Provider information that can be saved to use later

Members should be referred to participating providers.



To find a Molina provider, click “Find a Doctor or Pharmacy”

Provider Data Accuracy

Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement, as well as a National Committee for Quality Assurance (NCQA)-required element.

Important Reminder: Providers must validate the Provider Online Directory information at least quarterly for correctness and completeness.

Please notify Molina at least 30 days in advance for any of the following:

- Change in office location, office hours, phone, fax, or email
- Addition or closure of an office location
- Addition or termination of a provider
- Change in Tax ID and/or National Provider Identifier (NPI)
- Open or close your practice to new patients (PCP only)

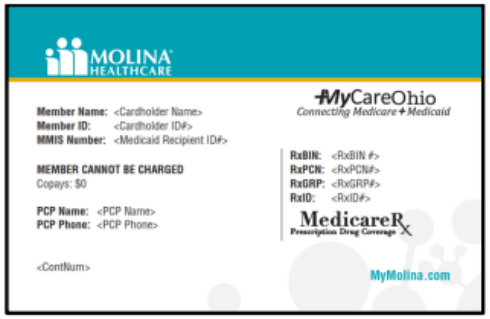
Please use the Provider Information Update Form to make these changes.

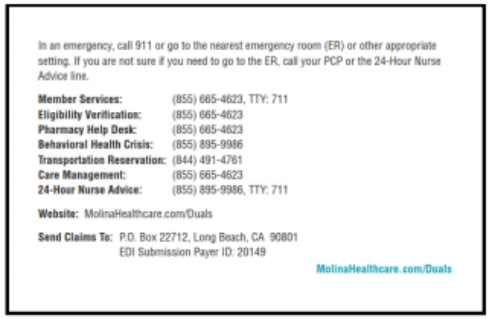
Reminder: The Ohio Department of Medicaid (ODM) is migrating to the new Provider Network Management (PNM) system in 2022 for provider information and updates.

Molina ID Cards

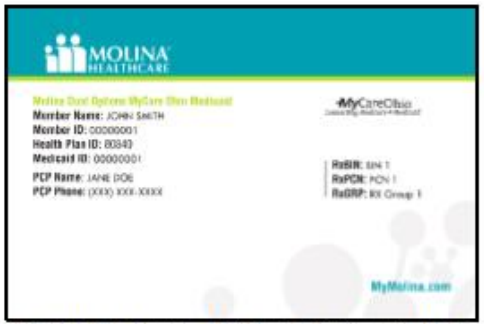
Providers are encouraged to review the most up-to-date version of the Molina Member Cards available in our Provider Manuals at MolinaHealthcare.com on the “Manual” page.

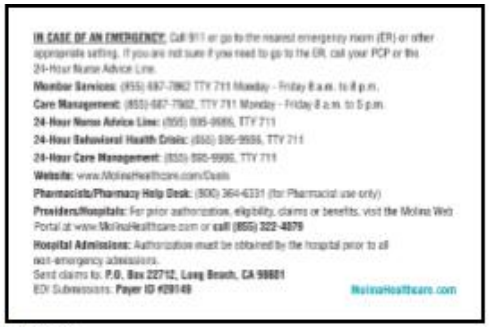
Sample Cards:



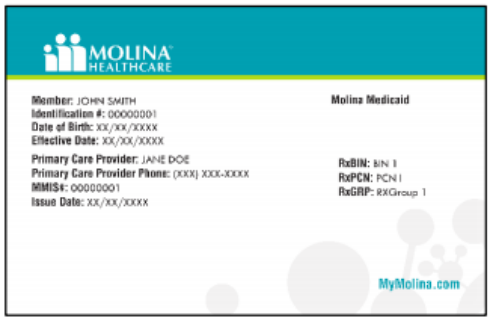


MyCare Ohio (Full Benefits)





MyCare Ohio (Opt-Out/Medicaid Only)



Medicaid

Molina ID Cards

Providers are encouraged to review the most up-to-date version of the Molina Member Cards available in our Provider Manuals at MolinaHealthcare.com on the “Manual” page.

Sample Cards:

Medicare

Marketplace

Prior Authorization (PA)

Prior Authorization (PA) is a request for prospective review. Requests for services on the Molina PA Code List are evaluated by licensed nurses and trained staff.

PA is designed to:				
Assist in benefit determination	Prevent unanticipated denials of coverage	Create a collaborative approach to determining the appropriate level of care	Identify care management and disease management opportunities	Improve coordination of care

The PA Code List is a list of the services that require a provider to submit a PA request and if there are limitations to the code.

View the PA Code List on our Provider Website, under the “Forms” tab

Utilize the PA Lookup Tool on our Provider Website and Provider Portal to determine if a PA is required

Provider Responsibilities

Molina expects our contracted providers will respect the privacy of Molina members (including Molina members who are not patients of the provider) and comply with all applicable laws and regulations regarding the privacy of patient and member Protected Health Information (PHI).

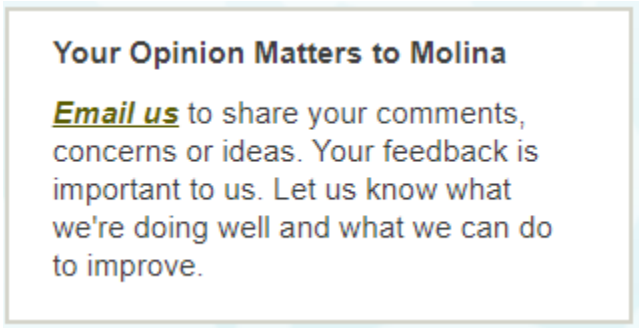
For additional information view the “Provider Responsibilities” section of the Provider Manual, located at MolinaHealthcare.com under the “Manual” tab. Topics include:

- Non-Discrimination of Health Care Service Delivery
- Provider Data Accuracy and Validation
- National Plan and Provider Enumeration System (NPPES) Data Verification
- Electronic Solutions/Tools Available to Providers
- Primary Care Provider (PCP) Responsibilities

It Matters to Molina

Molina wants your feedback! Please take time to share feedback with us about your experience working with Molina. Please let us know what we are doing well, and what we can do to improve your experience. Please share training ideas that would benefit your practice, references/resources we can develop.

Your feedback is important, and It Matters to Molina.



Ways to provide feedback includes:

- Click on the “Email us” link under “Your Opinion Matters to Molina” at the top of our Provider Website
- Email your Provider Services Team
- Take one of our post-training or general feedback surveys located on the It Matters to Molina page
- Join our Provider Advisory Committees

Monthly It Matters to Molina Provider Forum:

Molina offers monthly It Matters to Molina Provider Forums with either a set presentation topic, or as an open question and answer session between our provider partners and Molina subject matter experts. Find a list of upcoming trainings on the It Matters to Molina page.

Molina Provider Portal and Availity

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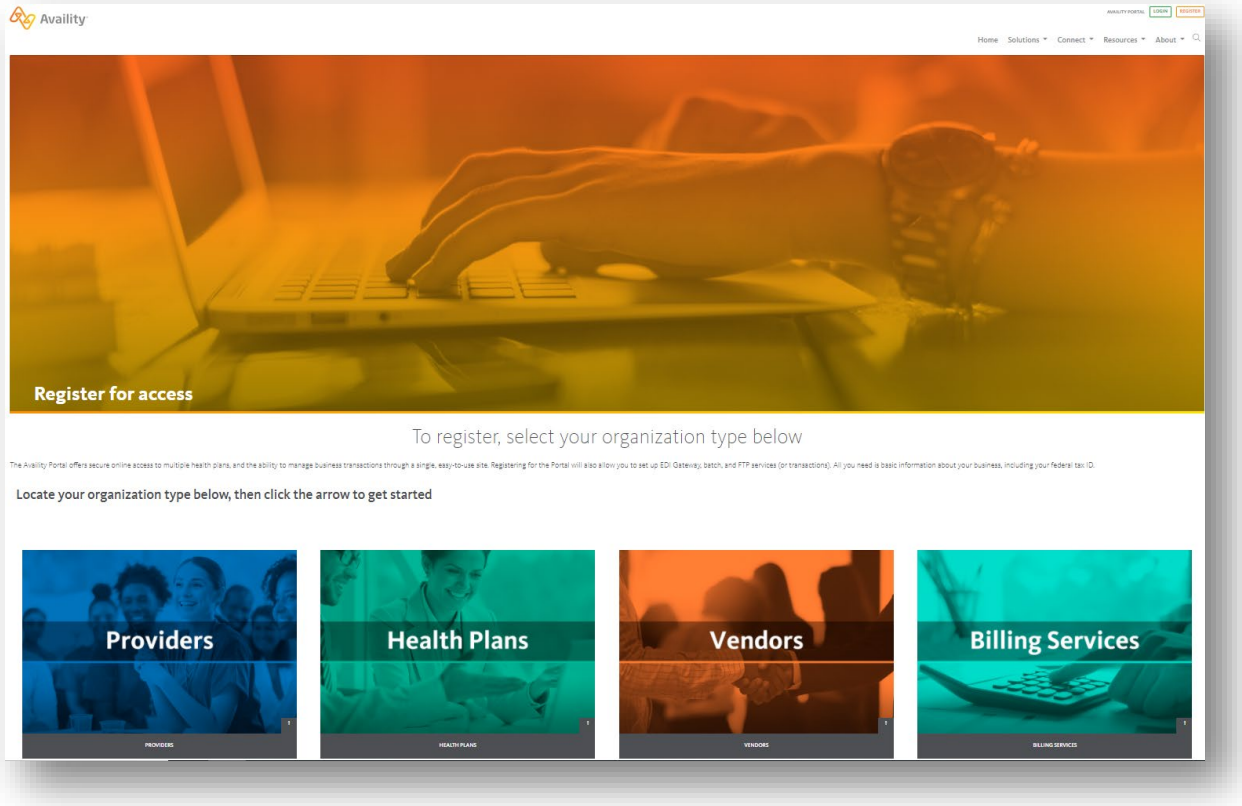
Provider Portal: Transition from Molina Provider Portal to Availity

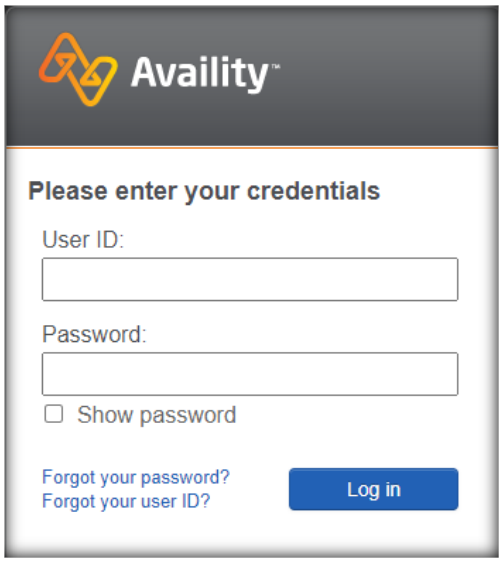
Molina has chosen Availity as its exclusive Provider Portal provider.

- The Molina Provider Portal, including all features, functionality, and resources will continue transitioning to Availity in 2022.
- This is a phased transition, with access to both the Molina Provider Portal and the Availity Portal being available as features and functionality are deployed on the Availity Portal.
- Features currently available on the Availity Portal include submitting new claims, correcting claims, accessing claims reports and claim status, adding attachments, eligibility verification, and Electronic Remittance Advice (ERA).
- Molina providers have access to Molina on Availity at this time.

Availity Provider Portal

Register for Availity at availity.com/provider-portal-registration and select your organization type.

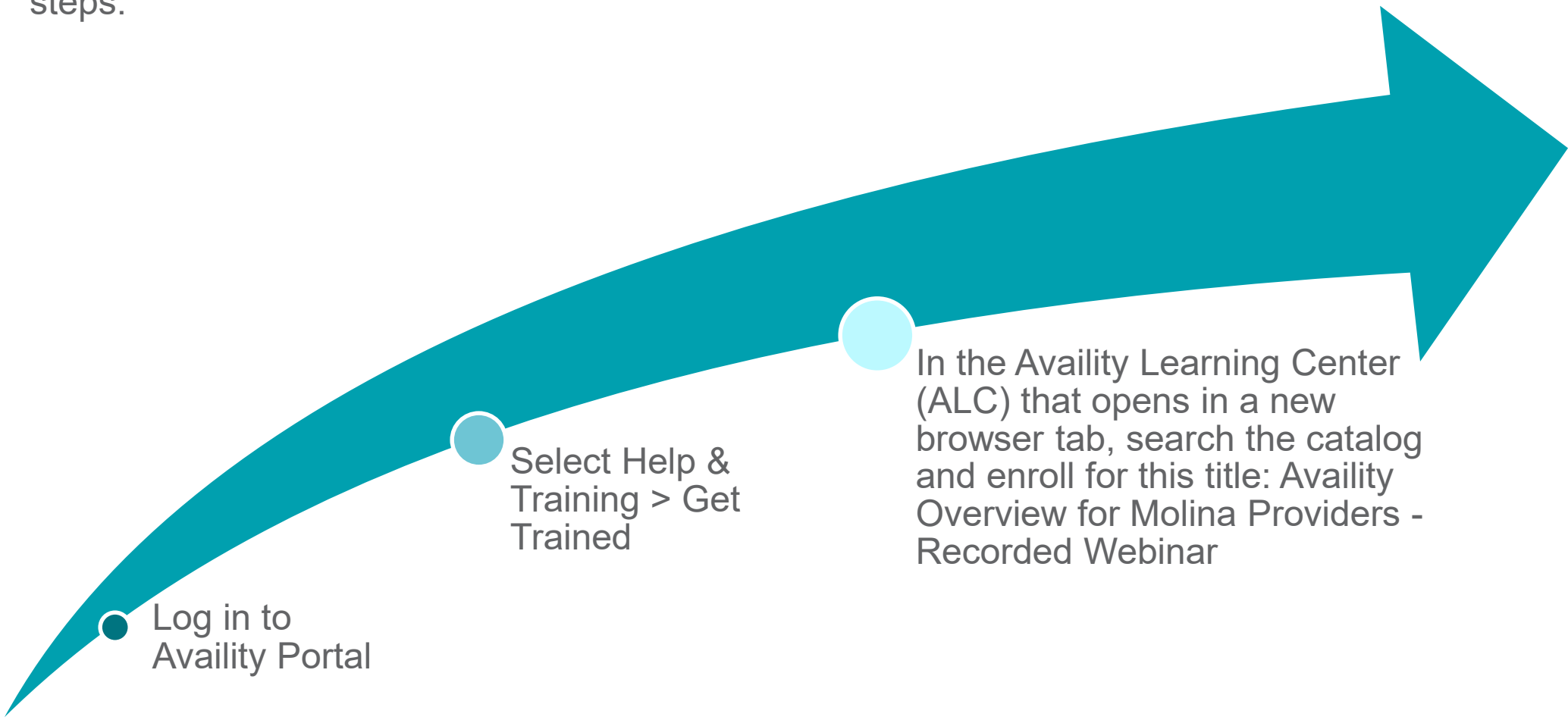




Log into Availity at: apps.availity.com/availity/web/public.elegant.login.

Availity Provider Portal

Once registered providers will have access to the Availity Portal training by following these steps:



Atypical Providers:
Under “News and Announcements” select “Atypical Providers: Here’s your Ticket to Working with the Availity Portal” to view training sessions.

Molina Provider Portal

The Molina Provider Portal is secure and available 24 hours a day, seven days a week. Self-service Provider Portal options include:

- Online Claim Submission
- Claims Status Inquiry
- Corrected Claims
- Healthcare Effectiveness Data and Information Set (HEDIS®) Missed Service Alerts for Members
- Member Eligibility Verification and History
- Update Provider Profile
- Online Claim Reconsideration Requests
- Member Nurse Advice Line Call Reports
- Check Status of Authorization Request
- Coordination of Benefits (COB)
- View PCP Member Roster
- Submit PA Requests

Reminder: The Molina Provider Portal including all features, Functionality, and resources will transition to Availity throughout 2022.

Quality

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Quality Improvement

Molina's Quality Improvement Department leverages quality improvement science and best practices to ensure measurable improvements in the care and service provided to our members.

Molina's Quality Improvement Program complies with regulatory requirements and accreditation standards.

The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service, and health of our members.

For more information on Molina's Health Management Program, call the Health Education line at (866) 472-9483

For more information about Molina's Quality Improvement initiatives, reach out to Provider Services at (855) 322-4079

View Molina's Clinical Practice Guidelines and Preventive Health Guidelines on the Provider Website

Access to Care Standards

Molina maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and Specialists.

Providers may not to discriminate against any member on the basis of any of the following:

- Military Status
- Pregnancy
- Religion
- Health Status, Status as Recipient of Medicaid Benefits, or Need for Health Services
- Age, Race, Creed, Color, or Genetic Information
- Marital Status
- Physical, Mental, or Sensory Disability
- National Origin or Ancestry
- Gender Identity or Sex Stereotyping
- Sex or Sexual Orientation
- Place of Residence
- Socioeconomic Status
- Medical (physical or mental) condition, or the expectation of frequent or high-cost care

Note: If you choose to close your panel to new members, you must give Molina 30 days' advance written notice.

Access to Care Standards, Continued

Category	Type of Care	Access Standard*
Primary Care Providers (PCP)	Emergency needs	Immediately upon presentation
	Urgent care	No later than the end of the following business day after the patient's initial contact with the PCP site
	Regular and routine care	Not to exceed six weeks
OB/GYN	Pregnancy (initial visit)	Within two weeks
	Routine visit	Within six weeks
Oncology	Emergency needs	Immediately upon presentation
	Urgent care	Not to exceed 24 hours
	Regular and routine care	Within six weeks
Non-PCP Specialist	Emergency needs	Immediately upon presentation
	Urgent care	Not to exceed 24 hours
	Regular and routine care	Not to exceed eight weeks

*Ohio Comprehensive Primary Care Program (CPC) Access To Care Standards – Ohio CPC practices should consult their contractual agreements for additional requirements.

Access to Care Standards, Continued

Category	Type of Care	Access Standard
Behavioral Health Specialists	Emergency needs	Immediately upon presentation
	Non-life-threatening emergency	Not to exceed six hours
	Urgent care	Not to exceed 48 hours
	Initial visit for routine care	Not to exceed ten business days
	Follow-up routine care	Not to exceed ten calendar days based off the condition

Additional information on appointment access standards is available from the Molina Quality Department at (855) 322-4079.

Access to Care Standards, Continued

Office Wait Times

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

After Hours Care

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

Measurement of Clinical and Service Quality

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

Medicaid and MyCare Ohio

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

Marketplace

- HEDIS®
- Qualified Health Plan (QHP) Enrollee Experience Survey
- Behavioral Health Satisfaction Assessment
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Activities

Medicare

- HEDIS®
- CAHPS®
- HOS
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Activities

Pharmacy

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Drug Formulary

- The Molina Drug Formulary was created to help manage the quality of our members' pharmacy benefit
- The Drug Formulary is the cornerstone for a progressive program of managed care pharmacotherapy
- Prescription drug therapy is an integral component of a member's comprehensive treatment program
- The Drug Formulary was created to ensure that members receive high-quality, cost-effective and rational drug therapy

The Molina of Ohio Drug Formulary for each line of business is available on the Provider Website at: molinahealthcare.com/members/oh/en-us/health-care-professionals/home.aspx.

Pharmacy

Prescriptions for medications requiring prior authorization or for medications not included on the Molina Drug Formulary may be approved when medically necessary and when Drug Formulary alternatives have demonstrated ineffectiveness.

When these exceptional needs arise, providers may fax a completed Prior Authorization/ Medication Exception Request to the below:

PA Pharmacy Fax – Medicaid and Marketplace:
(800) 961-5160

PA Pharmacy Fax – MyCare Ohio and Medicare:
(866) 290-1309

Health Care Services (Utilization Management/ Care Management)

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Health Care Services

Health Care Services is comprised of:

- Utilization Management (UM)
- Care Management (CM)

The Health Care Services Department:

- Conducts concurrent review on inpatient cases
- Processes prior authorizations and service requests
- Performs care management for members who will benefit from care management services

Key Functions of the UM Program

Resource Management

- PA and referral management
- Pre-admission, Admission and Inpatient Review
- Post service/post claim audits
- Referrals for Discharge Planning and Care Transitions
- Staff education on consistent application of UM functions

Eligibility and Oversight

- Eligibility verification
- Benefit administration and interpretation
- Verifying current Physician/ hospital contract status
- Delegation oversight
- Ensure authorized care correlates to member's medical necessity need(s) and benefit plan

Quality Management

- Satisfaction evaluation of the UM program using member and provider input
- Utilization data analysis
- Quality oversight
- Monitor for possible over or under-utilization of clinical resources
- Monitor for adherence to Centers for Medicare and Medicaid Services (CMS), NCQA, state and health plan UM standards

Note: Medical necessity means health care services that a physician, exercising prudent clinical judgement, would provide to a patient.

Pre-Service Authorization Request Process

Initial Organization Determinations/Pre-Service Authorization Requests – A request for expedited determinations may be made. A request is expedited if applying the standard determination timeframes could seriously jeopardize the life or health of the member, or the member's ability to re-gain maximum function.

Expedited Initial Requests: Must be made as soon as medically necessary	Standard Request: Must be made as soon as medically indicated
• Medicaid, MyCare Ohio, and Marketplace: Within 48 hours (including weekends and holidays) following receipt of the validated request • Medicare: No later than 72 hours after receipt of initial request for services	• Medicaid, MyCare Ohio, and Marketplace: Within a maximum of 10 calendar days after receipt of the request • Medicare: Within a maximum of 14 calendar days after receipt of request

A complete list of PA fax numbers is available on the Molina Healthcare Prior Authorization Request Form and Instructions.

Reminder: View the PA Code List on the Provider Website or use the PA Lookup Tool to determine if a PA is required. Find additional details on slide 14 of this presentation.

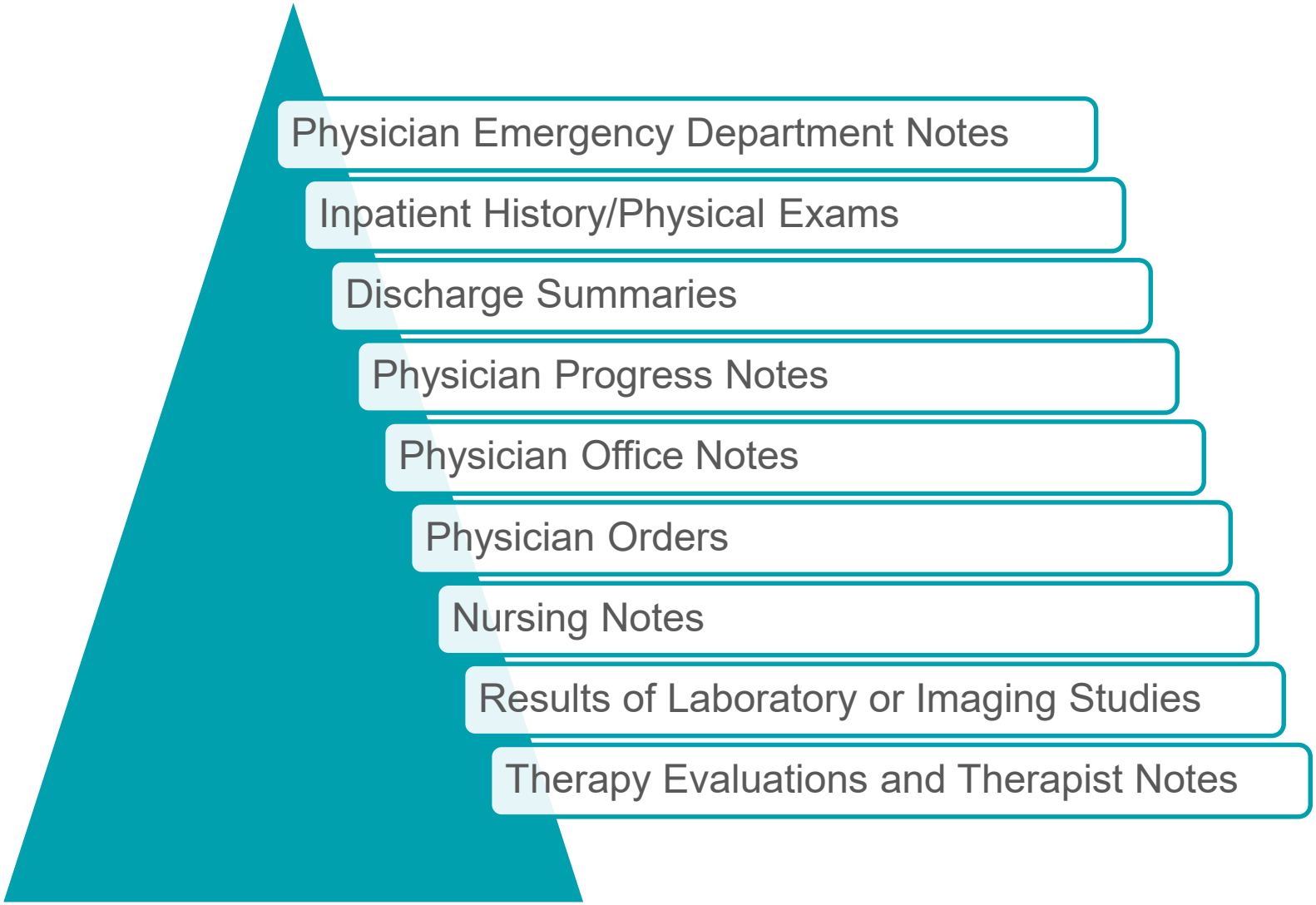
Elements of Utilization Management

Elements of the Molina Utilization Management Program include:

- Pre-admission, admission, and concurrent review
- Pre-service authorization
- Inpatient authorization management
- Medical necessity review
- Restrictions on the use of out-of-network providers

Clinical Information

Molina requires copies of clinical information be submitted for documentation in all medical necessity determination processes.



Care Management

Molina provides care management services to members to address a broad spectrum of needs, including chronic conditions that require the coordination and provisions of health care services.

Provides care coordination and health education for disease management

Identifies and addresses psychosocial barriers to accessing care

Care Management focuses on members who have been identified for Molina's Integrated Care Management (ICM) Program. The ICM Program:

Maintains the goal of promoting high quality care that aligns with a member's individual health care goal

To initiate, the member is screened for appropriateness for ICM Program enrollment using specified criteria

Referral to care management may be made by any of the following:

- Member/ Representative
- Member's PCP/ Specialist
- Hospital Staff
- Home Health Staff
- Molina Staff

Care Manager

The Role of Care Manager Includes:		
Coordination of quality and cost-effective services	Appropriate application of benefits for the member	Attention to member preference and satisfaction
Assistance with transitions between care settings and/or providers	Promotion of interventions in the least restrictive setting of the member's choice	Referral to, and coordination of, appropriate resources and support services
Creation of Individualized Care Plan (ICP), updated as the member's conditions, needs and/or health status change	Promote utilization of multidisciplinary clinical, behavioral and rehabilitative services	Provision of ongoing analysis and evaluation of the member's progress towards ICP adherence

Note: Members may receive health risk assessments that help identify physical health, behavioral health, medication management problems, and social determinants of health to target high-needs members who would benefit from assistance and education from a Care Manager.

Health Care Services Online Resources

Molina has a variety of online Health Resources that are available to providers, including:

- Provider Toolkits and Resources
- Opioid Safety Provider Education Resources
- Clinical Practice Guidelines and Preventive Health Guidelines
- Early Periodic Screening, Diagnostic and Treatment (EPSDT) Healthchek Resources
- Behavioral Health Resources, including PsychHub

Billing and Claims

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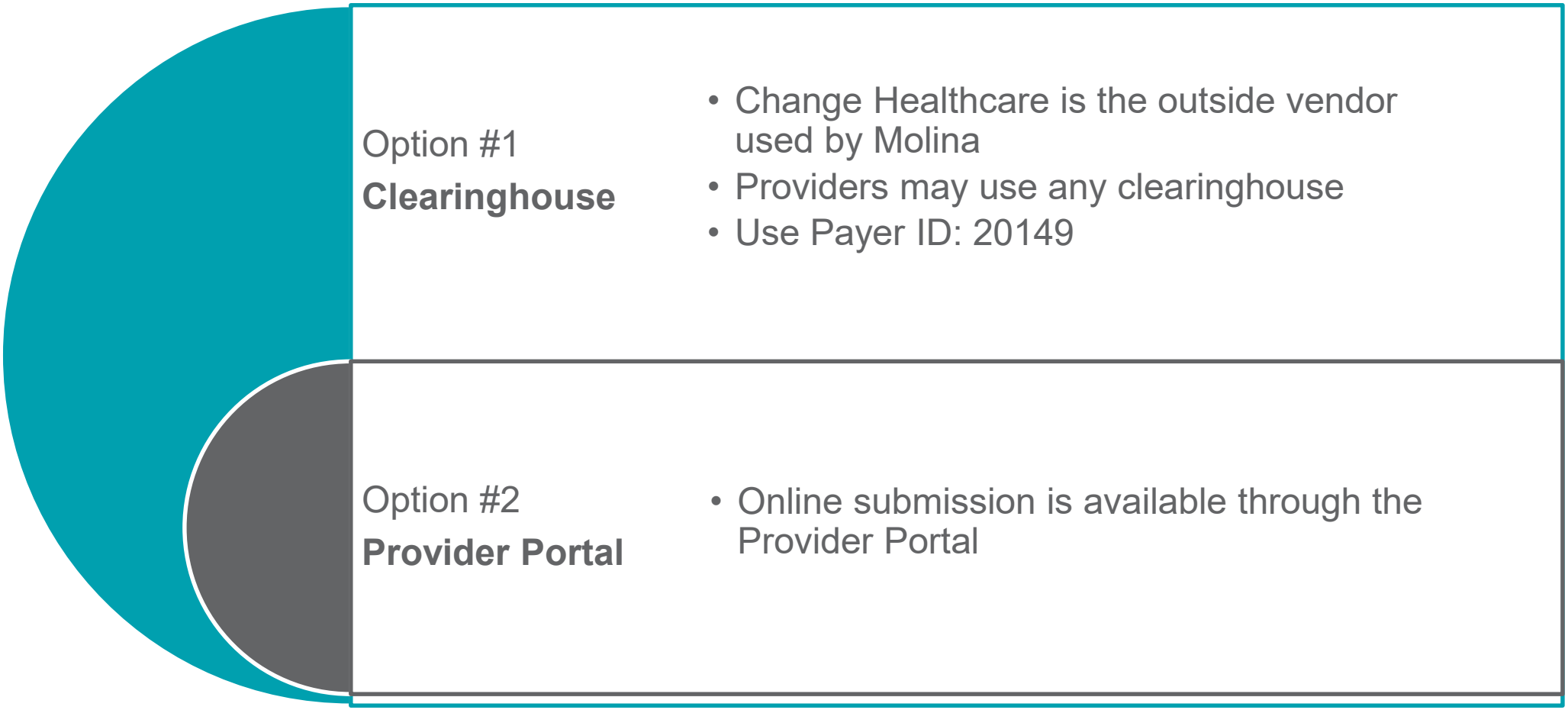
Claims Submission Options

Provider must utilize electronic billing through a Clearinghouse or the Provider Portal:



Reminder: The Molina Provider Portal including all features, functionality, and resources will transition to Availity throughout 2022.

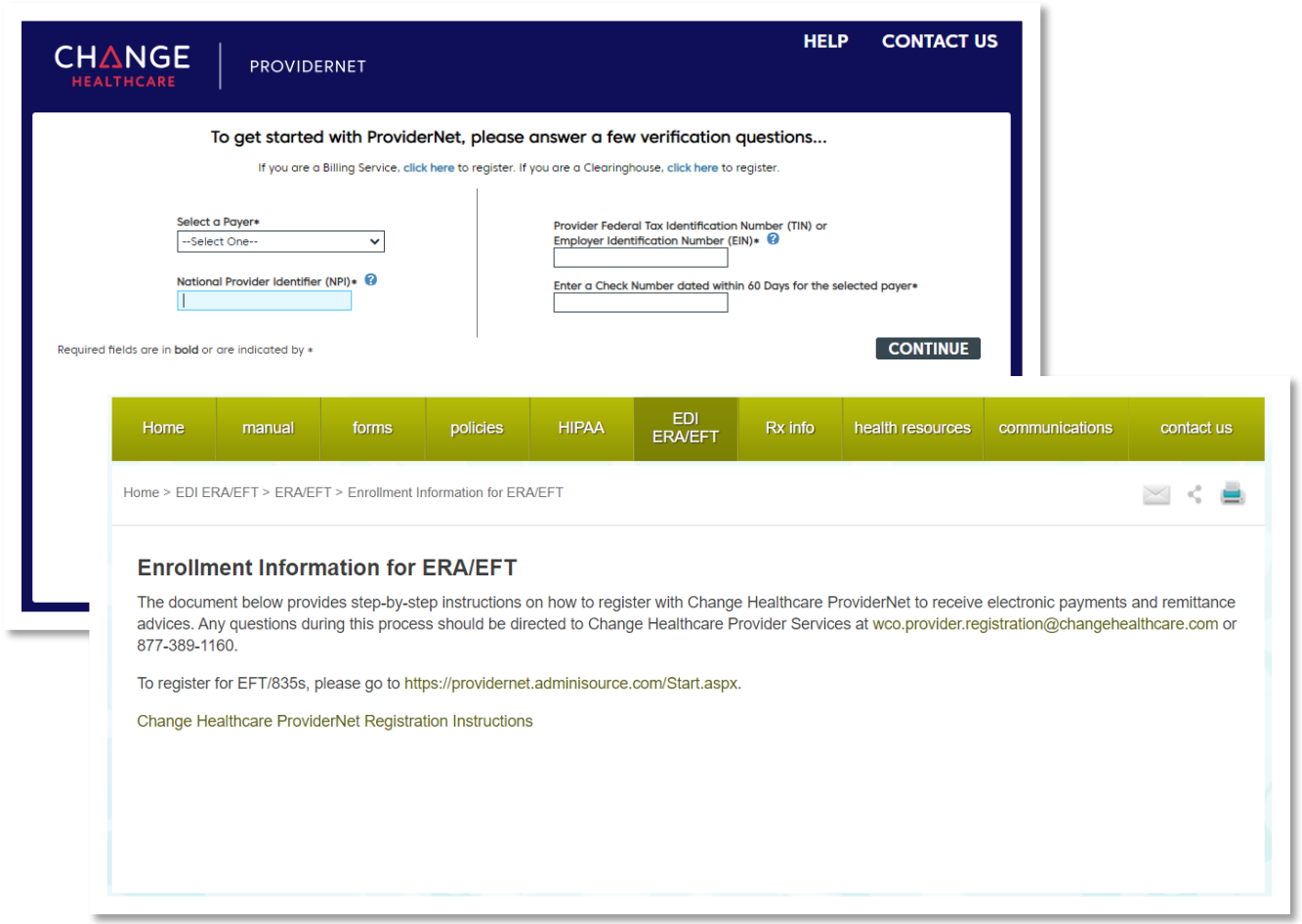
Electronic Payments and Remittance Advice

Molina partners with our payment vendor, **Change Healthcare**, for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA).

Access to Change Healthcare is **FREE** to our providers. We encourage you to register at providernet.adminisource.com/Start.aspx after receiving your first check from Molina.

If you have any questions about the registration process, contact Change Healthcare at (877) 389-1160 or via email at WCO.Provider.Registration@ChangeHealthcare.com.

Visit the EDI ERA/EFT pages at MolinaHealthcare.com for additional information.



Early Periodic Screening, Diagnostic and Treatment (EPSDT)

Medicaid-eligible children are entitled to receive a comprehensive package of preventive health care. This includes all well-child care recommended by the American Academy of Pediatrics (AAP) and the EPSDT child health requirements, known as Healthchek in Ohio.

- Molina requires the EPSDT data reported in block 24H be submitted on all EPSDT claims. If this field is left blank, the claim will be denied.
- ODM is federally required to annually report the number of EPSDT visits and referrals for follow-up or corrective treatment for Medicaid-eligible recipients 0 to 21 years of age.
- Per ODM Billing Guide for Institutional Claims, the referral field indicator should be reported in field 24H for Healthchek/EPSDT services

For more billing information, visit the Healthchek-EPSDT page, located at MolinaHealthcare.com, under the “Health Resources” tab.

Appeals and Grievances

MOLINA HEALTHCARE

Appeals, Grievances and Complaints

Appeal: An appeal is the request for a review of an adverse benefit determination.

Grievance: The Ohio Administrative Code defines a grievance as an expression of dissatisfaction with any aspect of Molina or participating providers' operations, provision of health care services, activities, or behaviors.

Complaint: A complaint is any dissatisfaction that a member has with Molina or any participating provider that is not related to the denial of health care services.

Molina maintains an organized and thorough grievance and appeals process to ensure timely, fair, unbiased, and appropriate resolutions. Molina members or their authorized representatives have the right to voice a grievance or submit an appeal through a formal process.

Molina ensures that members have access to the appeals process by providing assistance in a culturally and linguistically appropriate manner; including oral, written, and language assistance. Information is also included in the Member Handbook.

Members may authorize a designated representative to act on their behalf with written consent. The representative can be a friend, a family member, health care provider, or an attorney.

Appeals

Appeals: Molina will investigate, resolve, and notify the member or representative of the findings no later than the following time frames:

Receipt of Standard Appeal Requests:

- 15 calendar days of receipt for Medicaid and Molina Dual Options MyCare Ohio Appeals
- 30 calendar days of receipt for Marketplace and Medicare Appeals

Receipt of Expedited Appeal Requests:

- Determine within 24 hours if the appeal request meets expedited criteria
- If the appeal request meets expedited criteria, resolve within 72 hours of receipt

Members should exhaust the internal appeals process prior to filing an external appeal (e.g. State Fair Hearing or Independent External Review).

If the appeal resolution isn't fully resolved in the member's favor, Molina will notify the member of their external appeal rights.

Member Appeal Represented by the Provider

For member appeals represented by the provider, Molina must have written consent from the member authorizing someone else to represent them.

An appeal can be filed verbally or in writing within 60 days from the date of the Notice of Action.

The grid below summarizes your options by type of authorization and line of business:

	Outpatient			Inpatient		
	P2P	Authorization Reconsideration	Provider Rep. Member Appeal	P2P	Authorization Reconsideration	Provider Rep. Member Appeal
Medicaid/ Marketplace	Yes	Yes	Yes	Yes	Yes	Yes
Medicare/ MyCare Ohio	Yes*	No	Yes	Yes	Yes	Yes

* Due to regulatory requirements, for Medicare/MyCare Ohio outpatient decisions, a Peer-to-Peer (P2P) is a consultation only. A determination cannot be overturned via the P2P process.

If a patient wants the member to appeal on their behalf, the patient must tell Molina in writing using the Appeal Representative Form.

Grievances and Complaints

Grievances and Complaints: Molina will investigate, resolve, and notify the member or representative of the findings no later than the following time frames:

Line of Business	Access Grievance	Billing Grievance	Standard Grievances
MyCare Ohio	2 Business days	30 Calendar days	30 Calendar days
Marketplace	60 Calendar days	60 Calendar days	60 Calendar days
Medicaid	2 Business days	60 Calendar days	30 Calendar days
Medicare	2 Business days	30 Calendar days	30 Calendar days

Quality of Care and Potential Quality of Care Grievances

A Quality of Care (QOC) grievance is a type of grievance that is related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care.

Potential Quality of Care issues (PQOC) can be identified/reported by any employee, member, caregiver, and/or provider.

PQOCs include Serious Reportable Adverse Events (SRAE)/Hospital Acquired Conditions (HAC) and Never Events.

The direction a PQOC/QOC investigation takes is dependent on the issue being reviewed.

The PQOC/QOC investigation could involve inappropriateness of care, poor continuity of care, refusal of care, or the provider's plan of treatment which may have a negative impact on the member's health.

Provider expectations for PQOC/QOC are based on their contractual obligation to participate in the quality process and can include responding to requests for medical records or additional information.

QOC and PQOC Grievances, Continued

Examples of a QOC/PQOC grievance include care that adversely impacted or had the potential to adversely impact the member's health, and can include any of the following:

Medication Safety

Any medication error or inadequate medication management.

- Member is prescribed medication to which they are allergic
- Member is prescribed new medication and provider does not monitor the therapeutic effects

Treatment

Delay in diagnosis, treatment, or repetition of procedure or delay in or failure to refer.

- Abnormal lab results were not communicated to member or there was a failure to refer to an alternative provider for follow up
- Lack of ordering necessary labs

Procedures/Surgery

Wrong operation/procedure on a patient or wrong patient or unscheduled return to surgery.

- Member was readmitted to the hospital with post surgical complications

Medicaid and MyCare Ohio Quality of Service Grievances

- Quality of Service (QOS) is defined as any expression of dissatisfaction with the behavior of provider/staff, customer service received, or physical appearance of place of service.
- QOS examples include reported rudeness of provider/office staff, long wait time for a scheduled appointment, not enough chairs in reception area to accommodate waiting patients
- Provider Services Representatives will reach out to the office to get the provider details on the QOS, that will then be shared with ODM.
- QOS requests have a due date which will be shared with your office.
- Failure to respond or provide information on the QOS will be reported back to ODM as provider non-responsive.

Appeals, Grievances and Complaints

Members may file a grievance or complaint by calling Molina's Member Services Department:

- **Medicaid**: (800) 642-4168 (TTY/Ohio Relay (800) 750-0750 or 711), Monday - Friday from 7 a.m. to 7 p.m.
- **Molina Dual Options MyCare Ohio (full benefits)**: (855) 665-4623 (TTY 711), Monday - Friday from 8 a.m. to 8 p.m.
- **Molina Dual Options MyCare Ohio Medicaid (opt-out)**: (855) 687-7862 (TTY 711), Monday - Friday from 8 a.m. to 8 p.m.
- **Medicare**: (866) 472-4584 (TTY 711) – 8 a.m. to 8 p.m., Monday - Sunday
- **Marketplace**: (888) 296-7677 (TTY 711) – 8 a.m. to 7 p.m., Monday - Friday

Medicaid, Marketplace, and MyCare Ohio Opt-Out lines of business may also submit a grievance or complaint in writing to:	Medicare and MyCare Ohio Opt-In lines of business may also submit a grievance in writing to:
Molina Healthcare of Ohio, Inc. Attn: Appeals and Grievances Department P.O. Box 349020 Columbus, OH 43234-9020	Molina Healthcare Medicare Attn: Grievances and Appeals P.O. Box 22816 Long Beach, CA 90801-9977

Compliance

MOLINA HEALTHCARE

Medicaid ID Number

In order to comply with federal rule 42 CFR 438.602, providers are required to have enrolled or applied for enrollment with the ODM at both the group practice and individual levels to receive payment for clean claims submitted to Molina for covered services.

Providers without a Medicaid ID number will need to submit an application to ODM. Enrollment is available through the Medicaid's Information Technology System (MITS) portal or providers can start the process at medicaid.ohio.gov.

For dates of service on Aug. 15, 2021 and after, Molina will deny claims for providers who are not registered and active in the state's system. Providers who update their records after claims begin rejecting will need to submit corrected claims once the records are updated.

Reminder: ODM is migrating to a new Provider Network Management (PNM) system in 2022 for provider information and updates.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA requires providers to implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of a member's PHI.

Providers should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential	Molina strongly supports the use of electronic transactions to streamline health care administrative activities	Providers are encouraged to submit claims and other transactions using electronic formats

Certain electronic transactions are subject to HIPAA Transactions and Code Sets Rule including, but not limited to, the following:

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

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with Molina should refer to the HIPAA Transactions on our Provider Website under the "HIPAA" tab.

Cultural & Linguistic Competency

Molina is required to provide annual Cultural Competency (CC) training to our participating provider network. Providers are required to attest to Molina the completion of CC training.

Providers have the option to:

Molina offers educational opportunities in CC concepts for providers, their staff, and Community-Based Organizations.

Utilize Molina's CC training, located on the "Culturally and Linguistically Appropriate Resources/Disability Resources" page on our Provider Website, under the "Health Resources" tab and attest to Molina

Utilize their own CC training that meets the federal requirement and attest to Molina

View the Molina CC Attestation Form on the Provider Website, under the "Manual" tab.

Please note: Molina does not review and assess providers' training programs. Providers are mandated to complete training in compliance with the federal requirement and then attest to its completion.

Model of Care

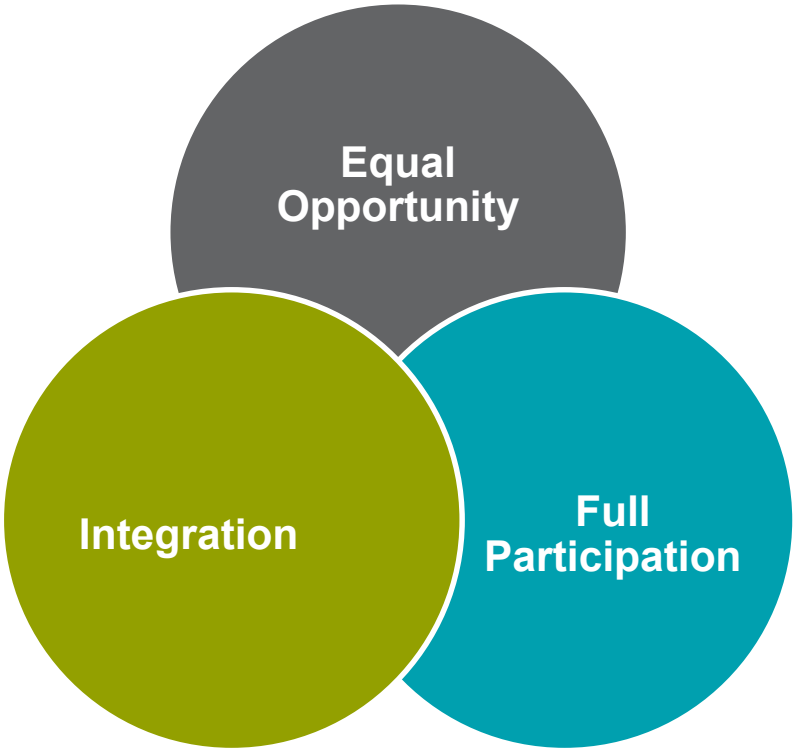
CMS guidelines require contracted Medicare medical providers to complete an annual basic training and attest to Molina: Molina's Dual Eligible Special Needs Plan (D-SNP) Model of Care.

- Find additional information at cms.gov, under Regulations & Guidance
- Under Guidance, select Manuals
- Then Internet-Only Manuals (IOMs)
- Select CMS 100-16 Medicare Managed Care Manual
- In Chapter 5 – Quality Assessment
- Select Section 20.2.1 – Model of Care Elements
- Then under 3. SNP Provider Network
- View C. MOC Training for the Provider Network

View the Molina Model of Care Training and Attestation Form on the Medicare Provider Website, under the "Model of Care" header.

Americans with Disabilities Act (ADA)

The Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities, including discrimination that may affect employment, public accommodations (including health care), activities of state and local government, transportation, and telecommunications. The ADA is based on three underlying values:



Compliance with the ADA extends, expands, and enhances the experience for **ALL** Americans accessing health care and ensures that people with disabilities will receive health and preventive care that offers the same full and equal access as is provided to others.

For more information view the "Molina Provider Education Series" on the "Culturally and Linguistically Appropriate Resources/Disability Resources" page on the Provider Website.

Anti-Discrimination Regulations

Molina complies with Title VI of the Civil Rights Act, the ADA, Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA), and other regulatory/contract requirements

Compliance ensures the provision of linguistic access and disability-related access to all members, including those with Limited English Proficiency (LEP) and members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability

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

For more information view the “Nondiscrimination of Health Care Services Delivery” section of the Provider Manual at MolinaHealthcare.com.

Ownership and Control Disclosure Form

Providers are required to complete the Ownership and Control Disclosure Form during the contracting process and re-attest every 36 months during the recredentialing process, or at any time disclosure needs to be made to the plan.

Providers who are contracted through a group affiliation should fill out the form at the group level. If a provider is contracted as an individual or independent provider, the form should be filled out at the provider level.

Providers are required to disclose any changes in Ownership and Control information in accordance with:

- 42 CFR 455.104 Disclosure by Medicaid Providers and Fiscal Agents: Information on Ownership and Control
- 42 CFR 455.105 Disclosure by Providers: Information Related to Business Transactions
- Ohio Revised Code (OAC) 5160-1-17.3 Provider Disclosure Requirements
- 42 CFR 438.230 Subcontractual Relationships and Delegation

The Ownership and Control Disclosure Form is available at MolinaHealthcare.com.

Fraud, Waste, and Abuse

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. Molina maintains a comprehensive plan, which addresses how Molina will uphold and follow state and federal statutes, and regulations.

For more information read the "Fraud, Waste, and Abuse" section of our Provider Manual at MolinaHealthcare.com. Information includes:

- Introduction and Mission Statement
- Definitions
- Regulatory Requirements
- Examples of Fraud, Waste, and Abuse by a Member
- Examples of Fraud, Waste, and Abuse by a Provider
- Review of Provider Claims and Claims System
- Prepayment Fraud, Waste, and Abuse Detection Activities
- Post-payment Recovery Activities

Do you have suspicions of member or provider fraud? The **Molina AlertLine** is available 24-hours a day, 7 days a week, and even on holidays at (866) 606-3889. Reports are confidential, but you may choose to report anonymously.

Member Advance Health Care Directives (Advance Directives)

Advance Directives are documents that state a member's wishes about receiving medical care and/or end-of-life care choices if the member is no longer able to make medical decisions due to serious illness or injury.

Anyone 18 years old or older who is of sound mind and able to make their own decisions can complete the document(s).

Members can change an advance directive whenever they want. It is a good idea to look over advance directives from time to time to make sure they still represent the member's wishes and cover all areas.

Are written to follow state laws. A lawyer is not needed to complete an Advance Directive.

Many of the people and places that give medical care have advance directives forms. Members may also be able to get these forms from Midwest Care Alliance's website at: www.midwestcarealliance.org. When there are no Advance Directives, the member's family and provider will work together to decide the best care for the member based on the information known about the member's end-of-life plans.

Member Advance Health Care Directives (Advance Directives)

The four types of Advance Directives are Living Will, a Do Not Resuscitate (DNR), a Durable Power of Attorney for Health Care (Health Care Power of Attorney or Health Care Proxy), and a Declaration for Mental Health Treatment

A Living Will states how a member wants to use life-support methods to lengthen life. It takes effect only when they are in a coma that is not expected to end, beyond medical help with no hope of getting better and can't make wishes known, or they expected to die and are not able to make their wishes known.	A DNR is written by a doctor, or in certain circumstances, a certified nurse practitioner or clinical nurse specialist. It instructs providers against performing cardiopulmonary resuscitation (CPR). In Ohio, there are two types of DNR Orders: Comfort Care and Comfort Care – Arrest.	A Health Care Power of Attorney is limited to health care matters. It allows the member to choose someone to carry out their wishes for their medical care. The person acts if the member cannot act for themselves and can be for a short or a long time period.	A Declaration for Mental Health Treatment gives specific attention to mental health care. It allows members to appoint a representative to make decisions while they lack the capacity to do so. The declaration can set forth certain wishes regarding treatment.

Member Advance Directives, Continued

Provider Responsibilities for Advance Directives:		
Providers must inform adult Molina members over 18 of their right to make health care decisions and execute Advance Directives	PCPs must discuss Advance Directives with a member and provide appropriate medical advice if the member desires guidance or assistance	In no event may any provider refuse to treat a member or otherwise discriminate against a member because the member has completed Advance Directives
Molina network providers and facilities are expected to communicate any objections they may have to a member directive prior to service when possible: • Members may select a new PCP if the assigned provider has an objection to the member's desired decision • Molina will facilitate finding a new PCP or specialist	Ohio law includes a conscience clause. If a provider cannot follow an Advance Directive because it goes against their conscience, they must assist the patient in finding another provider who will carry out the patient's wishes • Patients have the right to file a complaint related to Advance Directives with the Ohio Department of Health	Providers are instructed to document the presence of Advance Directives in a prominent location of the Medical Record • Auditors will also look for copies of Advance Directives • Molina will look for documented evidence of the discussion between the Provider and the member during routine Medical Record reviews

Provider Training

MOLINA HEALTHCARE

Molina Provider Training Opportunities

The Molina Provider Services Team offers multiple standard trainings to the provider network throughout the year. Any of the standard trainings can be requested by a provider for one-on-one training.

Standard Network Training

- General Provider Orientation: Scheduled Monthly
- Cultural Competency Videos
- Model of Care Training
- Availity Training

Note: These provider trainings are available on the Molina Provider Website under the “Manual” tab for providers to access as needed.

Specialized Provider Orientation

- Transportation Services: Covered Services, billing information, and resources
- Nursing Facility and Assisted Living: Covered services, billing information, and resources
- Claims and Billing: Key billing guidelines, modifiers, and general resources
- Health Care Services: Authorization Tools, Peer-to-Peers, supporting documentation, and reconsiderations

It Matters to Molina (IMTM) Forums

Molina offers It Matters to Molina (IMTM) Forums throughout the year. View upcoming trainings on the It Matters to Molina page.

Additional training presentations are available on the “It Matters to Molina” page, under “Molina Presentations,” and include previous It Matters to Molina (IMTM) Forums, Cultural Competency, and Model of Care.

- IMTM Open Forum for Questions and Answers
- IMTM Pregnancy Related Services Billing
- IMTM PEGA and Availity
- IMTM Molina Website Navigation
- IMTM Cost Recovery

Contact Molina

MOLINA HEALTHCARE

Frequently Used Email Addresses

Molina of Ohio Provider Services Contact Information:

Molina has designated email addresses based on provider types to help get your questions answered more efficiently or to connect you to training opportunities.

- Behavioral Health questions: BHProviderServices@MolinaHealthcare.com
- Hospital or hospital-affiliated physician group questions: OHProviderServicesHospital@MolinaHealthcare.com
- MyCare Ohio LTSS and Medicaid Ancillary questions: OHMyCareLTSS@MolinaHealthcare.com
- Nursing Facilities questions: OHProviderServicesNF@MolinaHealthcare.com
- Physician practice questions: OHProviderServicesPhysician@MolinaHealthcare.com
- General questions: OHProviderRelations@MolinaHealthcare.com

For additional contact information view the “Contact Information” section of the Provider Manual, located at MolinaHealthcare.com.

Molina Provider Training Survey

The Molina Provider Services Team hopes you have found this training session beneficial.

Please take a few minutes to complete the Molina Provider Training survey to provide feedback on this session.

The survey is located on the It Matters to Molina Page of our Provider Website, under the “Communications” tab.

Molina wants to hear about what other topics you’d like training on in the future.

Please share your feedback with us so we can continue to provide you with excellent customer service!