PASSPORT
BY MOLINA HEALTHCARE

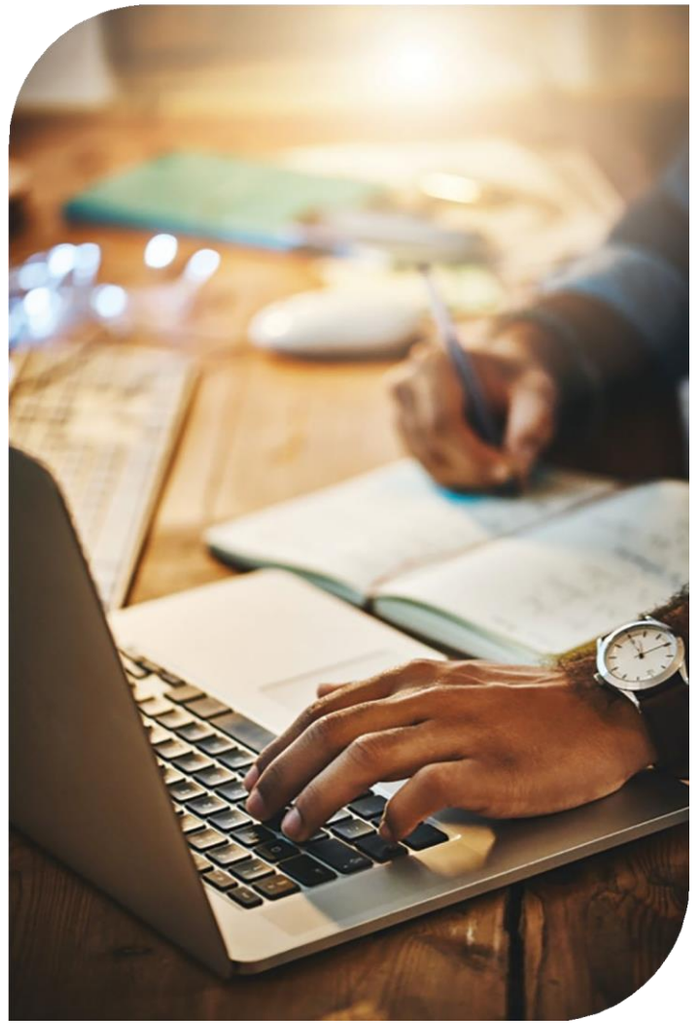
Provider Orientation

2026 | Provider Services

MHKY 2920 APP 03/23/2026 WZ 24867

Agenda

- Who We Are
- Member Rights and Responsibilities
- Provider Roles and Responsibilities
- Integrated Care Model
- Provider Tools and Resources
- Billing and Claims Information
- Healthcare Services
- Quality
- Dental, Vision and Pharmacy
- Compliance



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Who We Are

About Passport by Molina Healthcare

Our mission

To improve the health and lives of our members by delivering high-quality health care.

Our vision

We will distinguish ourselves as the low cost, most effective and reliable health plan delivering government-sponsored health care.

Our values

- Integrity Always
- Absolute Accountability
- Supportive Teamwork
- Member and Community Focused
- Honest and Open Communications

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The Molina Story

In 1980, the late **Dr. C. David Molina** founded Molina Healthcare with a single clinic and a commitment to provide quality healthcare to those most in need and least able to afford it.

Molina is a mission-driven health care company dedicated to delivering effective, reliable, and affordable health care to those who need it most. We believe every person, family and community deserves access to high-quality health care regardless of their situation. We strive to meet the physical, social, and emotional needs of each member and to strengthen the communities we serve. We do this by offering a holistic, community-based approach designed specifically to meet the individual needs of our members.

This commitment to providing access to quality care continues to be our mission today, just as it has been for the last 40 years.

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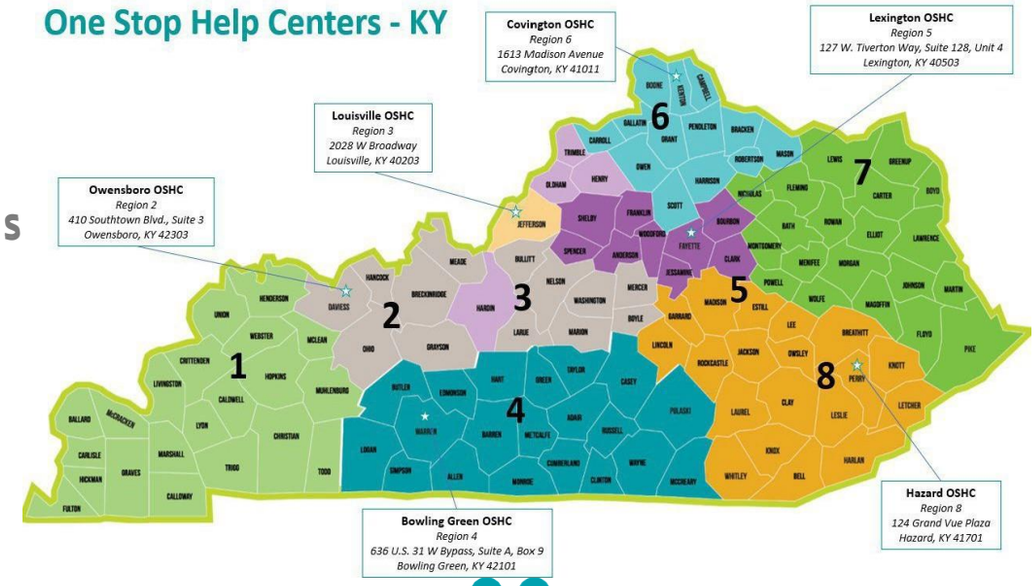
One-Stop Help Centers

To ensure our Enrollees benefit from local healthcare, resources, and supports, Passport has opened ***six One-Stop Help Centers*** across Kentucky available for member and provider walk-ins and serves as community resource centers focused on assisting with any member healthcare-related need.

The One-Stop Help Centers will aid providers, too. Providers can call or stop by a regional center to ask questions face-to-face; register complaints; receive training, education, and documentation; and attend meetings, as needed.

- Training, education, and access to programs and CBOs
- Free Wi-Fi, meeting rooms, ADA compliant, telehealth capabilities
- Enrollee and provider walk-ins welcome
- Face-to-face healthcare-related assistance



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Passport by Molina Healthcare
Lines of Business

Health Plans

Molina Medicaid

Molina Healthcare contracts with state governments to provide a wide range of quality health care services to families and individuals who qualify for government-sponsored programs, including Medicaid and the State Children's Health Insurance Program (SCHIP).

Molina Medicare

Molina Healthcare offers Medicare Advantage plans designed to meet the needs of individuals with Medicare or both Medicare and Medicaid coverage.

Integrated Medicaid/Medicare (Duals)

Molina Healthcare is a leader for the Medicare-Medicaid plans program as part of a member-centered health care approach for people who are eligible for both Medicaid and Medicare. We have been working with these members through our Medicaid and Medicare plans (MMPs) for many years, and this experience helps us provide these members with high-quality care that meets their unique needs.

Molina Marketplace

Molina Healthcare offers Marketplace (known as the Exchange in some states) plans in many of the states where we offer Medicaid health plans. Marketplace plans provide highly subsidized commercial coverage for people whose incomes make them ineligible for Medicaid and who don't have access to health insurance through their employment. Our plans allow our Medicaid members to stay with their providers as they transition between Medicaid and the Marketplace. Additionally, they remove financial barriers to quality care and keep members' out-of-pocket expenses to a minimum.

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Medicaid

Members Eligible for Medicaid Enrollment

To be enrolled with Passport, the individual shall be eligible to receive Medicaid assistance under one of the aid categories defined below:

- Temporary Assistance to Needy Families (TANF)
- Children and family related
- Aged, blind and disabled Medicaid only, receiving State Supplementation or receiving Supplemental Security Income (SSI)
- Pass through
- Poverty-level pregnant women and children including Presumptive Eligibility
- Under the age of 21 years and in an inpatient psychiatric facility
- Children under the age of 18 who are receiving adoption assistance and have special needs
- Dual eligible
- Disabled children
- Adults ages 19-64 with income under 138% of the Federal Poverty Limit (FPL)
- Former foster care children up to age 26

Members eligible to enroll with Passport will be enrolled beginning with the first day of the application month with the exception of (1) newborns who are enrolled beginning with their date of birth and (2) presumptively eligible (PE) Members who are eligible on their day of eligibility determination and (3) unemployed parent program Members who are enrolled beginning with the date the definition of unemployment or underemployment in accordance with 45 C.F.R. 233.100 is met. Presumptively Eligible Members will be added to Passport's Member Listing Report with an Enrollment date equal to the eligibility date described in (2) above. Please note, eligibility is determined by The Department for Medicaid Services.

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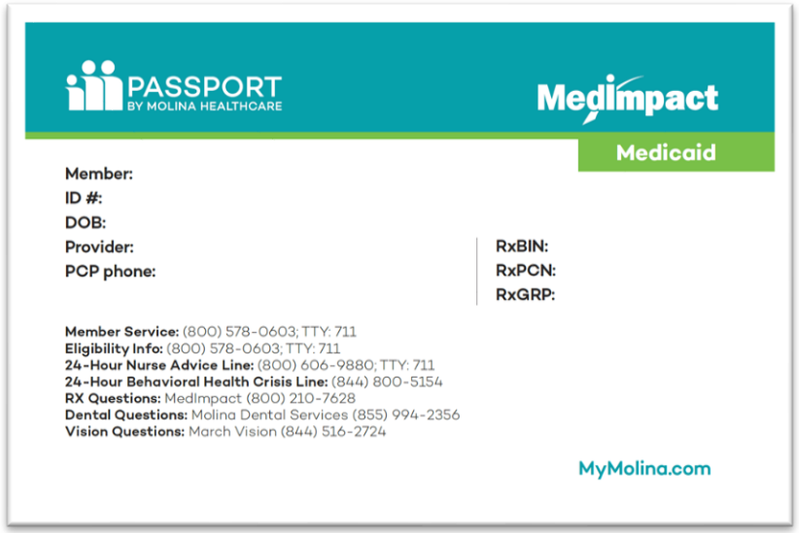
Passport Medicaid Member Identification Card



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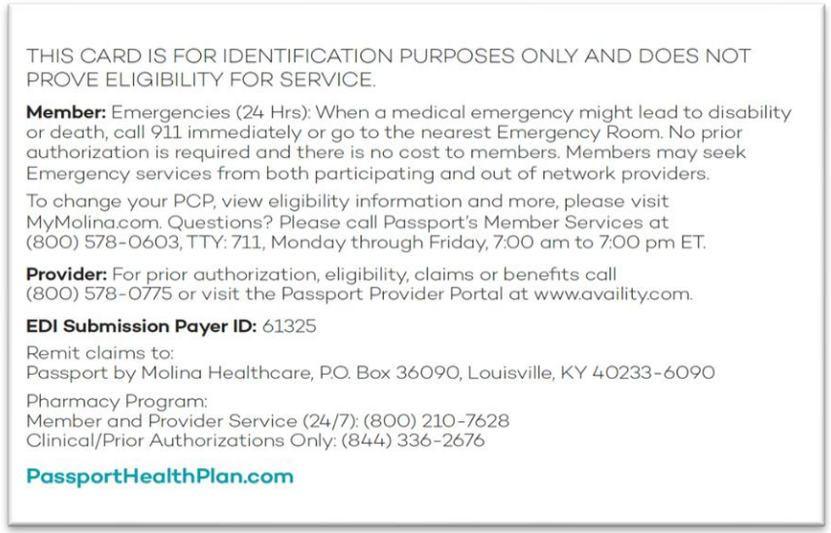

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Medicaid Member Resources

Passport is committed to providing our members with the best service possible. Members may reach out to us directly via our local, knowledgeable Member Services Team, find a provider in our online, searchable Provider Directory, review their information in the Member Portal, available 24/7, or visit our website for a copy of the Member Handbook and much more.

Member Services:
(800) 578-0603 / TDD / TTY 711
Monday – Friday 7a.m - 7p.m EST

Provider Online Directory:
PassportHealthPlan.com

Member Portal:
MyPassportHealthPlan.com
My Passport Health (Available in mobile app stores)

Member Handbook:
PassportHealthPlan.com

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Medicaid Benefits

Member benefits include, but are not limited to:

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic and Treatment Services
- Nursing facility Services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse midwife services
- Certified pediatric and nurse practitioner services
- Freestanding birth center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

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Medicaid 2026 Value Added Benefits for Members

Reward type: General wellness

The details	Who's eligible	The value
Complete a Health Risk Assessment (HRA)*	All members	$25 gift card credit
Have an annual adult preventative screening visit*	All members ages 22 & older	$25 gift card credit
Have an annual young adult wellness visit	Members ages 13 - 21	$50 gift card credit
Have an annual well-child visit*	Members ages 3 - 12	$25 gift card credit
Have up to 8 well-child visits on time*	Members birth - 30 months old	$10 gift card credit PER VISIT (max $80 gift card credit)
Complete an annual dental exam*	All members	$50 gift card credit
Get a colon cancer screening test* (Frequency dependent on specific screening test received)	Members ages 45 - 75	$25 gift card credit
Have a follow-up visit within seven days of an inpatient stay (no limits)*: • Medical stays go to PCP • Behavioral health stays go to behavioral health provider or PCP	All members	$50 gift card credit
Participate in Behavioral Health Case Management Engagement*	Members <21 yrs old enrolled in the SMI/SED CM Care Model who stay engaged 90 days	$25 gift card credit

For more member benefits and rewards information, click here!

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Medicaid 2026 Value Added Benefits for Members

Reward type: Diabetes

The details	Who's eligible	The value
Have a yearly diabetic retinal eye exam*	Members with diabetes ages 18 - 75	$50 gift card credit
Complete a yearly HbA1c test*	Members with diabetes ages 18 - 75	$50 gift card credit
Complete Diabetes Self Management Education & Support (DSMES) classes*	All members with diabetes type 1 or 2	$25 gift card credit

Reward type: Women's health

The details	Who's eligible	The value
Have a yearly mammogram*	Female members ages 40–74**	$25 gift card credit
Get a yearly pap test*	Female members ages 21–64**	$25 gift card credit
Get a yearly chlamydia screening*	Female members ages 16–24**	$25 gift card credit

For more member benefits and rewards information, click here!

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Medicaid 2026 Value Added Benefits for Members

Reward type: Maternal health

The details	Who's eligible	The value
Go to a prenatal visit during the first trimester or within 42 days of enrollment*	Pregnant moms ages 12 & older	$100 maternity gift card credit
Attend one postpartum visit 7–84 days after the birth of a baby*	New moms	$50 maternity gift card credit

Reward type: Vaccines/immunizations

Up to $190 in gift card credits for members who complete the following vaccine series* on or before child's 2nd birthday (provider attestation required)*:

• Rotovirus ($10) • Hep A ($10)	• Heb B ($10) • Tdap ($10) • Hib ($10)	• PCV ($10) • MMR ($10)	• Varicella ($10) • Polio ($10)	Influenza ($100) • 1st shot ($50) • 2nd shot ($50)

Up to $100 in gift card credits for members who complete the HPV vaccine series:

• 1st HPV, between ages 9-12 years ($50)	• 2nd HPV, between ages 9-12 years ($50)

Reward type: Other rewards

Stay connected and opt-in to email/text reminders as the head of household* ($10 gift card credit)

For more member benefits and rewards information, click here!

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Medicaid 2026 Value Added Benefits for Members

Value Added Benefit **Reward type: Free phone/data**

The details	Who's eligible	The value
A FREE cellphone with unlimited talk, text & data	All members 18 years and older	Free – no cost!
A FREE cellphone with unlimited talk, text & data	Members 16-17 who are : • Pregnant; or • Have a shelter address	Free – no cost!

Value Added Benefit **Reward type: Weight Watchers**

The details	Who's eligible	The value
Get up to 13 weeks of weight watchers digital program free. Members must have approval from their doctor, an email address, and a computer or smart device with internet access.	Members 18 years and older who are approved by their doctor and meet BMI requirements.	$40 value

Value Added Benefit **Reward type: GED**

The details	Who's eligible	The value
Vouchers to take the GED test free at testing centers and a gift card credit if you pass the exam.	Members ages 18 & older	Exam voucher (up to $120 value) and $50 gift card credit for passing

Value Added Benefit **Reward type: Asthma management**

The details	Who's eligible	The value
Members who sign up and complete the 3-month asthma disease management Breathe With Ease® Program	All members in the asthma disease management program	Mattress cover: $60 value Pillow cover: $20 value

For more member benefits and rewards information, click here!

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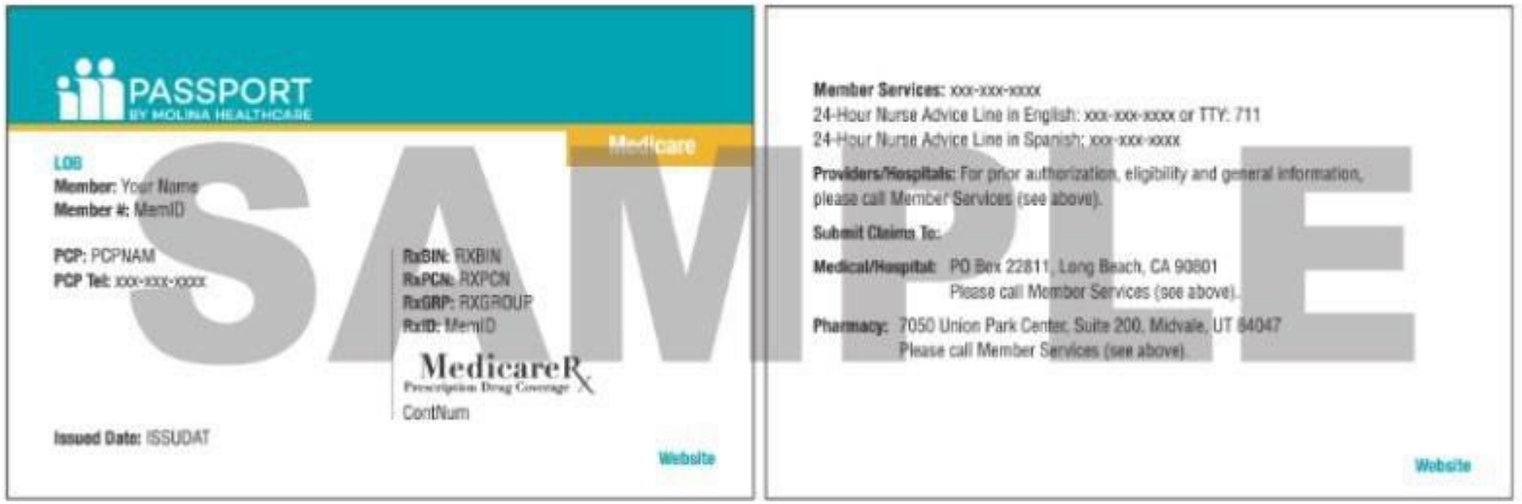
Passport Advantage

Passport Advantage Member Identification Card

Passport Advantage (HMO-SNP) Dual Eligible Special Needs Plan (D-SNP) is designed for beneficiaries who are eligible for both Medicare and Medicaid (dual eligible).

This plan offers all services covered by Original Medicare Parts A and B, prescription drug coverage, and more.

Member identification card example – medical services



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Passport Advantage Member Resources

Passport is committed to providing our members with the best service possible. Members may reach out to us directly via our local, knowledgeable Member Services Team, find a provider in our online, searchable Provider Directory, review their information in the Member Portal, available 24/7, or visit our website for a copy of the Member Handbook and much more.

Member Services:
(844) 859-6152 / TDD/TTY 711
7 days a week 8a.m-8 p.mEST

Provider Online Directory:
Passport Provider Oneline Directory

Member Portal:
MyPassportHealthPlan.com
My Passport Health (Available in mobile app stores)

Member Handbook:
PassportHealthPlan.com

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Marketplace

Marketplace

Health Insurance Marketplace (HIM)

The Health Insurance Marketplace (also known as the Exchange) is a one-stop shop for low-cost health insurance.

Depending on the consumer's income, the government covers part of the cost of Marketplace insurance. Molina Healthcare offers Marketplace plans in eight states.

The Marketplace is an outcome of the Affordable Care Act – more commonly known as health care reform or Obamacare.

On the Marketplace, consumers can look at the insurance options available to them all in one place.

Marketplace was created as a simple way for individuals and small businesses to buy affordable health care coverage.

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Marketplace Plans

- Constant Care Silver: Plans with the lowest costs for doctor visits and urgent care.
- Confident Care Gold: Plans with lower costs for expenses like doctor visits and out-of-pocket cost; generally higher premiums.

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

- Availity Portal at Availity.com
- Passport Provider Contact Center automated IVR system at (800) 578-0775.

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Marketplace Plans

Plans are standardized and cover the same benefits, but vary by level of copay, coinsurance, deductible and subsidy.

GOLD PLANS

- Ideal for mid-to-high earners
- Closely resembles employer-sponsored coverage

SILVER PLANS

- Ideal for low income as it is the closest to Medicaid
- Receives the most federal subsidy to cover the monthly premiums, copays, coinsurance, and deductible

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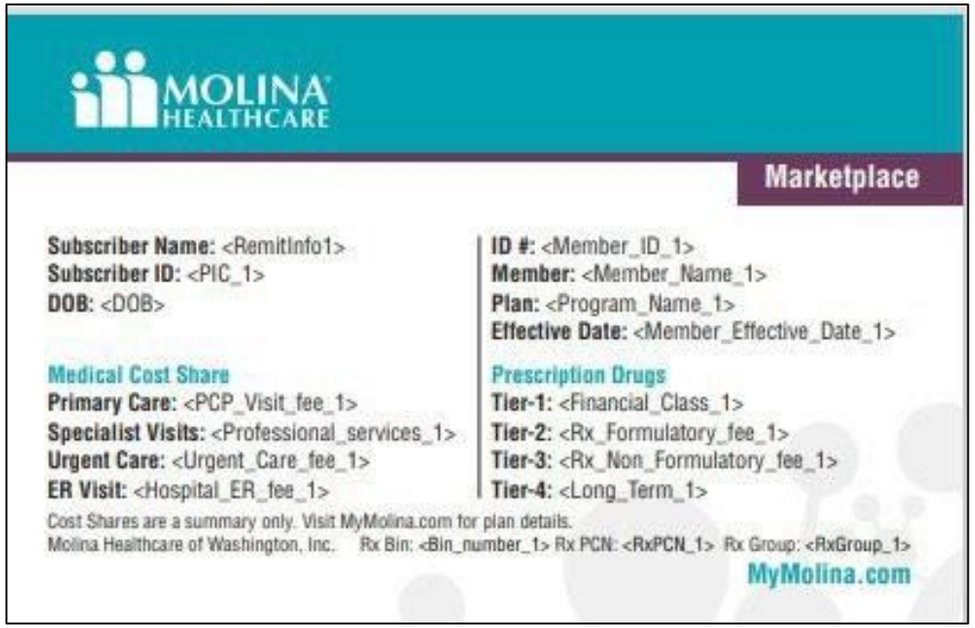
Marketplace Member Identification Card



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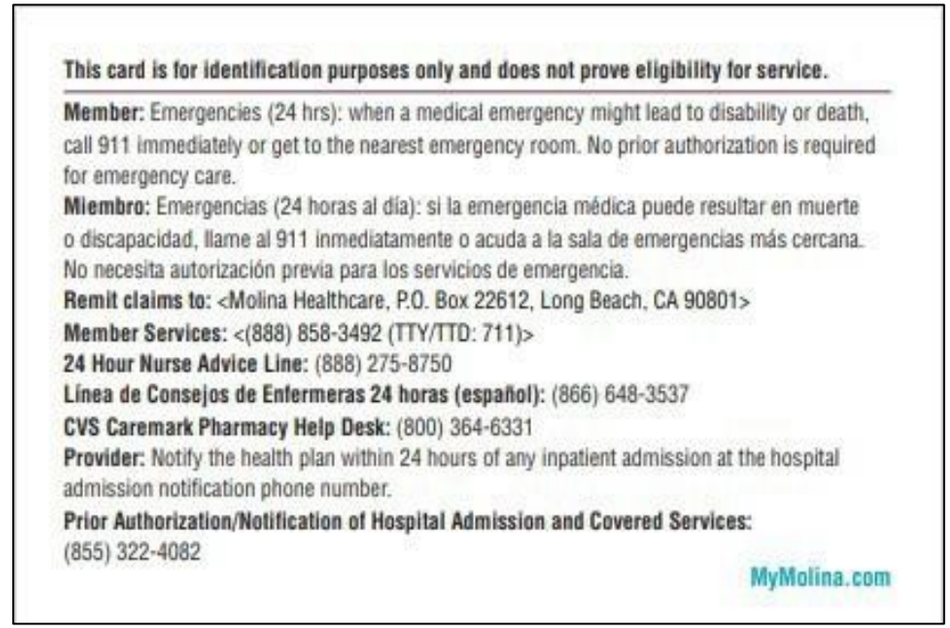

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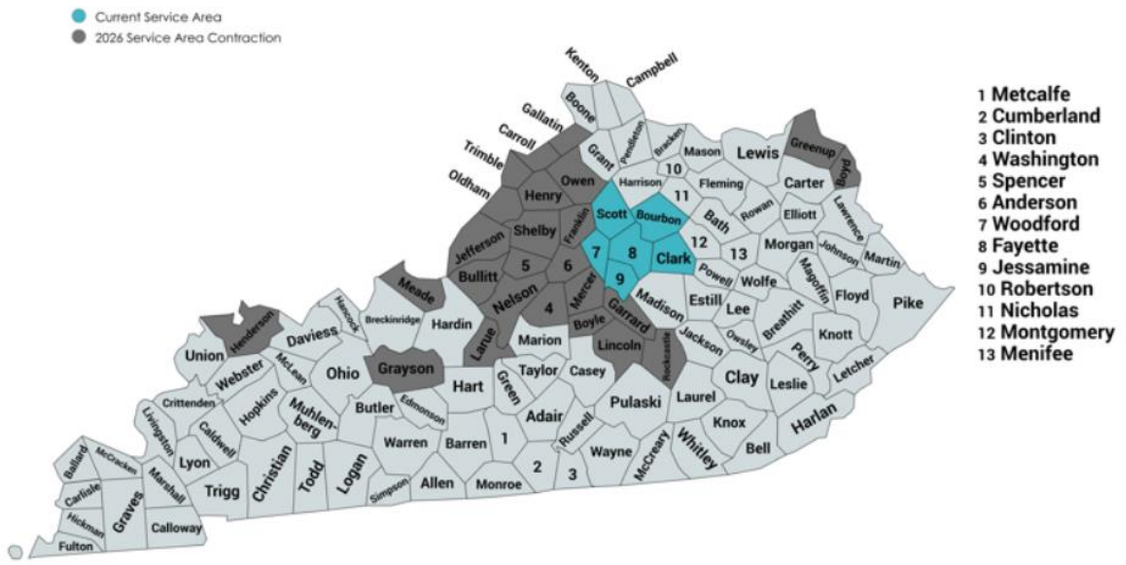
Marketplace Member Eligibility Service Area

Available Counties		
Anderson	Grayson	Nelson
Boyd	Greenup	Oldham
Boyle	Henderson	Owen
Bullitt	Henry	Rockcastle
Carroll	Jefferosn	Scott
Clark	Jessamine	Shelby
Fayette	Larue	Spencer
Franklin	Lincoln	Trimble
Gallatin	Meade	Washington
Garrard	Mercer	Woodford



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Marketplace Cost Sharing

Cost sharing is the deductible, copayment, or coinsurance that members must pay for covered services provided under their Passport Marketplace plan.

Cost sharing applies to all covered services, except preventive services, included in the Essential Health Benefits (as required by the Affordable Care Act).

It is the provider's responsibility to collect the copayment and cost share from the member to receive full reimbursement for a service.

The amount of the copayment and other cost sharing will be deducted from the Passport payment for all claims involving cost sharing.

Note! Balance billing a Passport Member for Covered Services is prohibited, other than for the Member's applicable copayment, coinsurance and deductible amounts.

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Marketplace Required Benefits

All Qualified Health Plans (QHP) must include the following 10 categories of Essential Health Benefits (EHB) defined by ACA:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity & newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Laboratory services
- Pediatric services, including oral and vision care
- Prescription drugs
- Rehabilitative and habilitative services
- Preventive and wellness services, and chronic disease management

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Marketplace Member Resources

Passport is committed to providing our member's with the best service possible. Members may reach out to us directly via our Member Services Team, find a provider in our online, searchable Provider Directory, review their information in the Member Portal, available 24/7 or visit our website for a copy of the Member Evidence of Coverage and much more.

Member Services:
1(833) 644-1621 / TDD/TTY 711
Monday – Friday 8:00 AM – 6:00 PM EST

Provider Online Directory:
Passporthealthplan.com/Marketplace > Members > Find a Doctor

Member Portal:
MyPassportHealthPlan.com
Passporthealthplan.com/Marketplace > Members > Member Resources > My Passport Health Plan

Member Evidence of Coverage:
Passporthealthplan.com/Marketplace > Members > Forms and Documents

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Behavioral Health
All Lines of Business

Behavioral Health

Under Passport, the following levels of care are covered, provided that the services are medically necessary, delivered by in-network providers, and proper authorization requirements are followed. DSM-5 and ASAM criteria should be used when assessing members for services and documented in the member's medical records.

Covered Services include:

- Inpatient mental health
- Crisis stabilization
- Emergency room visits
- Medical detoxification
- Psychiatric residential treatment facilities (PRTF) for ages 6-21 only
- Extended care Units (ECU) (EPSDT expanded services throughage 21 only)
- Residential substance use disorder services
- Outpatient Substance use disorder services
- Outpatient mental health services
- Electro-conclusive therapy (ECT)
- Transcranial Magnetic Stimulation
- Psychological and neuropsychological testing
- Community based outpatient services
- Behavioral health and substance use disorder EPSDT special service (up to age 21)
- Mobile crisis
- Community wrap around services
- Residential crisis stabilization
- Assertive community treatment (ACT)
- Peer support
- Parent training
- Wellness recovery support/crisis planning
- Crisis intervention
- Adults are covered on a psych unit affiliated with a hospital
- Free-standing psychiatric facilities only cover members under 21 and over 65 years of age for up to 15 calendar days per month for mental health services; services for SUD at free standing psychiatric facilities are covered as long as medical necessity is met
- Medication Assisted Treatment

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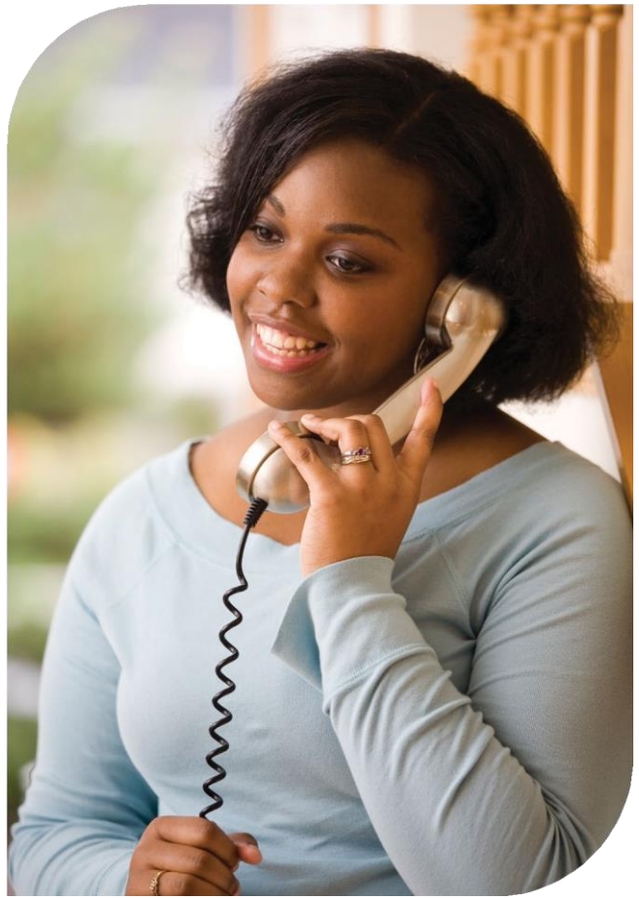
24/7 Nurse Advice Line & Behavioral Health Crisis Line

This telephone-based Nurse Advice Line is available to all Passport members. Members may call anytime they are experiencing any type of symptoms or need health care information. Registered nurses are available twenty-four (24) hours a day, seven (7) days a week to assess symptoms and help make good health care decisions.

The Behavioral Health Crisis Line is available for members who may be experiencing a behavioral health crisis or emergency twenty-four (24) hours a day seven (7) days a week.



	Medicaid	Medicare	Marketplace
Nurse Advice Line	(800) 606-9880 TTY/TDD 711	(800) 606-9880 TTY/TDD 711	(833) 644-1622 TTY/TDD: 711
Behavioral Health Crisis Line	(844) 800-5154	(844) 859-6152	(844) 800-5154

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Member Rights & Responsibilities

Member Rights and Responsibilities

As a Passport member, you are entitled to certain rights and services. You also have a responsibility to be an active participant in your health care. A good partnership between you and your health care provider(s) will improve our ability to provide appropriate services and your ability to receive the most benefit from the services. Here is a summary of your rights and responsibilities as a member:

Passport members have the right to:

- Respect, dignity, privacy, confidentiality, accessibility, and non-discrimination
- A reasonable opportunity to choose a Primary Care Provider (PCP) and to change to another Provider in a reasonable manner
- Consent for or refusal of treatment and active participation in decision choices
- Ask questions and receive complete information relating to your medical condition and treatment options, including Specialty Care
- Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and request a State Fair Hearing from Passport and/or the Department for Medicaid Services
- Timely access to care that does not have any communication or physical access barriers
- Prepare Advance Medical Directives
- Assistance with Medical Records in accordance with applicable federal and state laws
- Timely referral and access to medically indicated Specialty Care
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Receive information in accordance with 42 C.F.R. 438.10
- Be provided covered health care services
- Any Native American Indian, that is eligible to receive services from a participating I/T/U provider or an I/T/U Primary Care Provider (PCP), shall be allowed to receive services from that provider if part of Passport's Network (Indian Health Services, Tribally operated facility/program, and Urban Indian clinics)

Additionally, as a Passport member you have the right to request and obtain the information listed here annually. Additionally, any change in the information listed here will be communicated at least thirty (30) days before the intended affective date of a change:

- Names, locations, telephone numbers of (and non-English languages spoken by) Providers in Passport's network, including identification of Providers that are not accepting new patients (Including at a minimum, information on PCPs, specialists, and hospitals)
- Any restrictions on freedom of choice among network Providers
- Any changes in covered services by Passport due to moral or religious objections and how to obtain the service
- Member rights and protections, as specified in 42 C.F.R. 438.100, including the freedom to exercise your rights without negatively affecting the way Passport, our providers or the State treat you and freedom from other discrimination prohibited by State and Federal regulations

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Member Rights and Responsibilities

- Information on the right to file grievances and appeals and procedures
- Information on a State Fair Hearing, including the right to the hearing, method for obtaining a hearing and rules that govern representation at the hearing
- Amount, duration, and scope of benefits available in sufficient detail to ensure understanding of the benefits to which you are entitled
- Procedures for obtaining benefits, including authorization requirements
- How you may obtain benefits, including Family Planning Services, from Out-of-Network Providers
- To receive detailed information on how after-hours and emergency coverage is provided
- Post-stabilization care services rules
- Passport's policy on referrals for Specialty Care and for other benefits not furnished by your PCP
- Copayment or cost-sharing if required
- How and where to access any benefits that are available under Medicaid, but are not covered by Passport
- Any appeal rights made available to Providers to challenge the failure of Passport to cover a service
- Upon request, information on the structure and operation of Passport and physician incentive plans
- Right to request and receive a copy of Medical Records and request that the records be amended or corrected

Passport members have the responsibility to:

- Become informed about your rights
- Abide by Passport and the Department for Medicaid's policies and procedures
- Become informed about services and treatment options
- Actively participate in personal health and care decisions and practice healthy lifestyles
- Report suspected Fraud & Abuse
- Keep appointments or call to cancel
- Never let anyone use your Passport ID card or Medicaid ID Card
- Promptly apply for Medicare or other insurance when you are eligible

These rights and responsibilities are posted at PassportHealthplan.com. Passport staff and providers will comply with all requests concerning your rights.

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Provider Rights and Responsibilities

Provider Rights

Providers have the following rights:

- Providers have the right to expect 90 % of Clean Claims to be paid within 30 days of receipt by Passport.
- Providers have the right to file a claims appeal regarding payment or contractual issues and expect timely processing and decision of that appeal by Passport.
- In the event of coordination of benefits, Providers have the right to compensation from Passport up to the allowable rate for covered services, minus any payments received from primary payer. (If the member's primary insurance pays less than Passport's allowable rate, Passport will reimburse the additional amount up to our allowable rate.)
- Providers have the right to expect Passport will ensure a Nurse Advice line is available to members 24 hours per day, 7days per week.
- Providers have the right to expect Passport will ensure a Behavioral Health Crisis line available to members 24 hours per day, 7days per week.
- Providers have the right to expect prompt and accurate member eligibility information from Passport via the Provider Portal and by phone.
- Providers have the right to receive a timely response to Prior Authorization requests; within 2 business days from receiving all required information for standard requests; and within 24 hours from receiving all needed information for expedited/urgent requests.

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Primary Care Provider (PCP) Responsibilities

PCPs have a responsibility to:

- Have screening and evaluation procedure for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders;
- Provide all needed initial, periodic and inter-periodic health assessments for a member under the age of 21 years, and shall be responsible for providing or arranging for complete assessments at the intervals specified in the Kentucky approved periodicity schedule and at other times when Medically Necessary;
- Discuss Advance Medical Directives with all Passport members as appropriate;
- Submit an encounter for each visit where the Provider sees the member, or the member receives a HEDIS® services;
- Maintaining continuity of the member's health care;
- Maintaining a current medical record for the member, including documentation of all PCP and Specialty Care services;
- Provide primary and preventive care, recommend or arrange for all necessary preventive health care, including EPSDT for members under the age of 21 years;
- Arrange and refer members when clinically appropriate, to behavioral health Providers; Make referrals for Specialty Care and other Medically Necessary services, both in and out of network, if such services are not available with Passport's network; and
- Ensure members use Network Providers. If assistance is needed in locating a participating Passport Provider, please contact Passport at (800) 578-0775.

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Primary Care Provider Responsibilities: Medicaid EPSDT

Passport ensures compliance with Kentucky law and/or regulation (907 KAR 11:034) that delineates the requirements of all EPSDT Providers participating in the Medicaid program.

- The members' Primary Care Provider (PCP) shall provide EPSDT services to all eligible members in accordance with EPSDT guidelines issued by the Commonwealth and Federal government and in conformance with the DMS approved periodicity schedule.
- The PCP shall provide all needed initial, periodic, and inter-periodic health assessments in accordance with 907 KAR 1:034.
- The PCP assigned to each eligible member shall be responsible for providing or arranging for complete assessments at the intervals specified by the commonwealth department's approved periodicity schedule and at other times when Medically Necessary.
- The PCP shall provide all needed diagnosis and referrals to treatment/treating Providers/specialists for eligible members in accordance with Kentucky law and/or regulations.
- The PCP and other Providers in Passport's network shall provide diagnosis and treatment or provide a referral to out-of-network Providers who shall provide treatment if the service is not available within Passport's network.
- The PCP shall maintain a consolidated record for each eligible member, including reports of informing the member and/or their family about EPSDT, information received from other Providers and dates of contact regarding appointments and rescheduling when necessary for EPSDT screening, recommended diagnostic or treatment services and follow-up with referral compliance and send Passport reports from referral physicians or Providers.
- PCPs providing EPSDT services shall submit an encounter record for each EPSDT service provided according to requirements provided by DMS, including use of specified EPSDT procedure codes, referral codes and the member and/or their family's acceptance or refusal for EPSDT services.

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Behavioral Health Provider Responsibilities

Behavioral Health Providers have a responsibility to:

- Send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the PCP, with the member's or the member's legal guardian's consent.
- Follow Quality standards related to access.
- Ensure all members receiving inpatient psychiatric services are scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location, and name of the Provider. This appointment must occur within 7days of the discharge date. If a member misses a behavioral health appointment, the Behavioral Health Provider shall contact the member within 24 hours of a missed appointment to reschedule.
- Assist members with accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.
- Participate in quarterly Continuity of Care meetings hosted by the commonwealth-operated or commonwealth-contracted psychiatric hospital and assist members for a successful transition to community supports.

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Maintaining Provider Demographic Data

Passport strives to maintain the highest quality of provider data possible by enforcing policies that require notification prior to important provider demographic changes. All demographic changes must be submitted to Passport within **30 days**.

Providers are required to submit notification of changes including, but not limited to:

- Change in office location(s), office hours, phone, fax, or email.
- Addition or closure of office location(s).
- Addition or termination of a Provider (within an existing clinic/practice).
- Change in practice name, Tax ID and/or National Provider Identifier (NPI).
- Opening or closing your practice to new patients (PCPs only).
- Any other information that may impact Member access to care.

Provider Demographic Update forms are located at PassportHealthPlan.com

For questions regarding provider enrollment activities please contact:

Phone:
(800) 578-0775

In Writing:
Molina Healthcare, Inc
Attn: Credentialing Dept.
P.O.Box 2470
Spokane,WA 99210

Fax#:
(833) 529-1081
Email:
contracting@passporthealthplan.com

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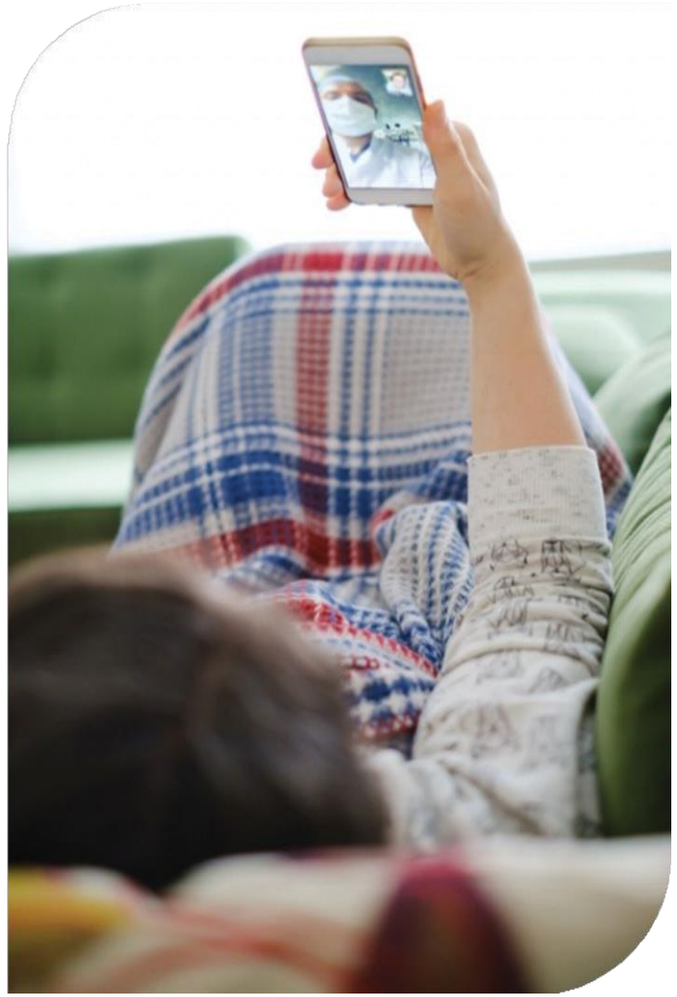
Telehealth Services

Passport Members may obtain Covered Services by Participating Providers through the use of Telehealth and Telemedicine services. Not all participating Providers offer these services. The following additional provisions apply to the use of **Telehealth and Telemedicine services**:

- Services must be obtained from a participating Provider.
- Services are meant to be used when care is needed now for non- emergency medical issues.
- Services are a method of accessing Covered Services, and not a separate benefit.
- Services are not permitted when the Member and Participating Provider are in the same physical location.
- Services do not include texting, facsimile or email only.
- Services include preventive and/or other routine or consultative visits during a pandemic.
- Covered Services provided through Store and Forward technology, must include an in-person office visit to determine diagnosis or treatment.



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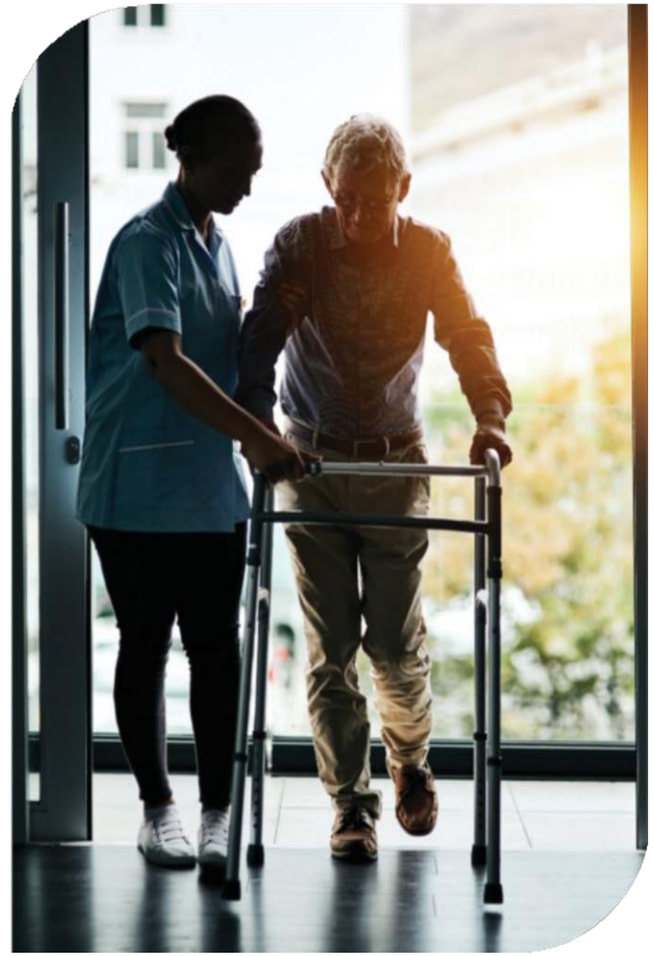
Advance Directives



Living will, living will directive, advance directive and directive are all terms used to describe a document that provides directions regarding health care decisions to the provider or to the person executing the document. In Kentucky, advance directives are governed by the Kentucky Living Will Directive Act.

In addition to reviewing the Kentucky Living Will Directives Act, providers should:

- On the first visit, as well as during routine office visits when appropriate, discuss the member's wishes regarding advance directives for care and treatment
- Document in the member's medical record the discussion and whether the member has executed an advance directive
- If asked, provide the member with information about advance directives
- Upon receipt of an advance directive from the member, file the advance directive in the member's record
- Not discriminate against a member because they have not executed an advance directive
- Communicate to the member if the provider has any conscientious objections to the advance directive as indicated above

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Continuity & Coordination of Care between Medical and Behavioral Health Care

- PCPs are expected to ensure appropriate screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems, including substance misuse or substance use disorder. PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, behavioral health providers may provide physical health care services if and when they are licensed to do so within the scope of their practice. For additional information on addressing BH needs in medical settings please see the Behavioral Health and Primary Care Provider Care Coordination training.

- Ongoing coordination of care between PCPs and behavioral providers is expected to ensure best outcomes for members; consent to collaborate with behavioral health providers should be obtained at time of referral and any changes in status should be communicated to the behavioral health provider by the PCP. For members who are receiving behavioral health services, Passport similarly requires that these providers obtain consent to share information with the PCP and then submit to the PCP an initial and quarterly summary report of the member's behavioral health status. Any other changes in member status should be communicated to the PCP in a timely manner.

- We encourage behavioral health providers to pay particular attention to communicating with PCPs at the time of discharge from an inpatient hospitalization. Passport strongly encourages open communication between PCPs and behavioral health providers.

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Primary Care –Member Assignment and Dismissals

Passport encourages members to choose their own PCP upon enrollment. Members will be assigned to an individual practitioner as their PCP.

A PCP may dismiss a Member from his/her practice under following circumstances:

- Incompatibility of the PCP/patient relationship
- Member has not utilized services in one (1) year of enrollment in the PCP's practice and the PCP has documented unsuccessful contact attempts by mail and phone on at least six (6) occasions during the year
- Inability to meet the medical needs of the member.

PCP Member Dismissals must be submitted to Passport using the PCP Member Dismissal Form

If	Then
Passport auto-assigned the member to the PCP and the member calls within the first month of membership with Passport…	The change will be backdated to the first (1st) of the current month.
The member contacts Passport to change their PCP due to other circumstances…	The change will be effective on the date was requested.

Note! This does not apply to members in the Lock-In Program.

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Preventive Health Guidelines

Preventive health guidelines can be beneficial to the provider and his/her patients. Guidelines are based on scientific evidence, review of the medical literature, or appropriately establishes authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations.

- For more information on our 2025 Medicaid Preventive Health Guidelines, click here.
- For more information on the 2025 Marketplace Preventive Health Guidelines, click here.
- For more information on our 2025 Medicaid Clinical Practice Guidelines, click here.
- For more information on our 2025 Marketplace Clinical Practice Guidelines, click here.

Visit PassportHealthPlan.com or PassportHealthPlan.com/Marketplace and click on Health Resources under the Health Care Professionals tab for more important information.

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Behavioral Health Discharge Planning

Behavioral Health Service Providers must assign a case manager prior to or on the date of discharge and provide basic, targeted or intensive Case Management services as Medically Necessary to Enrollees with SMI and co-occurring conditions who are discharged from an inpatient or residential stay for patients with SMI.

The Case Manager and other identified Behavioral Health Service providers shall also participate in Discharge Planning meetings to ensure compliance with Federal Olmstead and other applicable laws. Appropriate Discharge Planning shall be focused on ensuring needed supports and services are available in the least restrictive environment to meet the Enrollee's behavioral, and physical health and identified SDoH needs, including psychosocial rehabilitation and health promotion.

Appropriate follow up by the Behavioral Health Service Provider shall occur to ensure the community supports are meeting the needs of the Enrollee discharged from a state operated or state contracted psychiatric hospital. Passport will assist Behavioral Health Service Providers to ensure patients can access free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.

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Medicare 2026 Model of Care Training Required

Passport along with the Centers for Medicare and Medicaid Services require all medical providers contracted with Passport Advantage (DSNP) and Passport Medicare Choice (MAPD) to complete the annual Model of Care training. Training should be completed within 90 days of effective date with the Plan. We offer both virtual and in person trainings.

Virtual Training

- Training is available on our website or by accessing the below quick links. Please be sure to complete the attestation at the end of the training to ensure your office receives credit.
- Model of Care Provider Training Quick Reference Guide
- Model of Care Provider Training
- Model of Care Attestation
- MOC Training Deck 2025 - Molina Healthcare

In Person Training

- You may request an in-person or virtual Model of Care training for your office by contacting your Provider Services Representative.

Completed Attestation(s) can be submitted via email to PassportAdvantage.AnnualTraining@molinahealthcare.com or faxed to (502) 585-6060.

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Integrated Care Model

Integrated Care Model

Passport's Integrated Care Management Model is a non-delegated model that is managed in-house and focused on whole-person care.

Non-delegated

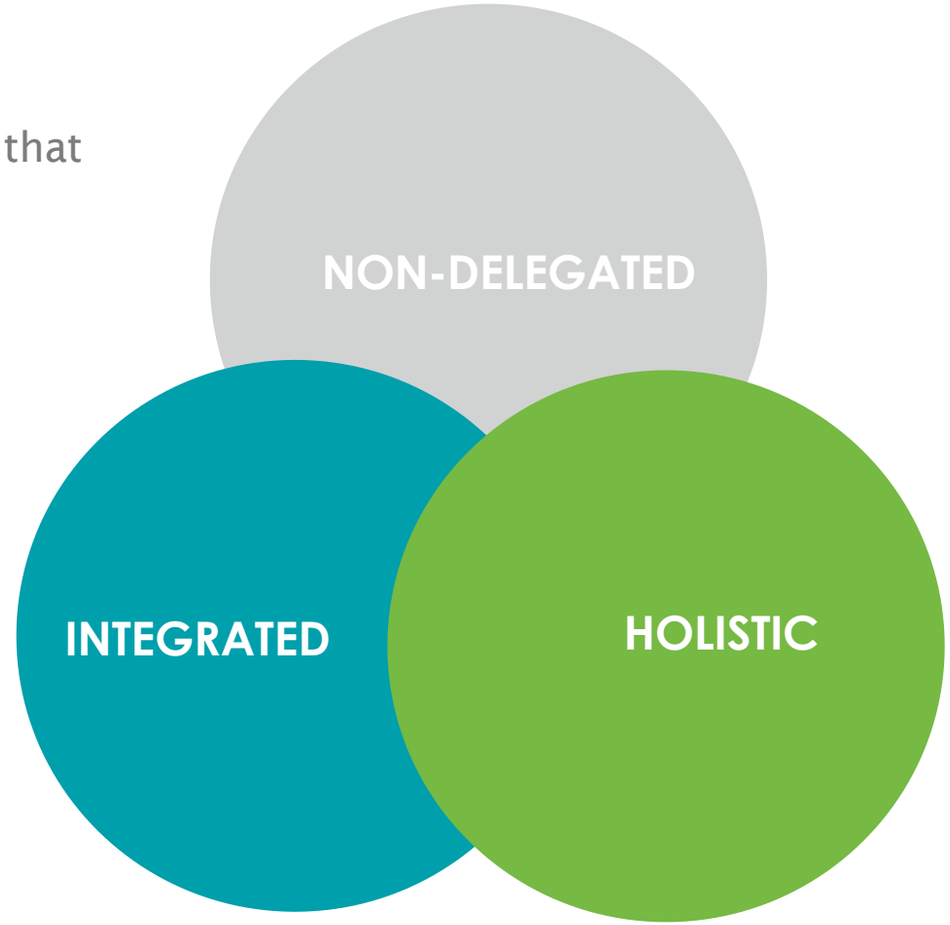
Passport does not outsource BH to an outside entity

Whole-person care

Passport supports a person-centered, evidence-based, trauma-focused and recovery-oriented model

Integrated principles

- Early intervention
- Evidence-based
- Seamless transition
- Recovery-oriented framework
- Innovation/Technology



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Integrated Care Coordination

Integrated UM and CM teams consult and collaborate during multi-specialty rounds.

Integrated BH and PH review teams, composed of Psychiatrists and Psychiatric Nurse Practitioners, RN reviewers.

Follows member post discharge and coordinates after care with PCPs.

Community specialists including housing specialists and peers with lived experience. Assists with effective transition in the community

Clinical SW and Professional counselors. Includes BH Professionals and RNs for members with BH primary case management needs. Provides assistance in healthcare access, advocacy & coordination.

Multidisciplinary teamworks together to identify trends in member needs and works to address health from both an aggregated and tailored, member level.

Regular integrated team meetings to ensure effective communication and coordination.

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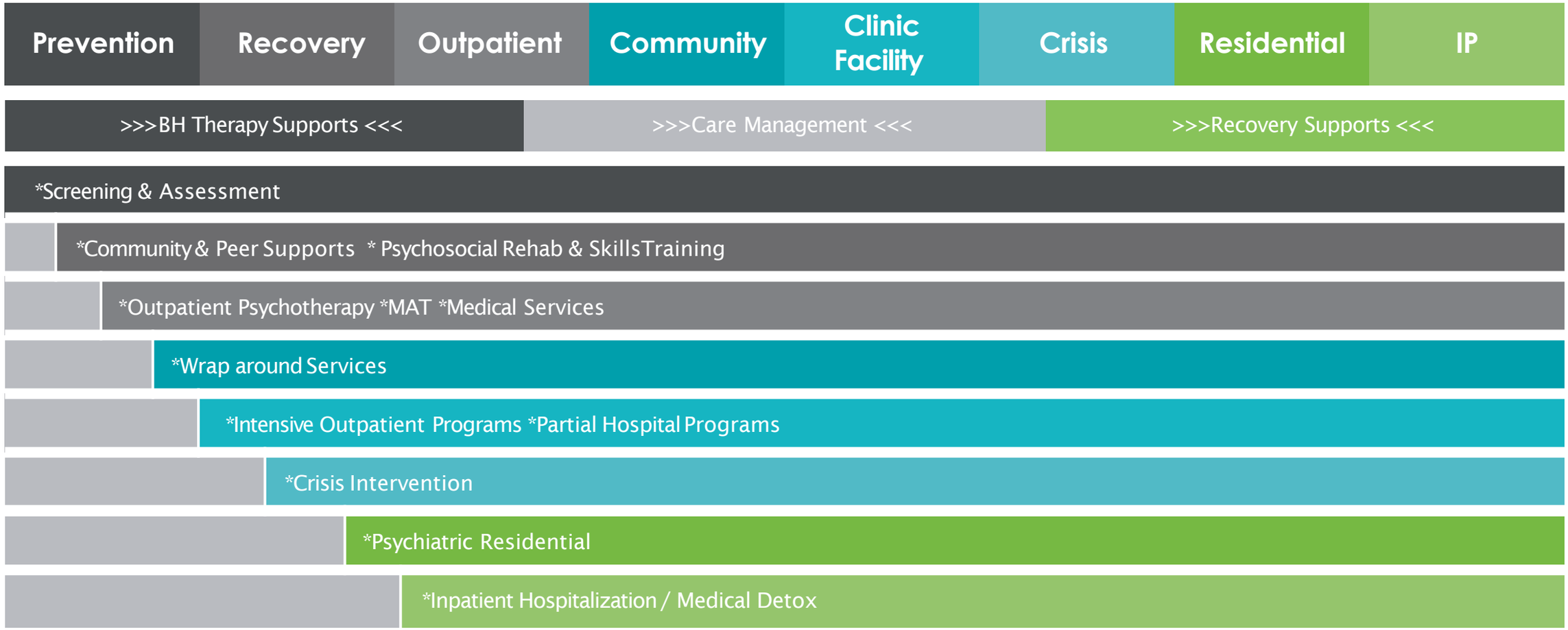
BH Managed Services

Passport supports a continuum of services that provides a framework for early intervention, treatment, and recovery while promoting collaboration and integration across all settings. The member can self-refer without a PCP referral.



Source: Continuum of BH services across the lifespan: farleyhealthpolicy.org with Passport BH alignment

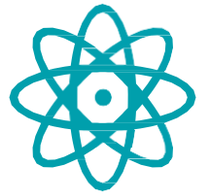
Provider Support

Learning modules

Evidence-based learning tools for providers, members, and care givers. Passport has partnered with Psych Hub to develop modules for BH specific topics.

BH provider toolkits

Provides online PCP provider resources to manage BH in the Physical Health setting. Provider network teams provide education for authorization and claims processes.



Care coordination

Offers partnerships with our care coordination and recovery specialists for access and linkage to community resources.

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Facilitating Exchange of Information for High Quality Collaboration for Continuity of Care

- With in-house BH, can use one source of data to work collaboratively with PCPs and BH provider
- Case Manager as the single point of contact coordinates communication between internal and external partners
- Tailored Transition of Care program following hospitalization
- Start discharge plans as part of UM admission process including assignment of Case Manager and plans for transition to community-based supports
- Case Managers and guardianship liaisons will participate in quarterly Continuity of Care/Discharge Planning meetings
- Web-based BH toolkit, additional trainings, information
- Facilitating data sharing through collaborative agreements with state hospitals
- Integrating Enrollee information from system partners
- Encouraging provider participation in the Kentucky Health Information Exchange (KHIE)

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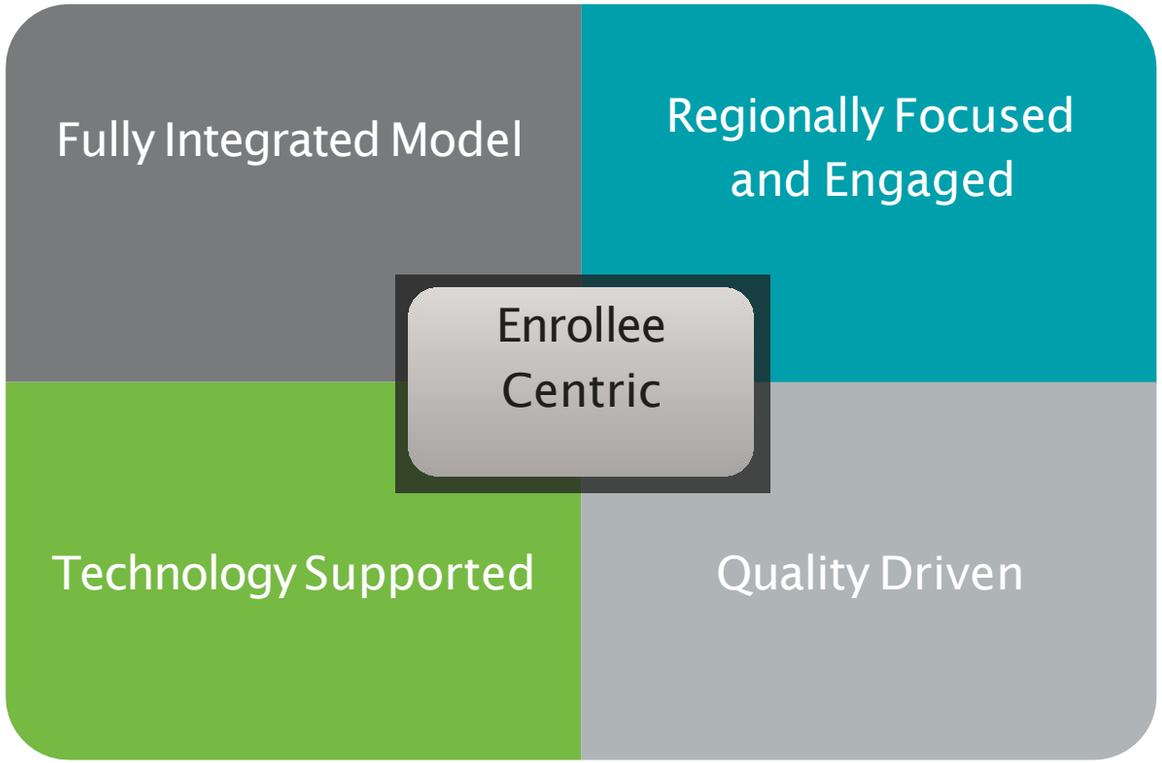
Provider Monitoring Methods

Network performance expectations clearly and consistently communicated through provider contracts, manuals, trainings, and included in performance feedback.



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Provider Tools and Resources

Medicaid & Passport Advantage Online Tools – Passport Website

- Provider Online Directories
- Preventative & Clinical Care Guidelines
- Provider Manual
- Access to Availity Essentials Provider Portal
- Prior Authorization Information
- Advanced Directives
- Claims Information
- Pharmacy Information
- HIPAA
- Fraud Waste and Abuse Information
- Frequently Used Forms
- Communications & Newsletters
- Trainingand Resources
- Important Contact Information
- Member handbook and other resources

PassportHealthPlan.com

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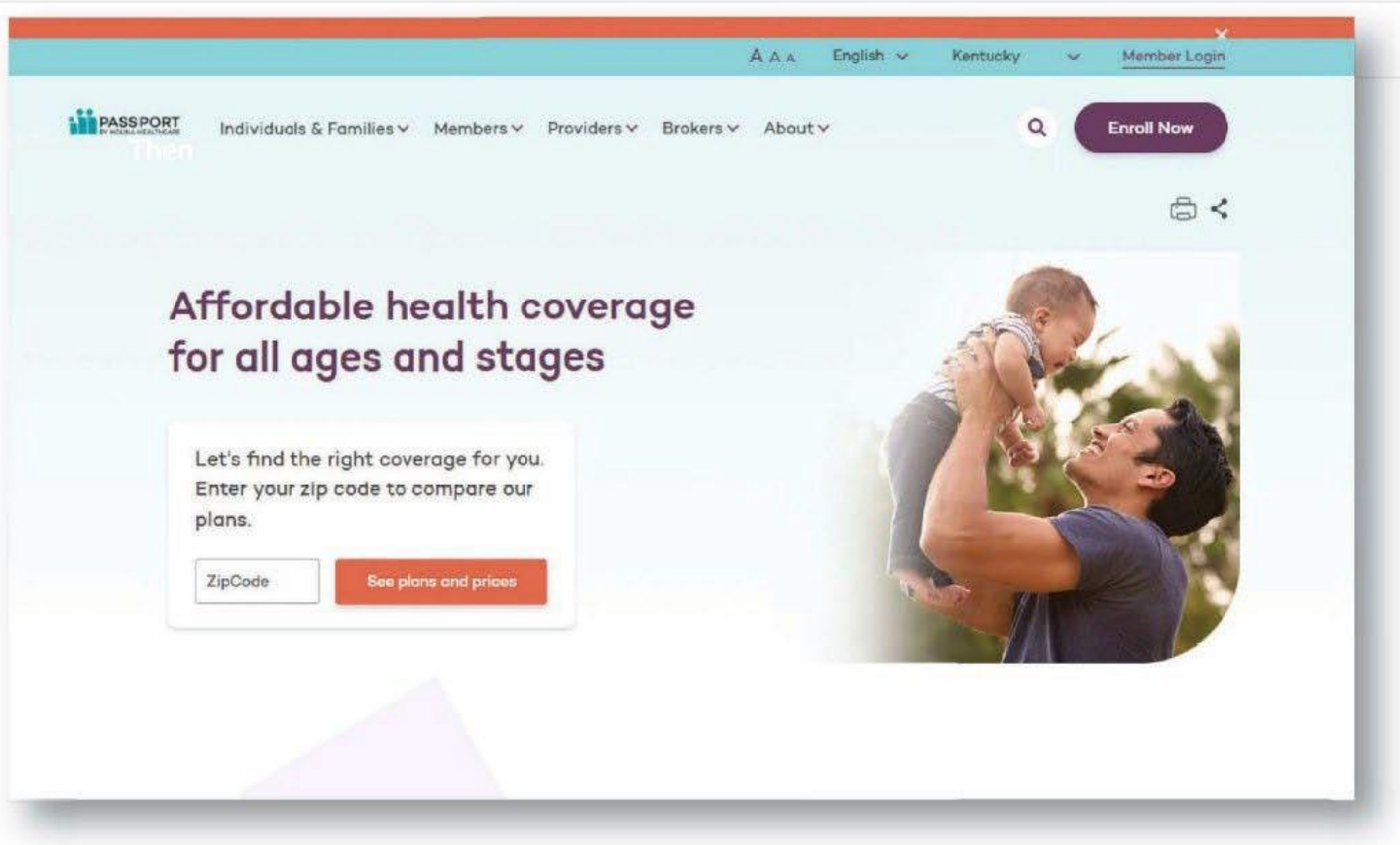
Marketplace Online Tools – Provider Website

www.Passporthealthplan.com/Marketplace

- Forms and Documents
- Provider Manual
- Provider Online Directory
- Payment Policies
- HIPAA
- EDI EFT/ERA
- Drug List
- Health Resources
- Communications
- FAQs



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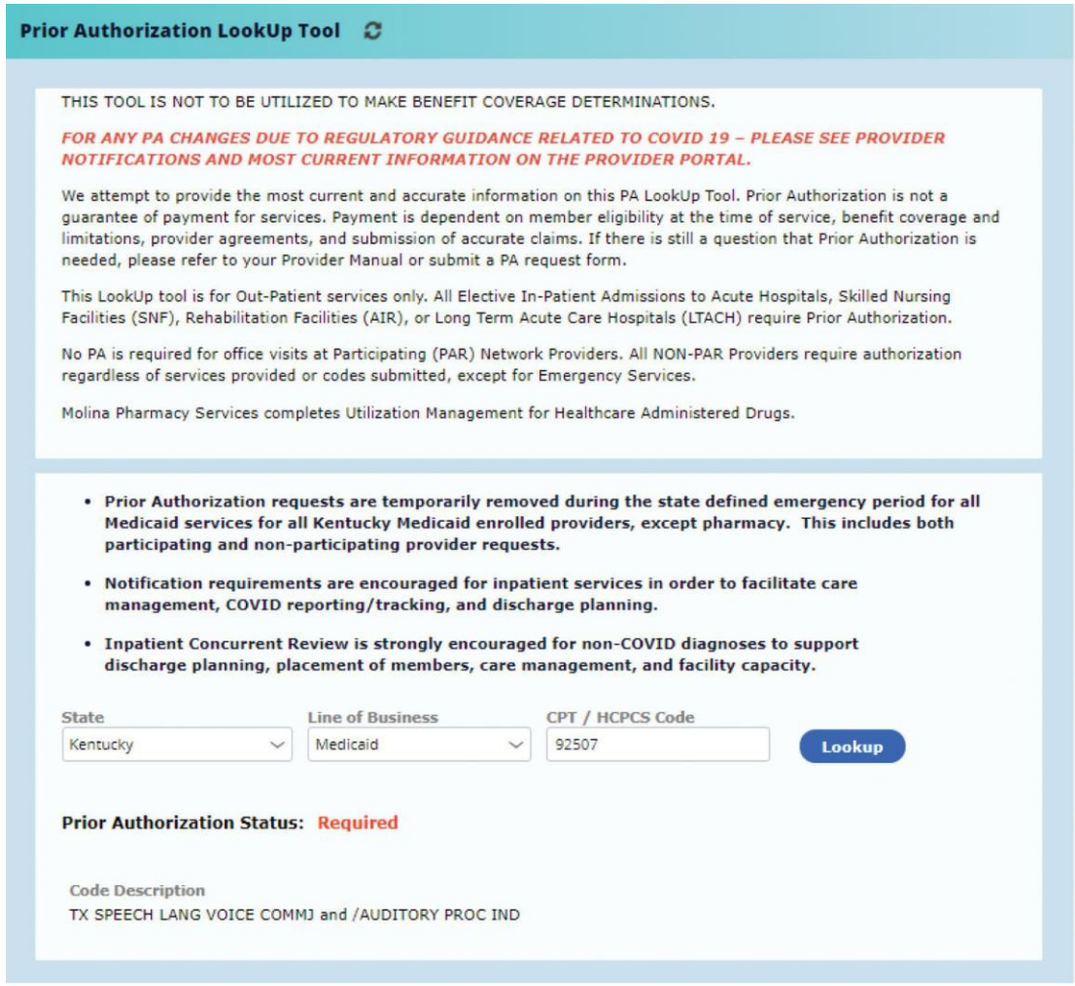
Prior Authorization Look-up Tool



The Prior Authorization Look-up Tool allows providers to enter a CPT or HCPCS code to determine authorization requirements in realtime!

To access the Prior Authorization Look-up Tool visit PassportHealthPlan.com and click on Health Care Professionals.

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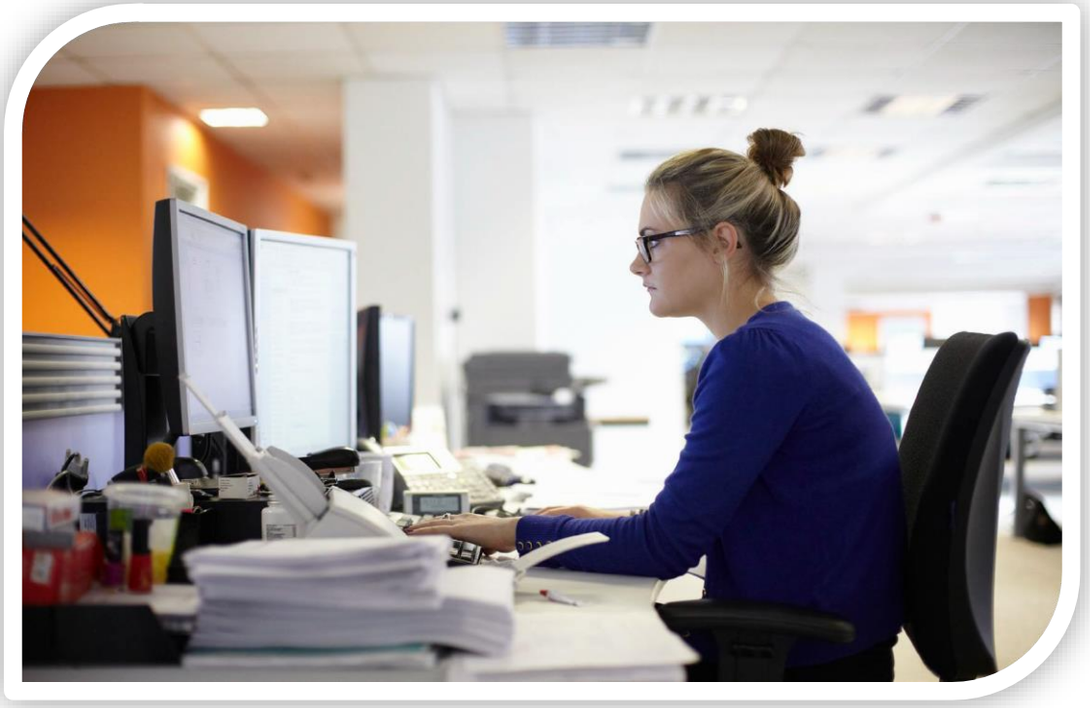
Passport Provider Portal - Availity Essentials

Passport utilizes Availity Essentials for our Provider Portal. Providers may register for access to our Provider Portal for services that include self-service member eligibility, claim status, provider searches, to submit requests for authorization and to submit claims.
The Provider Portal is a secure website that allows our providers to perform many self-service functions 24 hours a day, 7days a week.



Services offered by Availity Essentials and Passport include:

- Claim submission/resubmission
- Claim status
- Viewing remittance advice
- Obtaining member eligibility and benefits information
- Submitting authorization requests
- HEDIS Information

Organization Registration Resource Availity.com

PASSPORT BY MOLINA HEALTHCARE

Provider Manuals

Passport's Provider Manuals are written specifically to address the requirements of delivering healthcare services to our members, including the responsibilities of our participating providers and is considered an extension of your contract.

Providers may view the manuals on our website, at: PassportHealthPlan.com then selecting the Health Care Professionals tab and selecting the type of product.

Provider Manual Highlights	
Benefits Overview	Provider Roles and Responsibilities
Member Rights and Responsibilities	Claims and Reimbursement Information
Member Eligibility	Contracting, Credentialing and Enrollment
EPSDT and Preventative Care	Utilization Management and Referral Requirements
Care Management Programs	Access and Availability Standards
Transportation Services	Important Contact Information
Interpreter Services	Compliance Standards

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Verifying Member Eligibility

Passport offers various tools to verify membereligibility and encourages providers to checkeligibility prior to visits to ensure the memberis active on the date of service:

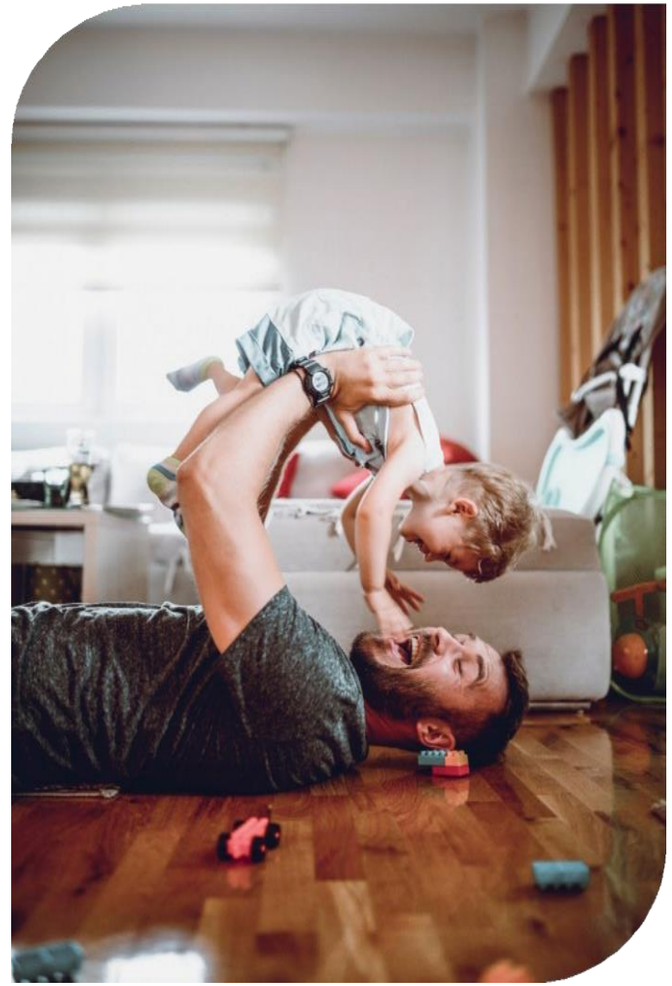
Phone:

Medicaid & Marketplace Provider Services: (800) 578-0775

Passport Advantage Provider Services: (844) 859-6152

Online:

Provider Portal, Availity Essentials: Availity.com
Kentucky HealthNet: kymmis.com



270/271 Transactions

For 270/271eligibilitybatch inquiry/responsevia SSI use payer ID **61325** (Medicaid & Marketplace)

Payer ID 66008 (Passport Advantage)

Please Note: At no time shoulda memberbe deniedservices because his/hername does not appear on the PCP's eligibility roster.If a memberdoes not appear on the eligibilityrosterplease utilizeone of the otherverification methods listedabove.

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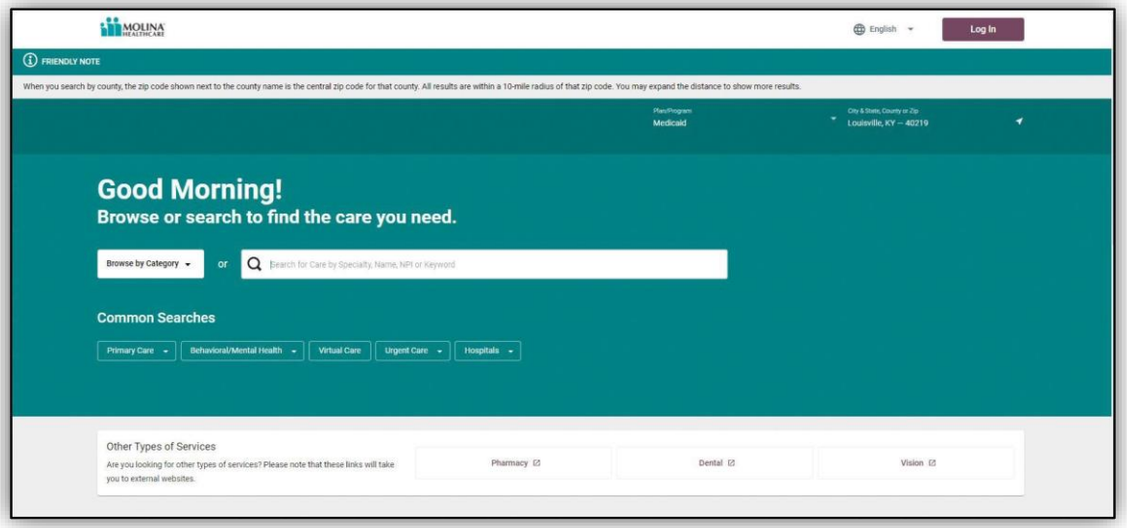
Provider Online Directory



To access our Medicaid Provider Online Directories, visit us at PassportHealthPlan.com, click on Find a Doctor or Pharmacy.

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA required element. Invalid information can negatively impact member access to care, member assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

Providers are encouraged to validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. For questions or to report data issues within the Provider Directory please contact Passport's Provider Services Team at

(800) 578- 0775.

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Connect With Us!

What's New Updates on the Passport

Website PassportHealthPlan.com

Our website has the most up-to-date information available 24/7!

Provider Newsletter

Our quarterly Provider Newsletter addresses a multitude of topics impactful to Molina's overall organization.

Passport News/eNews

Passport eNews provides real-time communications tailored to your provider type, delivered straight to your inbox while Passport News will be the same communication in a paper, mailed format. Click here to register for eNews.

News and Announcements in the Availity Essentials Portal

availity.com Check the News and Announcements of Passport's Payer Space in the Availity Essentials Portal!

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It Matters to Passport

Passport has adopted the "It Matters to Passport" provider outreach program, which offers several easy ways for providers to give feedback to the Plan on ways we can enhance the provider experience and deliver on our values of Integrity Always, Absolute Accountability, Honest and Open Communication and Supportive Teamwork.

Submit your feedback to the "It Matters to Passport" program:

Email:
ItMatters@MolinaHealthcare.com

Monthly Provider Forums
Visit PassportHealthPlan.com/ItMatters to view the schedule and register for a forum!

Online:
It Matters to Passport Suggestion Box

In Writing:
Passport by Molina Healthcare
Attn: Provider Services
2028 W. Broadway
Louisville, KY 40203

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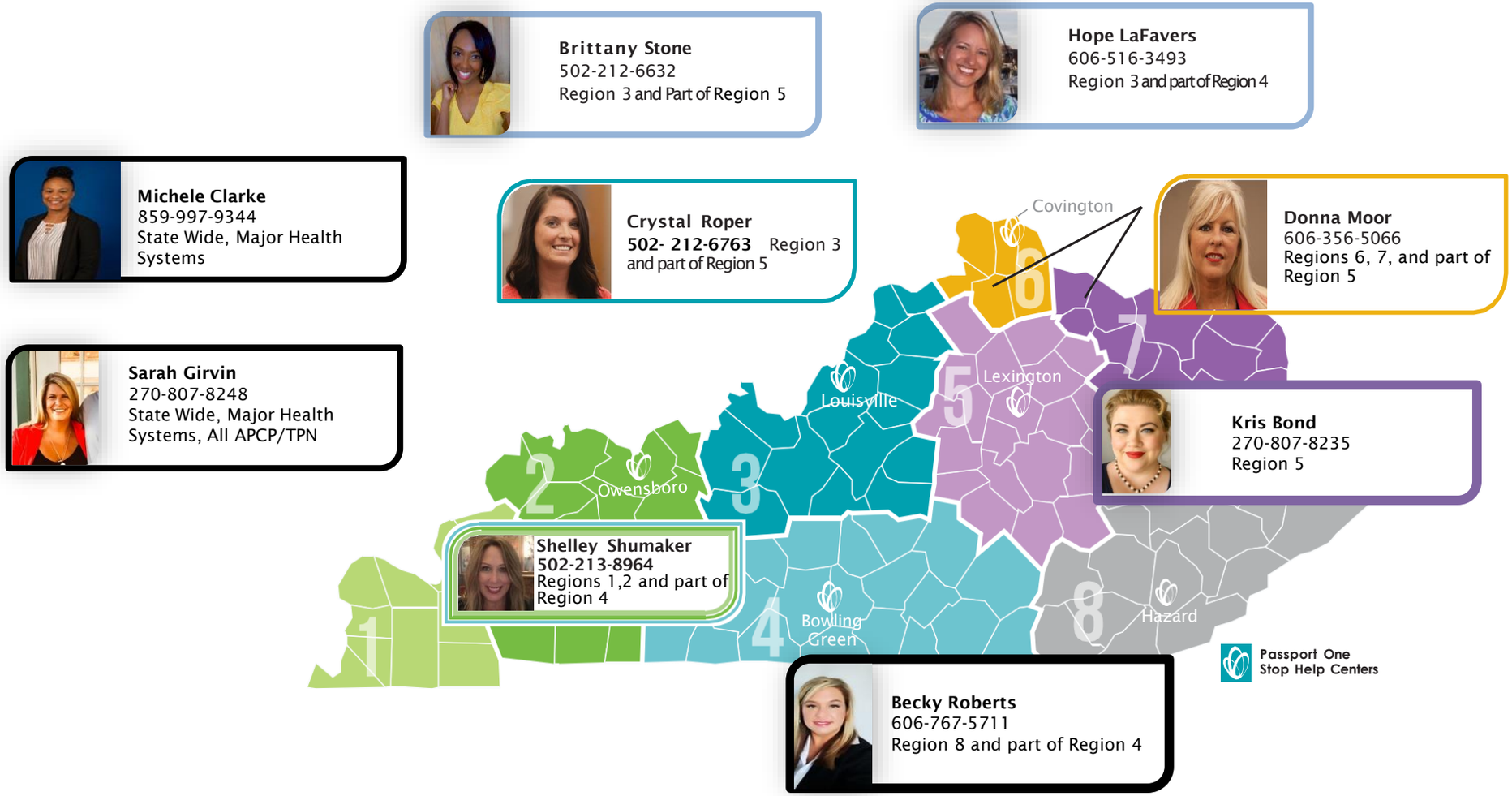
Your Sr. Provider Service Representatives

Click here to meet the Provider Services Team and obtain more information regarding your Provider Services Representative!



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Billing and Claims Information

Claims

Passport employs a local, dedicated Provider Claims Service Unit to assist with **medical and behavioral health** claims questions and concerns.

For all claims-related inquiries please contact the Provider Claims Service Unit at:

Phone:
(800) 578-0775 (Medicaid & Marketplace)
Monday – Friday 8:00 AM – 6:00 PM EST
(844) 859-6152 (Passport Advantage)

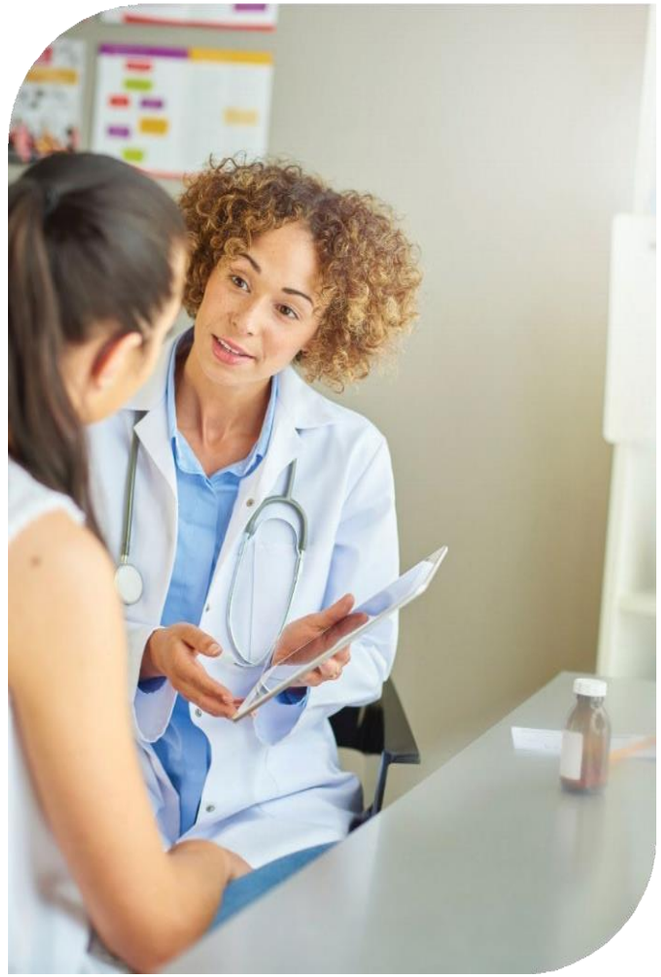
Online:
Availity.com

In Writing:
Medicaid
Passport by Molina Healthcare
P.O.Box 36090
Louisville, KY 40233-6090

Marketplace
Passport by Molina Healthcare
P.O. Box 43433
Louisville, KY 40253

Passport Advantage
P.O. Box 3805
Scranton, PA 18505

Tip! When calling, make sure to have your TIN/ NPI, member ID, and DOS ready for the customer service representative.



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Paper and Electronic Claim Submission

Passport accepts paper and electronic submissions of the CMS-1500 or UB04 claim forms for **medical and behavioral health** services. We highly encourage all in-network providers to submit claims electronically. Providers may submit initial and corrected claims via the methods listed below.

Electronic Claim Submissions: Electronic Data Interchange (EDI):

- Payer ID 61325 (Medicaid & Marketplace)
- Payer ID 66008 (Passport Advantage)

Passport uses SSI as its gateway clearinghouse. Providers can also continue to submit claims to their usual clearinghouse. Passport accepts EDI transactions through SSI via the 837P for Professional and 837I for institutional. To ensure all data being submitted to our gateway is received properly, your submitter must utilize the latest version of the 837 standard. Please ensure your office is tracking electronic transmissions using the acknowledgement reports. The reports assure claims are received for processing in a timely manner.

For EDI claim submission issues please contact EDI Customer Service:

- Email: EDI.claims@MolinaHealthcare.com
- Online Via Passport's Provider Portal, Availity Essentials (preferred): availity.com

Paper Claim Submissions:

Medicaid
Passport by MolinaHealthcare
P.O.Box 36090
Louisville, KY 40233-6090

Marketplace
Passport by Molina Healthcare
P.O. Box 43433
Louisville, KY 40253

Passport Advantage
P.O. Box 3805
Scranton, PA 18505

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Claim Status Inquiries

Passport offers various avenues to obtain claim status for medical and behavioral health claims. We encourage providers to utilize online/electronic tools to obtain claim status.

Electronic Claim Status Batch Inquiry/Response (276/277):
For 276/277 eligibility batch inquiry/response via SSI please use the below payer ID

- Payer ID 61325 Medicaid & Marketplace
- Payer ID 66008 Passport Advantage

Online Via Passport's Provider Portal, Availity Essentials: availity.com

Phone:
(800) 578-0775 (Medicaid & Marketplace)
Monday – Friday 8 a.m-6 p.m EST

(844) 859-6152 (Passport Advantage)

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Timely Filing and Resubmissions

Timely Filing:

Providers are encouraged to submit claims for covered services rendered to members as soon as possible following the inpatient discharge date or date of service. All claims shall be submitted via the approved claim forms and shall include any and all medical records pertaining to the claim if requested by Passport or otherwise requested for claim processing per Passport's policies and procedures.

Product	Payer ID	Initial Submission (clean claim)	Resubmissions/Corrections
Medicaid & Marketplace	61325	365 calendar days after discharge or the date of service or 365 calendar days after final determination by the primary payer	365 calendar days from the date of service
Passport Advantage	66008	180 calendar days after discharge or the date of service or 180 calendar days after final determination by the primary payer	180 calendar days from the date of service

Corrected Claims:

Corrected claims are new claims and must be submitted with the correct coding to denote if it is a replacement of a prior claim or a corrected claim for the 837I or the correct resubmission code for an 837P. Please refer to billing guidelines in the Provider Manual for more information.

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Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

Passport utilizes **ECHO Health** for electronic payments. In-network providers are encouraged to register for Echo Health within **30 days** of receiving their first reimbursement check from Passport.

Benefits of EFT/ERAs:

- Quicker Payment
- Ability to search historical ERAs with ease
- View, download, print and save ERAs for quick reference

How to enroll with ECHO Health:

- To register please visit: [ECHO Health]

Questions? Contact ECHO Health at (800) 946-7758

PASSPORT BY MOLINA HEALTHCARE

Appeals and Grievances

Appeal:

An appeal is a request for Passport review of an adverse action or a decision related to a covered service. A provider may request an appeal regarding payment or contractual issues by mail, fax, email or the Provider Portal. Appeals must be filed within **sixty (60) calendar days for Medicaid and one hundred eighty (180) calendar days for Marketplace** from the Adverse Benefit Determination or denial. Passport has **thirty (30) calendar days** to review the appeal and render a decision to reverse or affirm.

Grievance (Medicaid only):

A grievance is a notice of concern submitted to the health plan from a provider expressing dissatisfaction and requesting action such as an investigation. A provider may submit a grievance by mail, fax, email or the Provider Portal. Grievances must be filed no later than **sixty (60) calendar days** from the date the provider becomes aware of the issue generating the grievance. All Grievances will be resolved as expeditiously as possible; all will be resolved no later than **thirty (30) calendar days** from receipt. Provider grievances may fall info one of the following categories: administrative, contractual, healthcare delivery, member behavior.

Appeals and Grievances Contact Information:

E-mail:
MHK_Provider_GnA@Molina Healthcare.com

Online via the Provider Portal, Availity Essentials availity.com
(Preferred Submission Method)

Fax:
(866)315-2572 (Post Service)
(833)415-0673 (Pre Service)

Mail:
Passport by Molina Healthcare
Attn: Appeals & Grievances
PO Box 36030
Louisville, KY 40233-6030

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Appeals and Grievances – Passport Advantage

Appeal:

An appeal is a request for Passport review of an adverse action or a decision related to a covered service. A provider may request an appeal regarding payment or contractual issues by mail or fax. Appeals must be filed within **sixty (60) calendar days** from the Adverse Benefit Determination or denial. Passport has **thirty (30) calendar days** to review the appeal and render a decision to reverse or affirm.

Grievance:

A grievance is a notice of concern submitted to the health plan from a provider expressing dissatisfaction and requesting action such as an investigation. A provider may submit a grievance by mail, fax, email or the Provider Portal. Grievances must be filed no later than **sixty (60) calendar days** from the date the provider becomes aware of the issue generating the grievance. All Grievances will be resolved as expeditiously as possible; all will be resolved **3-60 days calendar days** from receipt, depending on the type of appeal. Provider grievances may fall info one of the following categories: administrative, contractual, healthcare delivery, member behavior.

Appeals and Grievances Contact Information:

Fax: (562) 499-0610

Mail:
Passport by Molina Healthcare
Attn: ProviderGrievance and Appeals
P.O.Box 22816
Long Beach, CA 90801-9977

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Coordination of Benefits/Third Party Liability

Medicaid is always the payer of last resort. Providers must verify a member's primary insurance coverage, if applicable, prior to submitting claims to Passport as all claims must be billed with the primary insurance payment information.

Passport may deny claims when a Third Party Liability (TPL) has been established and will pay claims for covered services when probable TPL has not been established or third-party benefits are not available to pay a claim.

Passport will attempt to recover any third-party resources available to members and shall maintain records pertaining to TPL collections on behalf of members for audit and review.

How to Verify Primary Insurance Coverage:

Phone:

Provider Services: (800) 578-0775
Medicaid & Marketplace

(844) 859-6152 (Passport Advantage)

Online (preferred):

Provider Portal, Availity Essentials: Availity.com
Kentucky HealthNet: kymmis.com

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Encounter Data

All providers are required to submit Claims/Encounter data to Passport for all services provided to our members. Passport uses this data for:

- Federal Reporting (CMS)
- Commonwealth Reporting (DMS)
- Rate Setting
- Risk Adjustment
- Improving Member Care (HEDIS)

Claims/Encounter data must be submitted within thirty (**30**) days from the date of service to meet Commonwealth and CMS encounter submission threshold and NCQA Quality Metrics. Additionally:

- Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I– Institutional, 837P – Professional, and 837D--Dental.
- Data must be submitted with Claims level detail for all non-institutional services provided.

Providers must correct and resubmit any Claims/Encounters that are rejected or denied by Passport. Claims/Encounters must be corrected and resubmitted within fifteen (**15**) days from the rejection/denial.

Passport has created 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers at PassportHealthPlan.com

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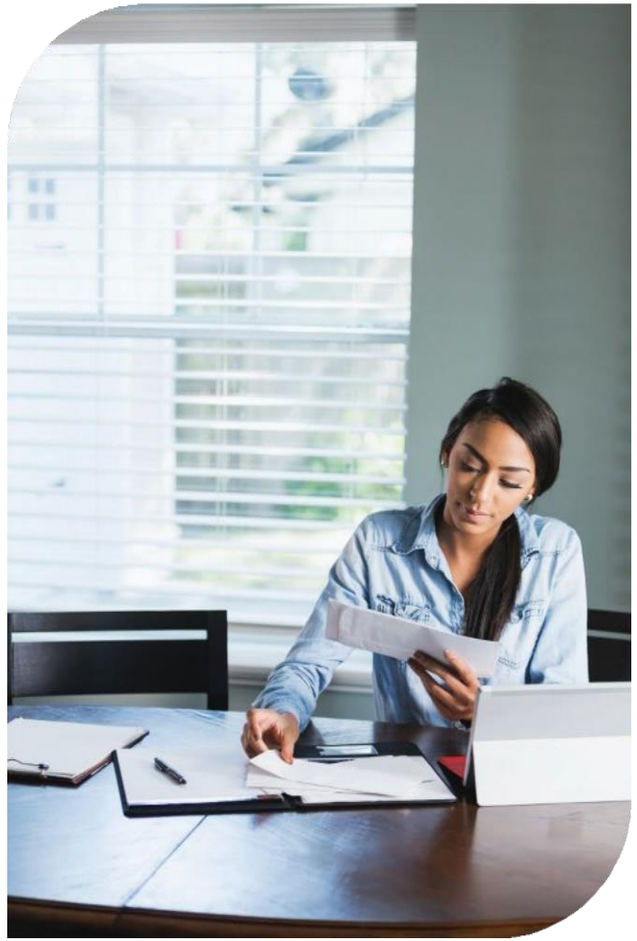
Balance Billing and Claims Payment

In accordance with your Kentucky Medicaid contract, providers are prohibited from billing Passport members for services rendered.

To ensure your office is receiving the expected payment for services rendered:

- Verify member eligibilityon the date of service
- Verify member's primary insurance coverage as applicable
- Submit claims within Passport's timely filing limits
- Obtain applicable authorization for services
- Submit claims with accurate coding and required backup documentation
- Ensure accurate provider data is in the correct, required fields

In the event of a denial of payment, providers shall look solely to Passport for compensation for services rendered.



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Healthcare Services

Authorization Review Guide

REFER TO PASSPORT'S WEBSITE OR PRIOR AUTHORIZATION LOOK-UP TOOL/MATRIX FOR SPECIFIC CODES THAT REQUIRE AUTHORIZATION. ONLY COVERED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT.

For coverage of codes, refer to the Kentucky Department of Medicaid Services Fee Schedules and the Passport Member and Provider Manual.

OFFICE VISITS TO CONTRACTED/PARTICIPATING (PAR) PROVIDERS & REFERRALS TO PARTICIPATING NETWORK SPECIALISTS DO NOT REQUIRE PRIOR AUTHORIZATION. EMERGENCY ROOM SERVICES/URGENT CARE DO NOT REQUIRE PRIOR AUTHORIZATION.

- **Non-Contracted Providers: authorization of services or items required with the exception of ER and Urgent Care**
- **All Medical & Behavioral Health Inpatient Admissions; LTAC; Rehabilitation; Residential; Partial**
- **Select Outpatient Behavioral Health Services : Mental Health and Substance Use Disorder; Refer to PA Look Up tool or PA Matrix**
- **Select Outpatient Medical/Surgical Services : Refer to PA Look Up tool or PA Matrix**
- **Advanced Imaging Services**
- **EPSDT Special Services**
- **Miscellaneous & Unlisted Codes: Should an unlisted or miscellaneous code be requested, documentation and rationale must be submitted with the request**
- **Experimental/Investigational Procedures ; Cosmetic, Plastic and Reconstructive Procedures**
- **Select Cardiology / Oncology Services: Select services for adults over the age of 18 administered through Evolent**
- **Transplants/Gene Therapy, including Solid Organ and bone Marrow (excluding cornea transplant)**
- **Transportation Services: Non-emergent air transportation requires authorization**

EXCEPTIONS

- **Occupational, Physical & Speech Therapy:** (Home and Facility Based) Evaluation and the first 20 visits for each discipline per member per calendar year do not require prior authorization ; Authorization is required prior to the 21st visit
- **Home Health Services:** Evaluation and first 6 visits per calendar year do not require authorization; Authorization is required on the 7th visit
- **Sleep Studies :** No authorization is required when Sleep Study is performed in the Home
- **Maternity Admissions**:
  - Authorization required on day 4 for a NVD and day 6 for a C-section
  - Newborn (not admitted to NICU): Authorization required if infant stays > 5 day
  - NICU: All NICU admissions, regardless of length of stay, require authorization through Progeny
- **Intensive Outpatient Therapy** : Authorization required after 16 visits per member per calendar year
- **H2027 Psychoeducation :** Prior authorization required for services exceeding 100 units (units measured in 15 min increments) per member per calendar year
- **H0038 Peer Support:** Prior authorization required for services exceeding 200 units (units measured in 15 min increments) per member per calendar year
- **H0035:** Partial Hospitalization for Substance Use Disorder and Mental Health: Prior authorization required for services exceeding 6 visits/units per calendar year
- **Applied Behavior Analysis Services:** Authorization required after 48 units, in any combination of codes, per member per calendar year

Refer to the PA Look Up Tool or the PA Matrix for specific codes/services requiring authorization

The PA Matrix is updated quarterly

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Submitting Prior Authorization Requests Medicaid & Marketplace

Providers may submit **medical and behavioral health** priorauthorization requests to Passport's Utilization Management department in a variety of convenient ways:

Online:
Passport Provider Portal, Availity Essentials:
availity.com

Mail
Passport by Molina Healthcare
Attn: Utilization Management
2028 W. Broadway
Louisville, KY 40203

Medical and Behavioral Health:
Phone: (800) 578-0775 – option 4
Fax: (833) 454-0641 (Medicaid)
(833) 322-1061 (Marketplace)

Transplants:
Phone: (855) 714-2415
Fax: (877) 813-1206

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

Medical/Behavioral Health SA Appeals:
Phone: (844) 795-3508
Fax: (866) 315-2572
Email: MHK_GnA@MolinaHealthcare.com

Note! The Utilization Management Department does not conduct Retrospective Review. Please submit records for retrospective requests with your claims submission.

PASSPORT BY MOLINA HEALTHCARE

Submitting Prior Authorizations for Passport Advantage

Online:
Passport Provider Portal, Availity Essentials:
availity.com

Fax:

Advanced Imaging	(877) 731-7218
Pharmacy (Part D and Part B drugs and for Medicaid-covered drugs when the Member is in an integrated plan providing Medicaid wrap benefits)	Part D: (866) 290-1309 Part B (J-Codes): (800) 391-6437
Hospital Inpatient Admission and Concurrent Review (physical health)	Fax: (844) 834-2152
Prior authorization (physical health and behavioral health)	Fax: (844) 251-1450
Medicare Transplants	Fax: (877) 813-1206
Post Acute Admission (SNF, LTAC and AIR)	Fax: (833) 912-4454

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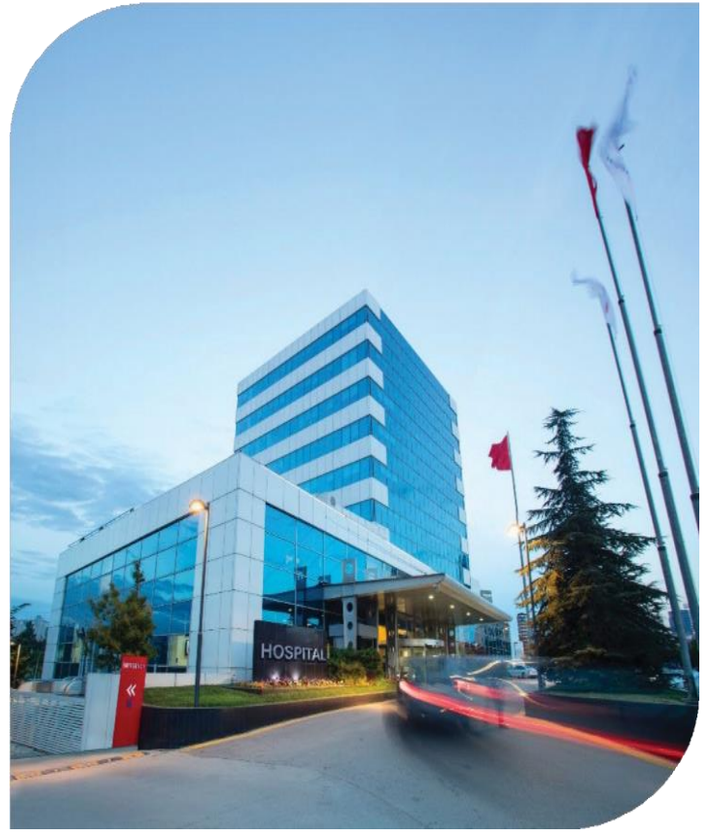
Submitting Emergent Inpatient Admissions

Passport requires notification of all emergent inpatient admissions **within 48 hours** of admission or by the following business day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning.

We require that the notification includes:

- Member demographic information,
- Facility information,
- Date of admission and
- Clinical information sufficient to document the Medical Necessity of the admission.

Emergent inpatient admission services performed without meeting notification, Medical Necessity requirements or failure to include all of the needed clinical documentation to support the need for an inpatient admission, will result in a denial of authorization for the inpatient stay.



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Authorization Requests - Responses

Passport strives to complete UM review in a timely manner to accommodate the urgency of a member's medical situation.

Standard Request	Urgent Request
Reviewed within five (5) business days of receipt.	Reviewed within one (1) business day of receipt.

What to expect upon review determination:

Provider notification of the determination is generally sent via fax or the Provider Portal, depending upon how the initial request was submitted to Passport.

- **Approvals** will include the authorization number, approved date span and approved services
- **Denials** contain written notification of the denial and the denial reason along with a letter outlining appeal rights
- **Partial Approvals** include the authorization number and approved date span and services. Notification of the denial is also included along with a letter outlining appeal rights

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Evolent– Cardiology Prior Authorizations

Passport partners with Evolent (formerly New Century Health) to administer prior authorizations for select **cardiology** services for members ages 18 years and older.

Prior authorization is required for the below list of Cardiology services for member's ages 18 and over:

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

Providers may submit **cardiology** prior authorization requests to Evolent in a variety of convenient ways:

Online:

NCH Provider Web Portal
My.NewcenturyHealth.com

Phone:

(888) 999-7713
Cardiology– Option 3

Fax:

(714) 582-7547

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Evolent– Oncology Prior Authorizations

Passport partners with Evolent (formerly New Century Health) to administer prior authorizations for select **oncology** services for members 18 years and older. A member must have a cancer diagnosis along with the code/drug in scope for oncology.

Services in scope for Oncology:

- Infused and oral chemotherapy, hormonal therapeutic treatment, supportive agents, and symptom management medications
- Brachytherapy
- Conformal
- IMRT (Intensity-Modulated Radiation Therapy)
- SBRT (Stereotactic Body Radiation Therapy)
- IGRT (Image-Guided Radiation Therapy)
- 3D (3-Dimensional
- SRS (Stereotactic Radiosurgery)
- Radiopharmaceuticals
- Proton and Neuron Beam Therapy
- CAR-T

Providers may submit **oncology** prior authorization requests to Evolent in a variety of convenient ways:

Online:
NCH ProviderWeb Portal
my.newcenturyhealth.com

Phone:
(888) 999-7713
Oncology – Option 6

Fax:
Medical Oncology: (213) 596-3783
Radiation Oncology: (714) 494-8366

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Referrals

Referrals may be made when medically necessary services are beyond the scope of the PCP's practice. Information is to be exchanged between the PCP and Specialist to coordinate care of the patient. PCPs and Specialists are encouraged to document referrals in the member's medical record and report to Passport via box 17of the CMS-1500 claim form.

Referrals allow:

- Optimization of care at appropriate levels and locations
- Reduction in duplication of services
- Patient-centered care coordination

Direct Access services do NOT require a referral and include:

- Primary care vision services
- Primary care dental and oral surgery services
- Voluntary family planning services
- Maternity care for members under 18 years of age
- Immunizations for members under 21 years of age
- Sexually transmitted disease screening, evaluation and treatment
- Tuberculosis screening, evaluation and treatment
- Human Immunodeficiency Virus (HIV) and other communicable disease testing
- Chiropractic services
- Behavioral Health Services

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Health Management Programs

Passport offers programs to help our members and their families to manage a diagnoses health condition.

Our Health Management Programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Cardiovascular Disease (CVD) management/Congestive Heart Disease
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management
- Obesity
- Weight Management
- Smoking Cessation
- Organ Transplant
- Severe Mental Illness(SMI) and Substance Use Disorder
- Maternity Screening and High-Risk Obstetrics

For more information about our programs, please call Health Management at (800) 578-0775.

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Care Management

The Intensive Care Management (ICM) program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Passport case manager will assess the Member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services, and identify and address any barriers the Member experiences to accessing appropriate care. For more information about our Care Management program, click here.

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

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Catastrophic or end-stage medical conditions (e.g, neoplasm, organ/tissue transplants, End Stage Renal Disease)
- Comorbid chronic illnesses (e.g., asthma, diabetes, COPD, CHF).
- Preterm births
- High-technology home care requiring more than 2 weeks of treatment
- Member accessing Emergency Department services inappropriately
- Individuals with Special Health Care Needs, including but not limited to:
  - Blind/disabled children under age 19
  - Adults over the age of 65
  - Homeless Members
  - Individuals with chronic physical health illnesses
  - Individuals with chronic behavioral health illnesses, such as SMI
  - Children receiving services in a Pediatric Prescribed Extended Care facility or unit
  - Children receiving EPSDT Special Services
  - Members under guardianship with Department for Aging and Independent Living (DAIL)
  - Members over utilizing prescription drugs.

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Referral to Care Management

Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the ICM program.

The case manager works collaboratively with the member and all participants of the MCT when warranted, including the PCP and specialty Providers, such as, discharge planners, ancillary Providers, the local Health Department or other community-based resources when identified.

The referral source should be prepared to provide the case manager with demographic, health care and social data about the member being referred.

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

Phone:
(800) 578-0775

Fax:
(800) 983-9160

Health Education and Care Management Referral Form

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Health Risk Assessment

Member Health Risk Assessments (HRA) are used to identify a person's specific health conditions, functional status, social determinants, accessibility needs and other characteristics as well as personal strengths, resources and abilities.

The HRA is performed by an individual or a team of specialists and may involve family, or other significant people to inform care planning and the level of required services and supports

For members identified through HRA completion, referral, risk scoring and stratification, or other methods as determined by Passport as potentially in need of a higher level of Health Management Program services, Passport shall conduct a comprehensive HRA to determine the member's Health Management Program service needs.

The Health Risk Assessment shall at a minimum assess the following:

- Member's immediate, current and past health care, mental health and SUD needs;
- Psychosocial, functional, and cognitive needs;
- Social Determinants of Health, including employment and housing status;
- Ongoing conditions or needs that require treatment or care monitoring;
- Current care being receiving, including health care services or other care management;
- Current medications, prescribed and taken;
- Support network, including caregivers and other social supports; and
- Other areas as identified by Molina or the Department.

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Care Management: Case Managers

Case Managers (CM) are nurses and social workers who conduct health risk assessments either by phone or face-to-face to identify member needs and develop specific interventions to help meet those needs.

All Members are eligible for Case Management services; different levels of interventions are based on the individual needs and conditions of each member:

- **Health Management** - Health Management is focused on disease prevention and health promotion. It is provided for members whose lower acuity chronic conditions put them at risk for future health problems.
- **Case Management** - Case Management is provided for members who are at high risk for re-hospitalization post-ToC intervention with case management needs that warrant triage. 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 including LTSS.
- **Complex Case Management** - Complex Case Management is provided for members who have experienced a critical event or diagnosis requiring the extensive use of resources and need additional support navigating the health care system. The primary goal of Complex Case Management is to help members improve functional capacity and regain optimum health in an efficient and cost-effective manner.
- **Intensive Needs Case Management** - Level 4 focuses on members having an end-stage diagnosis that would otherwise meet criteria for palliative care or hospice services. This level includes members at high risk for re- hospitalization post-ToC intervention with continued need for stabilization, comfort care or other high intensity, highly specialized services.

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Transition of Care (ToC)

Transition of Care happens when a member moves from one health care setting to another, usually during an acute health care episode.

Examples:

- Hospital → Rehab/Skilled Nursing Facility
- Hospital/Rehab/Skilled Nursing Facility → Home

The purpose of the ToC program is to improve clinical outcomes, identify and address transition of care needs, and promote member self-determination and satisfaction, while reducing hospital readmissions and emergency department visits by:

- Ensuring the member is fully prepared to continue the plan of care throughout the entire transition
- Engaging the member directly so they have an active voice in the implementation of their individualized plan of care.
- Facilitating the fundamental elements of the program designed to produce positive outcomes: medication review, practitioner and/or specialist follow-up appointments, assessment of health status, dietary and nutritional needs, and home health and DME needs.
- Supporting the member through the transition and coordinating needed services with appropriate providers and other payor sources.
- Promoting Member self-management and encouraging empowerment.

These contacts occur as follows

- First Contact/Member Assessment- attempted while member is still inpatient or during first discharge contact
- Second Contact – performed within 5 calendar days after discharge
- Subsequent Contacts – based on member need and preference

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Pharmacy Coordinated Services Program (CAP)

Passport's Coordinated Services Program (CAP) is designed to encourage better health behaviors, increase personal responsibility in health care, and ensure medical, and pharmacy benefits are received at an appropriate frequency and setting, and are medically necessary. Members may be referred to care management prior to lock-in to educate and support behavioral changes and positive health outcomes. If member's behaviors do not change, regardless of care management engagement, the Case Manager will initiate member enrollment into the CAP program. The member's Case Manager will contact their assigned PCP to make the PCP aware of the member's potential to be locked-in to certain Providers and settings of care as a part of the Coordinated Services Program. Members have the right to appeal their status.

Members who meet any of the following criteria during two consecutive 180-day periods will be evaluated for enrollment in the program. Members who meet three (3) or more of the below criteria will be automatically enrolled:

- Received four or more abuse potential drugs or;
- History of addiction or drug dependence with abuse potential drugs or;
- Obtained prescriptions for abuse potential drugs from four or more prescribers or;
- Has a poisoning overdose with a benzodiazepine, prescription opioid, or abuse potential drug; or
- Utilized four or more pharmacy locations or;
- Received one narcotic analgesic one benzodiazepine and one muscle relaxant; or
- Received a concurrent prescription of opioids and benzodiazepines or antipsychotics.

Non-Emergent Settings CAP Enrollment Criteria

Members who have three (3) emergency department visits at three (3) different locations OR had 4 or more ED visits for a condition that was not an emergency medical condition during two consecutive 180-day periods will be evaluated for enrollment in the Coordinated Services Program.

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Quality

Quality Improvement

Passport has established a Quality Improvement Program that 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. In our quality program description, we describe our program governance, scope, goals, measurable objectives, structure and responsibilities. Quality Improvement Program findings are communicated to contracted providers through newsletters, faxes and the website.

Passport requires contracted Providers and Medical Groups to comply with the following core elements and standards of care:

- Have a Quality Improvement Program in place
- Comply with and participate in Passport's Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential Quality of Care and/or Critical Incident investigations
- Cooperate with Passport's quality improvement activities that are designed to improve quality of care and services and member experience
- Allow Passport to collect, use and evaluate data related to practitioner performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service, and access and availability
- Allow access to Passport Quality personnel for site and medical record review processes
- EQRO – External Quality Review Organization refers to a vendor and its affiliated with which the Commonwealth may contract

Contact Us!

Phone:
(800) 578-0775

Mail:
Passport by Molina Healthcare
Attn: Quality Department
2028 W. Broadway
Louisville, KY 40203

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Early Periodic Screening, Diagnosis, and Treatment (EPSDT) (1 of 2)

EPSDT is a national Medicaid benefit, authorized under the Federal Social Security Act. EPSDT benefit provides comprehensive screening, diagnostic, treatment and preventative healthcare services for children under the age of 21 who are enrolled in Medicaid. EPSDT is key to ensuring children receive appropriate preventative, dental, mental health, developments and specialty services.

EPSDT checkups are free for any child who is a Passport

- **Early:** Identifying problems early, starting at birth.
- **Periodic:** Checking children's health at periodic, age-appropriate intervals.
- **Screening**: Doing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems.
- **Diagnosis:** Performing diagnostic tests to follow up when a risk is identified.
- **Treatment:** Medically necessary treatment services to address any identified problems

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Early Periodic Screening, Diagnosis, and Treatment (EPSDT) (2 of 2)

EPSDT Special Services

- EPSDT provides any Medically Necessary diagnosis and treatment for members under the age of 21 indicated
  - as the result of an EPSDT health assessment or any other encounter with a licensed or certified health care professional, even if the service is not otherwise covered by the Medicaid Program.
- These services which are not otherwise covered by the Medicaid Program are called EPSDT Special Services and include benefits such as:
  - Glasses
  - Chiropractic
  - Incontinence supplies
- EPSDT Special Services shall be available for eligible member, including a Provider who can deliver the Medically Necessary services described in federal Medicaid law.

For more information on EPSDT, check out our EPSDT ProviderTraining.

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Population Health Management Program

Population Health Management (PHM) is a model of care aligned with the Nation Committee of Quality Assurance (NCQA) defined program that supports populations across the care continuum, promoting healthy behaviors and targeted inventions for those identified as high risk or who have chronic conditions.

The PHM Program includes:

- High-risk pregnant women
- Behavioral health (comprising mental health and/or substance use disorder (SUD) diagnosis)
- Housing
- Food insecurity
- Education
- Socioeconomic status
- Social determinates of health

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Value Based Payment Continuum (VBC)

Passport recognizes the need to 'meet providers where they are." Our VBC payment methodologies support the objective with an accountable care continuum of value-based models which reward quality improvements and incentivize cost of care.

VBC Program 2-Prong Approach:

- Quality Driven
- Pay for quality (P4Q) model with strong foundation on HEDIS
- Incentive opportunity per eligible members per month after quality benchmark target met
- Quality benchmarks based on NCQA thresholds and plan experience
- Provider Engagement
- Quarterly reporting and JOC meetings
- Data sharing
- Chronic condition validation
- SDoH documentation initiative

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Access and Availability Standards

As part of our commitment to providing the best quality of care to your patients (our members), Passport, in conjunction with the National Committee for Quality Assurance (NCQA) and the Department for Medicaid Services (DMS), have identified key Access and Availability standards. Please ensure your practice is following these outlined practices. Check out the Access and Availability Quick Reference Guide for an easy-to-refer-to handout!

Physical accessibility & appearance standards:

- Handicapped/Wheel Chair Accessible
- Clean Appearance
- Adequate Seating
- Posted Office Hours
- Well-Lit Waiting Room

Access standards:

- Members should be scheduled at the rate of six (6) or less per hour
- PCPs shall not exceed a panel ratio of one (1) PCP to 1,500 members
- Specialist care providers shall not exceed a ratio of one (1) specialist to 5,000 members
- Behavioral Health Care providers shall not exceed a ratio of one (1) behavioral health provider to 5,000 members

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Access and Availability Standards (cont.)

Office Standards:

- Wait time should not exceed 30 minutes
- PCP should have a 'no-show' follow-up policy
- Office should have a system in place to remind patients of appointments
- Office should have a policy in place for reporting communicable diseases
- Office should have documented office standards for orderliness, security and confidentiality or medical records
- Office should have an organized, secure and confidential filing system for medical records
- Offices closed during lunch must have phone coverage via answering service or answering machine. Messaged must be returned by the end of the business day.

After-Hours Care

A PCP's office telephone must be answered in a way that the member can reach the PCP or another designated provider.

- Telephone must be answered by an answering service that can contact the PCP or other designated on-call provider
- Telephone must be answered by a recording directing the member to call another number to reach the PCP or other designated on-call provider
- Telephone must be transferred to another location where someone will answer and be able to contact the PCP or other designated on-call provider
- After-hours phone calls must be returned within 30 minutes

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Access and Availability Standards (1 of 2)

Appointment standards:

MedicalCare Providers	
Preventative Care Appointments (For All Medical ProviderTypes)	Within 30 days
Urgent Appointments (For All Medical ProviderTypes)	Within 48 hours
After Hours/Emergency Care	24 hours a day/7days a week
Family Planning Services (Counseling and Medical)	Ages 18+: As Soon As Possible/Within 30 Calendar Days Under Age 18: As Soon As Possible/Within 10 Calendar Days
Pregnancy Preventative Care	1st Trimester – within 14 days 2nd Trimester – within 7 days 3rd Trimester – within 3 days
If a referral is required before making an appointment for specialist care, any such appointment shall be made within 30 days for routine care or 48 hours for urgent care.	

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Access and Availability Standards (2 of 2)

Appointment standards:

Behavioral Health Care Providers	
Life-Threatening Emergency	Immediately
Non Life-Threatening Emergency	Within 6 hours
Urgent Care	Within 48 hours
Routine Care	Initial Visit: within 10 business days of request Follow-up Visit: within 30 calendar days of request
Post-Discharge Outpatient Aftercare	Within 7calendar days of discharge
Referrals	Within 30 calendar days
Note: Behavioral Health Providers must contact memberswho havemissed an appointment within 24 hours to reschedule. Additional information on appointment access standards is available from your local Passport Quality Department.	

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Provider Maintenance of Medical Records

Passport requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. Providers should maintain the following medical record keeping best practices:

Confidentiality of records

Medical records are maintained in an area that is only accessible to practitioner office staff and have policies addressing privacy and confidentiality of member information.

Organization of records

There shall only be one medical record per patient. Each record is bound or pages fastened to prevent loss of medical information. `All pages within the medical records hall contain the member's name or ID number. Information within the medical record shall be organized in chronological order with the most recent information appearing first.

Documentation

All records shall be legible and contain personal data such as date of birth, address and telephone numbers, emergency contact information, etc. Each chart shall have a completed immunization record, problem list, medication list and a treatment plan. All entries in the medical record shall be signed or initialed and dated.

Access and availability of records

Hospital/Provider permits Passport access to member clinical records at no cost, to inspect, review and copy within ten (10) Business days of receipt of request. Members have the right to all information contained in the medical record as required by law. When a member changes PCPs, the medical records or copies of medical records shall be forwarded to the new PCP within ten (10) days. When releasing records to an entity other than Passport, providers are first required to obtain written consent from the member.

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Kentucky Health Information Exchange (KHIE) and Electronic Health Records (EHR) program

KHIE is a secure, interoperable electronic network that supports the statewide exchange of patient health information among healthcare providers across the Commonwealth. Participants with certified electronic health record technology can access, locate, and share needed patients health information with other participants at the point of care.
If the provider does not have an electronic health record, they must still sign a participation agreement with KHIE and sign up for

Direct Secure Messaging services so clinical information can be shared securely with other providers in their community of care.

- Passport encourages all network providers to sign a participation agreement with KHIE within one (1) month of contracting with Passport.
- For more information, please visit: khie.ky.gov

The Medicare and Medicaid **Electronic Health Records (EHR) Program (Promoting Interoperability)** encourages providers to demonstrate meaningful use of certified EHR technology.

- For more information, please visit: chfs.ky.gov/agencies/dms/ehr/Pages/default.aspx

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Dental

Dental partner - SkyGen

Passport partners with **SkyGen** to provide dental benefits to our Members.

Contact SkyGen:
Providers: 1-800-508-6965

Covered services include:

Under Age 21

- Diagnostic and Preventive Services (D0100-D1000 series)
- Restorative Services (D2000 series)
- Endodontic Services (D3000 series)
- Periodontics (D4000 series) – All procedures require prior authorization
- Dentures/Prosthodontics (D5000 series)-Denture adjustments, repairs, and relines within 6 months of initial delivery
- Oral Surgery (D7000 series)-removal of cysts, etc. (require post review and pathology report)
- Orthodontics (D8000 series) –All procedures require prior authorization
- General Services (D9000 series)

Over Age 21

- Diagnostic & Preventive Services (D0100-D1000 series)
- Restorative Services (D2000 series)
- Endodontic Services (D3000 series) – Apicoectomy codes only
- Periodontics (D4000 series) – Periodontal scaling and root planning
- Oral Surgery (D7000 series) – removal of cysts, etc. (require post review and pathology report)
- General Services (D9000 series)-Anesthesia services (when medically necessary post review required)

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Vision

Vision Partner – March Vision

Passport partners with **March Vision** to provide vision benefits to our Members.

Contact March Vision:
(844) 516-2724 (Members: Option 1 / Providers: Option 2)
MarchVisionCare.com

For detailed covered vision services, please refer to marchvisioncare.com/providerreferenceguides.aspx (Select State Kentucky)

Covered services include (but not limited to):

20 and Under

- Routine Exam (1 service date every 12 months)
- Necessary Medical Services (when services are performed by an optometrist and are within the scope of licensure)
- Eyeglasses (1 pair every calendar year when the recipient has a diagnosed visual condition when criteria is met)
- Eyeglasses Replacement(s) (1 pair every calendar year)
- Medically Necessary Contact Lenses (when criteria is met)
- No Copay

21 and Older

- Routine Exam (1 service date every 12 months)
- Necessary Medical Services (when services are performed by an optometrist and are within the scope of licensure)
- Eyeglasses ($100 allowance every 2 years for eyewear. Allowance may be used toward one pair of eyeglasses or contact lenses.)
- Eyeglasses Replacement(s) (not covered)
- Medically Necessary Contact Lenses (not covered)
- No Copay

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Pharmacy

Medicaid PharmacyBenefit Manager– MedImpact

MedImpact is the Pharmacy Benefit Manager (PBM) for Passport effective July 1,2021.

Contact MedImpact:
Phone:(800) 210-7628
Prior Authorization Call Center: (844) 336-2676
Drug Prior Authorization Fax: (858) 357-2612

BIN: 023880
PCN: KYPROD1
GRP: KYM01

- The "Formulary",also knownas the "PreferredDrugList" (PDL), is available on the Passport website.
- Physician administered drugs (PAD) are covered throughthe medical benefit, Passport.
- Fax PAD requests to: (844) 802-1406
- Prescriptions for medications requiring prior approval, for most injectable medications or for medications not included on the formulary, may be approved when medically necessary and when formulary alternatives have demonstrated ineffectiveness.When these exceptional needs arise, providers may fax a completed Prior Authorization/Medication Exception Request.

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Marketplace & Passport Advantage Pharmacy Benefit Manager – CVS Caremark

CVS Caremark is the Pharmacy Benefit Manager (PBM) for Passport Marketplace.

Contact CVS Caremark:
Provider Services: (800) 578-0775
Member Services: (833) 644-1621

Prior Authorization Submission:
Fax: (833) 322-1061
www.Availity.com

- Passport will only process completed PA request forms, the following information must be included for the request form to be considered complete:
  - Member first/last name, date of birth and identification number
  - Prescriber first/last name, NPI, phone and fax number
  - Drug name, strength, quantity and direction of use
  - Diagnosis
- The Drug Formulary, Physician Administered Preferred Drug List, Specialty Medication Administration Site of Care policy and Medication Prior Authorization Criteria and Clinical Policies is available on the Passport website: www.passporthealthplan.com/Marketplace > Providers

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Compliance

Federal Civil Rights Laws

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives federal funds or other federal financial assistance.

Americans with Disability Act (ADA) prohibits the discrimination against people with disabilities and outlines requirements around access and providing communications in accessible formats like braille, audio and large print.

Affordable Care Act Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities.

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

- **Phone:** (866) 606-3889 TTY/TDD : 711
- **Online:** MolinaHealthcare.AlertLine.com
- **Email:** Civil.Rights@PassportHealth.com

Should you or a Passport Member need more information, you can refer to the Health and Human Services website.

Potential penalties:

- Loss of federal and state funding
- Legal action
- "Informed consent" issues which may also lead to medical malpractice charges
- Change in participation status with Passport

PASSPORT BY MOLINA HEALTHCARE

Culturally and Linguistically Appropriate Services (CLAS) standards

Communication and language assistance (5-8 of 15):

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

PASSPORT BY MOLINA HEALTHCARE

Cultural and Linguistic Expertise

National census data shows that the United States' population is becoming increasingly diverse. Passport has a demonstrated history of developing targeted health care programs for a culturally diverse membership and is well-positioned to successfully serve these growing populations by:

- Contracting with a diverse network of community-oriented providers who have the capabilities to address the linguistic and cultural needs of our members;
- Educating employees about the differing needs among members; and
- Developing member education material in a variety of media and languages and ensure that the literacy level is appropriate for our target audience.

Providers are required to participate in and cooperate with Passport's provider education and training efforts as well as member education and efforts. Providers are also to comply with all health education, cultural and linguistic, and disability standards, policies, and procedures.

Additional Cultural and Linguistic Resources are available to providers such as:

- Low-literacy materials
- Translated documents
- Accessible formats (i.e., Braille, audio or large font)
- Cultural sensitivity trainings and cultural/linguistic consultation

Providers may request interpreters for members whose primary language is other than English by calling Passport's Contact Center toll free at (800) 578-0775. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the member to a qualified language service Provider.

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Additional information on culturally linguistically appropriate services is available at PassportHealthPlan.com, from your local Provider Services Representative, and by calling Provider Services at (800) 578-0775

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Reporting of Communicable Diseases

902 KAR 2:020 requires health professionals to report communicable diseases to local health departments serving the jurisdiction in which the patient resides or to the Kentucky Department for Public Health (KDPH).

Report **immediately** by **phone** to the local health department or the KDPH:

- Unexpected pattern of cases, suspected cases or deaths which may indicate a newly recognized infectious agent
- An outbreak, epidemic, related public health hazard or act of bioterrorism such as Smallpox

Kentucky Department for Public Health in Frankfort
Phone: (502) 564-3418 or (888) 9REPORT (973-7678)

For a complete list of communicable diseases and their mandatory reporting timeframes, please visit:
chfs.ky.gov/agencies/dph/Pages/default.aspx

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Provider-Preventable Conditions

Passport shall not pay a provider for provider-preventable conditions that meet the following criteria:

- Is identified in the State Medicaid plan;
- Has been found by the Department for Medicaid Services (DMS), based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
- Has negative consequences for the Enrollee;
- Is auditable; and
- Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Providers are required to report provider-preventable conditions associated with claim for payment or member treatments for which payment would otherwise be made.

For more information regarding provider-preventable conditions, please refer to the following resources:

42 CFR 438.3 (g)

42 CFR 447.26

907 KAR 14:005

PASSPORT BY MOLINA HEALTHCARE

Fraud, Waste & Abuse

Passport seeks to uphold the highest ethical standards for the provision of health care services to its members, and supports the efforts of federal and state authorities in their enforcement of prohibitions of fraudulent practices by providers or other entities dealing with the provision of health care services.

"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 ß 455.2)

- Under applicable federal law or KRS 205.8451-KRS205.8483, "Fraud" means an intentional deception or misrepresentation made by a recipient or a provider with the knowledge that the deception could result in some unauthorized benefit to the recipient or provider or to some other person. It includes any act that constitutes fraud under applicable federal or state law.

"Waste" means health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program."

- "Waste" means generally, but is not limited to, the overutilization or inappropriate utilization of services or misuse of resources, and typically is not a criminal or intentional act.

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs 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 programs. (42 CFR ß 455.2)

- Abuse means, Provider Abuse and Recipient Abuse, as defined in KRS 205.8451: "Provider abuse" means, with reference to a health care provider, practices that are inconsistent with sound fiscal, business, or medical practices, and that result in unnecessary cost to the Medical Assistance Program established pursuant to this chapter, or that result in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes practices that result in unnecessary cost to the Medical Assistance Program. "Recipient abuse" means, with reference to a medical assistance recipient, practices that result in unnecessary cost to the Medical Assistance Program or the obtaining of goods, equipment, medicines, or services that are not medically necessary, or that are excessive, or constitute flagrant overuse or misuse of Medical Assistance Program benefits for which the recipient is covered.

PASSPORT BY MOLINA HEALTHCARE

False Claims Act, 31 USC Section 3279

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim.

The act *does not* require proof of a specific intent to defraud the U.S. government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as:

- Knowingly making false statements,
- falsifying records,
- double-billing for items or services,
- submitting bills for services never performed or items never furnished or
- otherwise causing a false claim to be submitted.

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Deficit Reduction Act

The Deficit Reduction Act ("DRA") was signed into law in 2006. The law, which became effective on January 1, 2007, aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities, including our state Plans who receive or pay out at least $5 million in Medicare and Medicaid funds per year, must comply with DRA. Providers doing business with Molina Healthcare and their staff have the same obligation to report any actual or suspected violation of Medicare and Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims;
- How providers will detect and prevent fraud, waste, and abuse;
- Employee protected rights as whistleblowers.

The Federal False Claims Act and the applicable Medicaid False Claims Act have Qui Tam language commonly referred to as "whistleblower" provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act(s). The whistleblower may also file a lawsuit on their own. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

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Deficit Reduction Act (cont.)

The Federal False Claims Act and the applicable Medicaid False Claims Act contain some overlapping language related to personal liability. **For instance, the applicable Medicaid False Claims Act has the following triggers:**

- Presents or causes to be presented to the state a Medicaid claim for payment where the person receiving the benefit or payment is not authorized or eligible to receive it.
- Knowingly applies for and receives a Medicaid benefit or payment on behalf of another person, except pursuant to a lawful assignment of benefits, and converts that benefit or payment to their own personal use.
- Knowingly makes a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program.
- Knowingly makes a claim under the Medicaid program for a service or product that was not provided.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to his/her role in furthering a false claims action is entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority
- Two times the amount of back pay plus interest
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare plans will take steps to monitor our contracted providers to ensure compliance with the law.

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Examples of Fraud, Waste and Abuse

Health care fraud includes but is not limited to the making of intentional false statements, misrepresentations or deliberate omissions of material facts from, any record, bill, claim or any other form for the purpose of obtaining payment, compensation or reimbursement for health care services.

By a Member	By a Provider
Lending an ID card to someone who is not entitled to it	Billing for services, procedures and/orsupplies that have not actually been rendered or provided
Altering the quantity or number of refillson a prescription	Providing services to patients that are not medically` necessary
Making false statements to receive medical or pharmacy services	Balance-Billing a Medicaid member for Medicaid covered services
Using someone else's insurance card	Double billing or improper coding of medical claims
Including misleading information on or omitting information from an application for health care coverage or intentionally giving incorrect information to receive benefits	Intentional misrepresentation of manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of Provider/Practitioner or the recipient of services, "unbundling" of procedures, non-covered treatments to receive payment, "upcoding", and billing for services not provided
Pretending to be someone else to receive services	Concealing patients misuse of their ID Card
Falsifying claims	Failure to report a patient's forgery/alteration of a prescription

Detecting Fraud, Waste and Abuse

Passport regards health care fraud, waste and abuse as unacceptable, unlawful and harmful to the provision of quality health care in an efficient and affordable manner. Passport has therefore implemented a plan to prevent, investigate, and report suspected health care fraud, waste and abuse to reduce health care costs and to promote quality health care.

Detection Type	Summary
Review of provider claims and claims systems	Passport claims examiners are trained to recognize unusual billing practices and to detect fraud, waste and abuse. If an examiner detects fraud, waste or abuse, this is documented and sent to the compliance department.
Prepayment Fraud, Waste and Abuse	Through the implementation of claims edits, Passport's claims payment system is designed to audit claims concurrently in order to detect and prevent paying claims that are inappropriate.
Post-payment Recovery Activities	Provider will provide Passport, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Passport, in Passport's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Passport Members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Passport and without charge to Passport. In the event Passport identifies fraud, waste or abuse, Provider agrees to repay funds or Passport may seek recoupment.
Claim Auditing	Provider acknowledges Passport's right to conduct pre and post-payment billing audits. Provider shall cooperate with Passport's Special Investigations Unit and 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 as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Passport's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an over payment.

Reporting Suspected Fraud, Waste & Abuse

Rememberto include the following information whenreporting:

- Nature of complaint
- The names of individuals and/orentity involved in suspected fraud and/orabuse including address, phone number, member ID numberand any other identifying information

Phone:
Passport's Compliance AlertLine
(866) 606-3889

OR

Office of Medicaid Fraud and Abuse Control
(877) ABUSE TIP (877) 228-7384

Online:
MolinaHealthcare.alertline.com

Mail:
Passport by Molina Healthcare
Attn: Compliance
2028 W. Broadway
Louisville, KY 40203

OR

Office of Medicaid Fraud and Abuse Control
1024 Capital Center Dr, Suite 200
Frankfort, KY 40601

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Department of Medicaid Programs

CAA 2023 Required Section 5121

The Department of Medicaid Services (DMS) must comply with the Consolidated Appropriations Act (CCA) of 2023 requiring Medicaid and Children's Health Insurance Program provisions under section 5121. These provisions target Improving the health of justice-involved youth. This will be effective January 1, 2025.

As directed by DMS, Passport by Molina Healthcare will coordinate with Kentucky-based prisons, jails, juvenile detentions, and development centers thirty (30) Days pre-release to support coordination and warm hand-off activities to ensure continuity of care.

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CAA 2023 Required Section 5121

Passport by Molina will provide the following services 30-day post-release from incarnation that are medically necessary and align with DMS covered service guidelines.

Screening and Diagnostic Services including

- EPSDT
- Behavioral Health screenings and diagnostic services
- Dental Services; and
- Coordination of activities to ensure the continuity of care post-release

Targeted Case Management

- Comprehensive assessment of medical, education and social needs
- Development of a person-centered care plan; and
- Monitoring and follow-up to ensure the care plan is effectively implemented.

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1115 Reentry Waiver Program

The 1115 Reentry Waiver Program assist individuals return to society from incarceration. This waiver gives the prisons and jails an opportunity to work with Medicaid and Passport by Molina Healthcare to support individuals not only during incarceration but also during the critical transition from incarceration to community.

Passport by Molina Healthcare will coordinate with prisons and Youth development centers to provide the provision of services as defined by DMS. The services will be offered for a period of 60 days pre-release and 30 days post release to eligible adults and juveniles as defied in section 24.8 of the waiver.

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1115 Reentry Waiver Program

The services that will be available through this program are:

Case Management
- Comprehensive assessment of medical, educational and social needs.
- Development of person-center care plan
- Notification of immediate clinical, behavioral, educational, or social needs to the correctional staff.
- Referrals and linkages to appropriate care post-release.
- Monitoring and follow up to ensure the care plan is effectively implemented.

Medication-assisted Treatment (MAT)
- MAT services with accompanying counseling for individuals diagnosed with a substance use disorder up to 60 days prior to release.

Pharmacy Benefit
- 30-day supply of all clinically required prescriptions medication (inclusive of the over-the-counter
- Medications and if applicable, a prescription/written order for Medical supplies, Equipment,
- And appliance immediately upon release.

Pre-release Coordination of Services
- Warm transfers
- Face to Face outreach
- Virtual outreach

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Email us at KYProviderRelations@MolinaHealthcare.com