Provider Orientation

2018 | Molina Healthcare

MOLINA HEALTHCARE

MHO-2465
1018

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History and Service Areas

MOLINA HEALTHCARE

A Story of Change and Growth

1980
FIRST PATIENT

Molina Healthcare is born. Originally named Molina Medical Centers, our primary care clinics begin serving communities in Southern California.

1984
100,000 MEMBERS

Molina Healthcare begins serving communities in **California** through its first licensed health plan.

1987
110,000 MEMBERS

Molina Healthcare begins servicing communities in **Utah** and **Michigan**.

2000
250,000 MEMBERS

Molina Healthcare begins serving communities in **Washington**.

2003
500,000 MEMBERS

Molina Healthcare becomes a **publicly-traded company** is listed on the New York Stock Exchange as MOH.

2004
750,000 MEMBERS

Molina Healthcare begins serving communities in **New Mexico**.

2005
900,000 MEMBERS

Molina Healthcare begins serving communities in **Texas** and **Ohio**.

2006
1 MILLION MEMBERS

Molina Healthcare begins offering services to people with **Medicare**..

2008
1.25 MILLION MEMBERS

Molina Healthcare begins serving communities in **Virginia** and **Florida**.

2010
1.5 MILLION MEMBERS

Molina Healthcare begins offering services to people with **Molina Medicaid Solutions.**

Molina Healthcare begins serving communities in **Wisconsin**.

2011
1.7 MILLION MEMBERS

Molina Medicaid Solutions' system in **Maine** receives federal certification

2012
1.8 MILLION MEMBERS

Molina Healthcare is named a **FORTUNE 500** company.

Molina Medicaid Solutions' system in **Idaho** receives federal certification

2013
1.9 MILLION MEMBERS

Molina Healthcare begins serving communities in **Illinois**.

Molina Healthcare begins managing acute care services for **College Medical Center**.

Molina Healthcare implements first-ever **MMIS partnership model** between state and U.S. territory.

2014
2.6 MILLION MEMBERS

Molina Healthcare begins serving communities in **South Carolina**.

Molina Healthcare begins serving dual-eligible populations in **California**, **Illinois** and **Ohio**..

Molina Healthcare starts offering services through the **Health Insurance Marketplace**.

2015
3.5 MILLION MEMBERS

Molina Healthcare begins serving communities in the **Commonwealth of Puerto Rico**.

Molina Healthcare begins serving dual-eligible populations in **Michigan**, **South Carolina** and **Texas**..

2017
4.5 MILLION MEMBERS

Molina Healthcare begins serving communities in **Mississippi**..

MOLINA HEALTHCARE

Recognized for Quality, Innovation and Success

Fortune 200 Company

Top 100 Best Corporate Citizens
by Business Ethics

Molina Healthcare of Ohio

Accolades & Awards

2009
NCQA Accredited
2009 - 2016

2011
Pinnacle Honoree
by Ohio Association of Health Plans
2011 - 2013

2012
Best Place to Work Honoree
by Columbus Business First

2014
Pillar Award for Community Service
by Medical Mutual

2015
Corporate Caring Award Finalist
by Columbus Business First

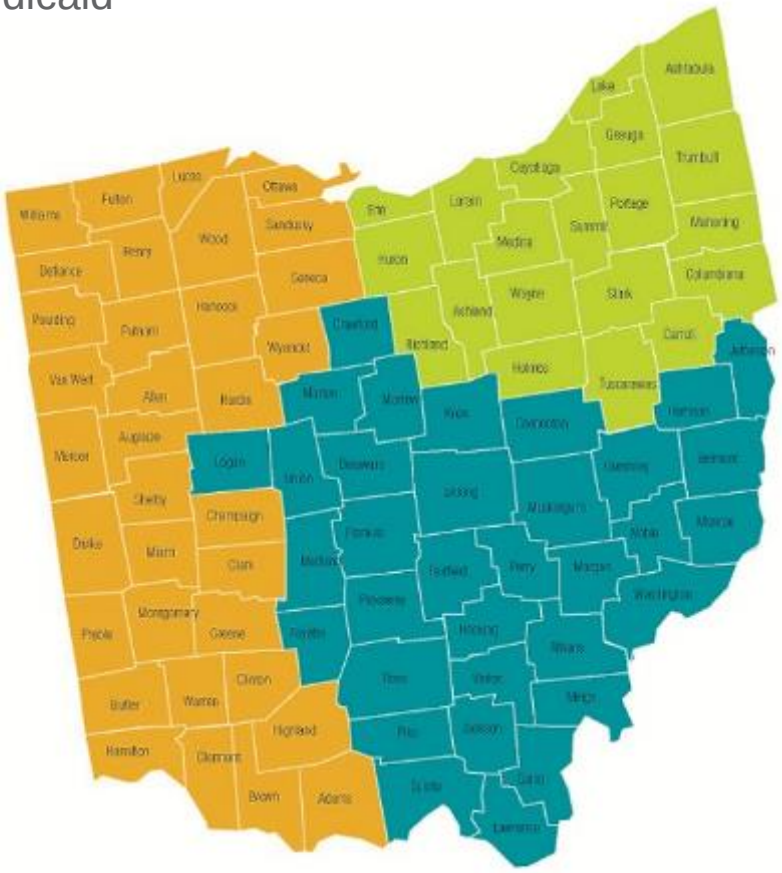
2016
Healthy Practices Honoree
by Ohio Department of Health

2017
NCQA Commendable

MOLINA HEALTHCARE

Service Maps

Medicaid



Medicaid Regions

- Central/Southeast
- West
- Northeast

These selected Applicants must successfully demonstrate that they have met all Ohio Department of Medicaid requirements before they can receive final approval to begin providing services to Medicaid consumers in these regions.

MyCare Ohio

MOLINA HEALTHCARE

Service Maps

Medicare

Marketplace

Provider Resources

MOLINA HEALTHCARE

Provider Online Resources

Provider Manual
Dental Manual
Provider Online Directory
Provider Portal
Preventive & Clinical Care Guidelines
Prior Authorization Information
Advanced Directives
Claims Information
Claim Reconsiderations
Pharmacy Information
HIPAA
Fraud, Waste and Abuse Information
Frequently Used Forms
Communications & Newsletters
Member Rights & Responsibilities
Contact Information

www.MolinaHealthcare.com/OhioProviders

Provider Services

Satisfaction

- Provider representatives, advocates and engagement teams
- Annual assessment of provider satisfaction

Communication

- Provider Bulletin and Provider Newsletters
- Online Provider Manuals
- Online trainings and Molina Healthcare Provider Portal
- Interactive Voice Response (IVR) Provider Service Line

Technology

- 24-hour Provider Portal
- Electronic Funds Transfer and Electronic Remittance Advice
- Prior authorization submission

Provider Manual Highlights

• Benefits and Covered Services	• Interpreter Services
• Claims, Encounter Data and Compensation	• Compliance and Fraud, Waste and Abuse
• Member Grievances and Appeals	• Member Rights and Responsibilities
• Credentialing and Re-credentialing	• Preventive Health Guidelines
• Delegation Oversight	• Provider Responsibilities
• Eligibility and Enrollment	• Quality Improvement
• Health Care Services	• Transportation Services
• Health Insurance Portability and Accountability Act (HIPAA)	• Utilization Management, Referral and Authorization
• Long-term Supports & Services	• Model of Care
• Pharmacy	• Contacts

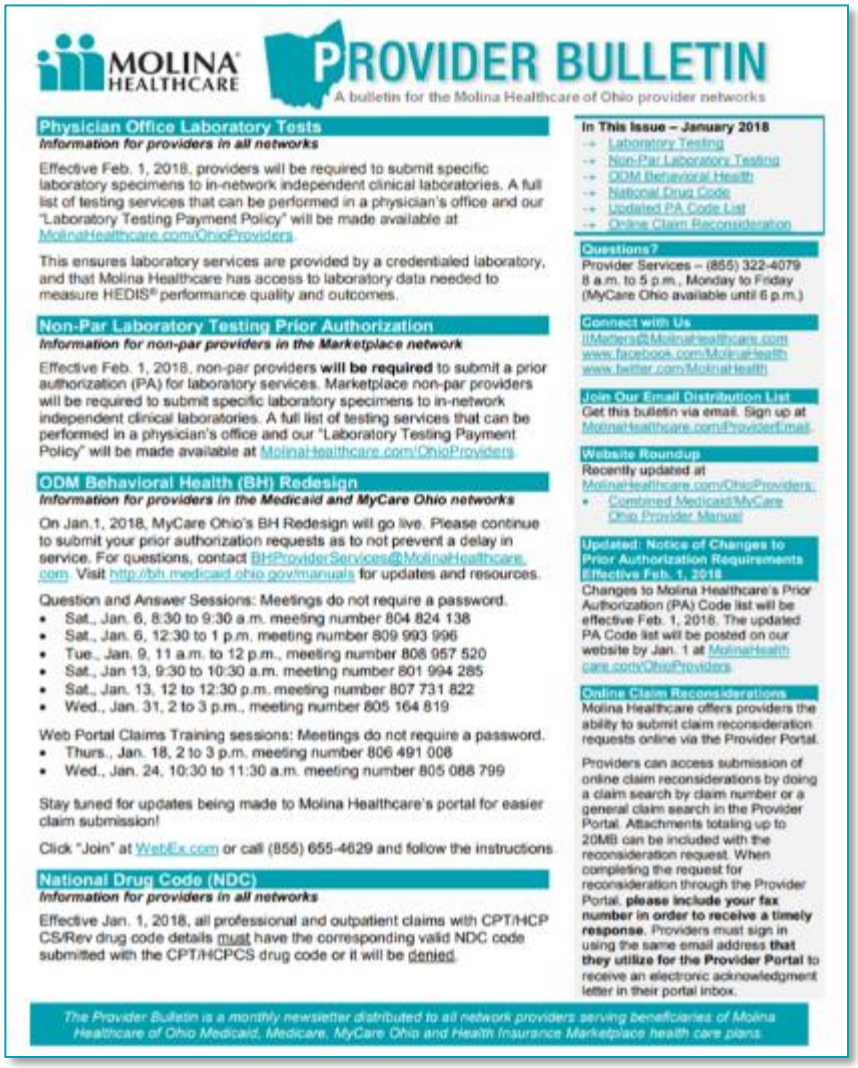
Find the manual on our provider website at www.MolinaHealthcare.com/OhioProviders

Provider Bulletin

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

The Provider Bulletin includes:

- Prior authorization changes
- Provider training opportunities
- Updates to the Molina Healthcare Formulary
- Changes in policies that could effect claim submission, billing procedures or appeals
- Updates to the Molina Healthcare Provider Portal



MOLINA HEALTHCARE

PROVIDER BULLETIN

A bulletin for the Molina Healthcare of Ohio provider networks

Physician Office Laboratory Tests

Information for providers in all networks

Effective Feb. 1, 2018, providers will be required to submit specific laboratory specimens to in-network independent clinical laboratories. A full list of testing services that can be performed in a physician's office and our "Laboratory Testing Payment Policy" will be made available at MolinaHealthcare.com/OhioProviders.

This ensures laboratory services are provided by a credentialed laboratory, and that Molina Healthcare has access to laboratory data needed to measure HEDIS® performance quality and outcomes.

Non-Par Laboratory Testing Prior Authorization

Information for non-par providers in the Marketplace network

Effective Feb. 1, 2018, non-par providers **will be required** to submit a prior authorization (PA) for laboratory services. Marketplace non-par providers will be required to submit specific laboratory specimens to in-network independent clinical laboratories. A full list of testing services that can be performed in a physician's office and our "Laboratory Testing Payment Policy" will be made available at MolinaHealthcare.com/OhioProviders.

ODM Behavioral Health (BH) Redesign

Information for providers in the Medicaid and MyCare Ohio networks

On Jan.1, 2018, MyCare Ohio's BH Redesign will go live. Please continue to submit your prior authorization requests as to not prevent a delay in service. For questions, contact BHProviderServices@MolinaHealthcare.com. Visit http://bh.medicaid.ohio.gov/manuals for updates and resources.

Question and Answer Sessions: Meetings do not require a password.

- Sat., Jan. 6, 8:30 to 9:30 a.m. meeting number 804 824 138
- Sat., Jan. 6, 12:30 to 1 p.m. meeting number 809 993 996
- Tue., Jan. 9, 11 a.m. to 12 p.m., meeting number 808 057 520
- Sat., Jan 13, 9:30 to 10:30 a.m. meeting number 801 994 285
- Sat., Jan. 13, 12 to 12:30 p.m. meeting number 807 731 822
- Wed., Jan. 31, 2 to 3 p.m., meeting number 805 164 819

Web Portal Claims Training sessions: Meetings do not require a password.

- Thurs., Jan. 18, 2 to 3 p.m. meeting number 806 491 008
- Wed., Jan. 24, 10:30 to 11:30 a.m. meeting number 805 088 799

Stay tuned for updates being made to Molina Healthcare's portal for easier claim submission!

Click "Join" at WebEx.com or call (855) 655-4629 and follow the instructions.

National Drug Code (NDC)

Information for providers in all networks

Effective Jan. 1, 2018, all professional and outpatient claims with CPT/HCPCS/Rev drug code details must have the corresponding valid NDC code submitted with the CPT/HCPCS drug code or it will be denied.

In This Issue – January 2018

- Laboratory Testing
- Non-Par Laboratory Testing
- ODM Behavioral Health
- National Drug Code
- Updated PA Code List
- Online Claim Reconsideration

Questions?

Provider Services – (855) 322-4079 8 a.m. to 5 p.m., Monday to Friday (MyCare Ohio available until 6 p.m.)

Connect with Us

ItMatters@MolinaHealthcare.com
www.facebook.com/MolinaHealth
www.twitter.com/MolinaHealth

Join Our Email Distribution List

Get this bulletin via email. Sign up at MolinaHealthcare.com/ProviderEmail.

Website Roundup

Recently updated at MolinaHealthcare.com/OhioProviders:

- Combined Medicaid/MyCare Ohio Provider Manual

Updated: Notice of Changes to Prior Authorization Requirements Effective Feb. 1, 2018

Changes to Molina Healthcare's Prior Authorization (PA) Code list will be effective Feb. 1, 2018. The updated PA Code list will be posted on our website by Jan. 1 at MolinaHealthcare.com/OhioProviders.

Online Claim Reconsiderations

Molina Healthcare offers providers the ability to submit claim reconsideration requests online via the Provider Portal.

Providers can access submission of online claim reconsiderations by doing a claim search by claim number or a general claim search in the Provider Portal. Attachments totaling up to 20MB can be included with the reconsideration request. When completing the request for reconsideration through the Provider Portal, **please include your fax number in order to receive a timely response.** Providers must sign in using the same email address **that they utilize for the Provider Portal** to receive an electronic acknowledgment letter in their portal inbox.

The Provider Bulletin is a monthly newsletter distributed to all network providers serving beneficiaries of Molina Healthcare of Ohio Medicaid, Medicare, MyCare Ohio and Health Insurance Marketplace health care plans.

Visit our website at www.MolinaHealthcare.com/OhioProviders to join our distribution list.

Provider Online Directory

Molina Healthcare providers are encouraged to use the Provider Online Directory on our website to find a network provider or specialist.

Members should be referred to participating providers.

To find a Molina Healthcare provider, visit www.MolinaHealthcare.com/OhioProviders and click “Find a Doctor or Pharmacy”

Provider Online Directory

Providers are encouraged to review their information on the Provider Online Directory for accuracy

Important Reminder:

Please notify Molina Healthcare at least 30 days in advance when you have any of the following:

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

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

Provider Portal

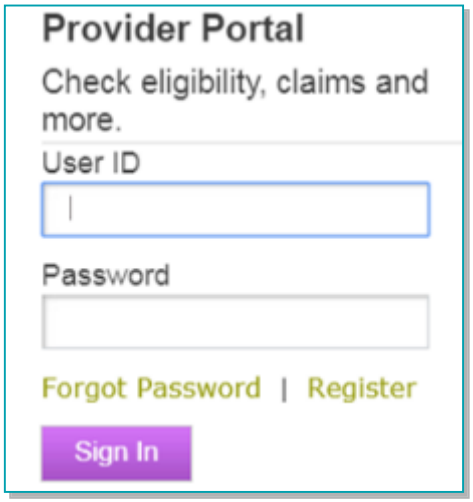
The Provider Portal is secure and available 24 hours a day, seven days a week. Register for access to our Provider Portal for self-services, including:

Online Claim Submission	Claims status inquiry
Online Claim Reconsideration Requests	Corrected Claims
Member eligibility verification and history	Coordination of benefits (COB)
Member Nurse Advice Line call reports	Update provider profile
Submit Prior Authorization (PA) Requests	Status check of authorization requests
View Primary Care Provider (PCP) member roster	Health Effectiveness Data and Information Sheet (HEDIS®) missed service alerts for members

Register for Provider Portal

Visit www.MolinaHealthcare.com/OhioProviders to register. You will need the TIN and your Molina Healthcare Provider Identification number.

If you need a Molina Healthcare Provider ID number, contact Provider Services at (855) 322-4079.



Begin registration

- Click “New Registration Process”
- Select “Other Lines of Business”
- Select State
- Select role type “Facility or Group”
- Click “Next”

Required fields

Enter:

- First name
- Last name
- Email address
- Email address again to confirm

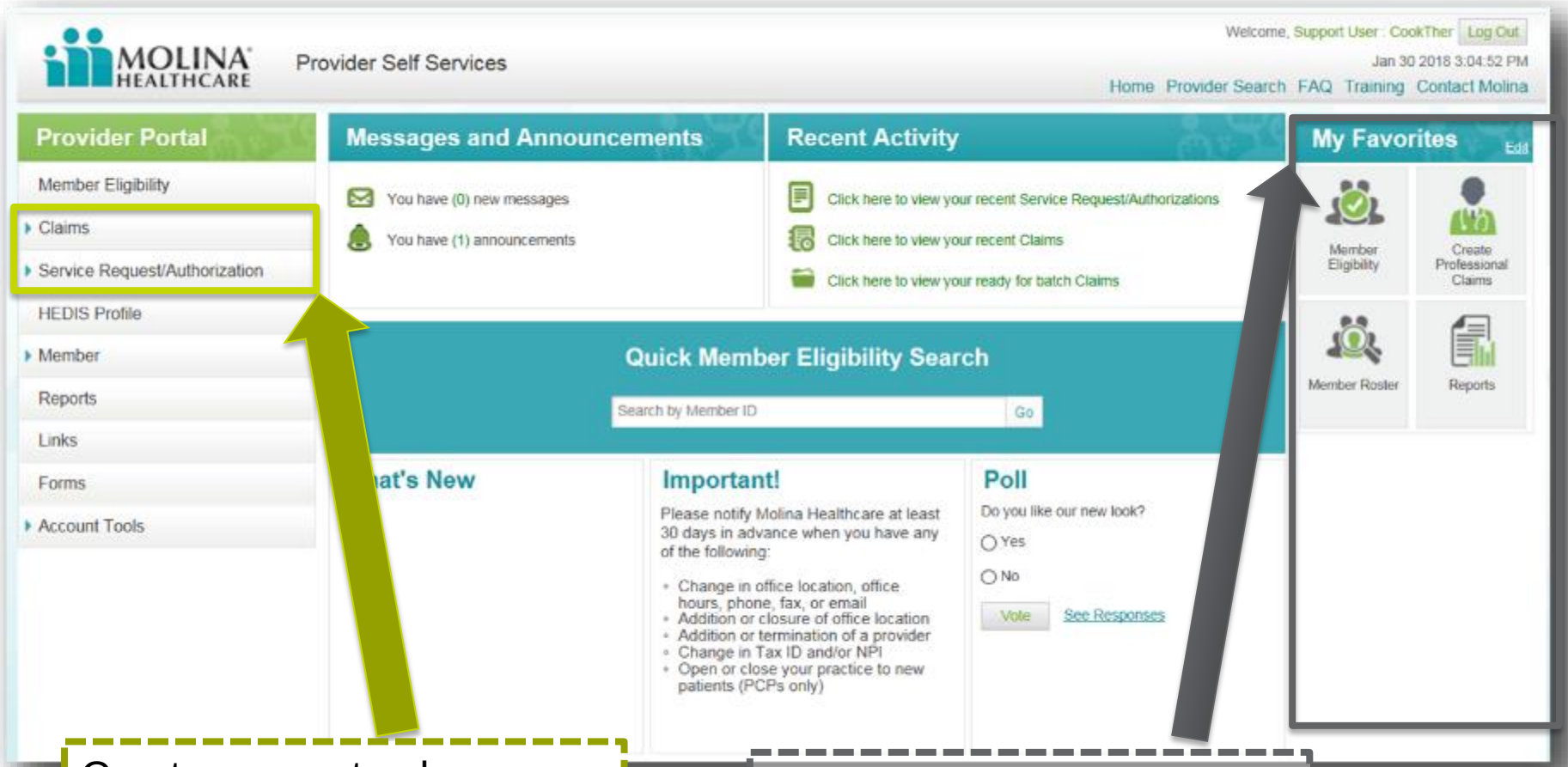
Username and password

- Create a unique user ID using 8-15 characters
- Create a unique password using 8-12 characters
- Select three security questions and enter answers

Complete registration

- Accept “Provider Online User Agreement” by clicking on the check box
- Enter the code in the textbox as shown in the image
- Click “Register”

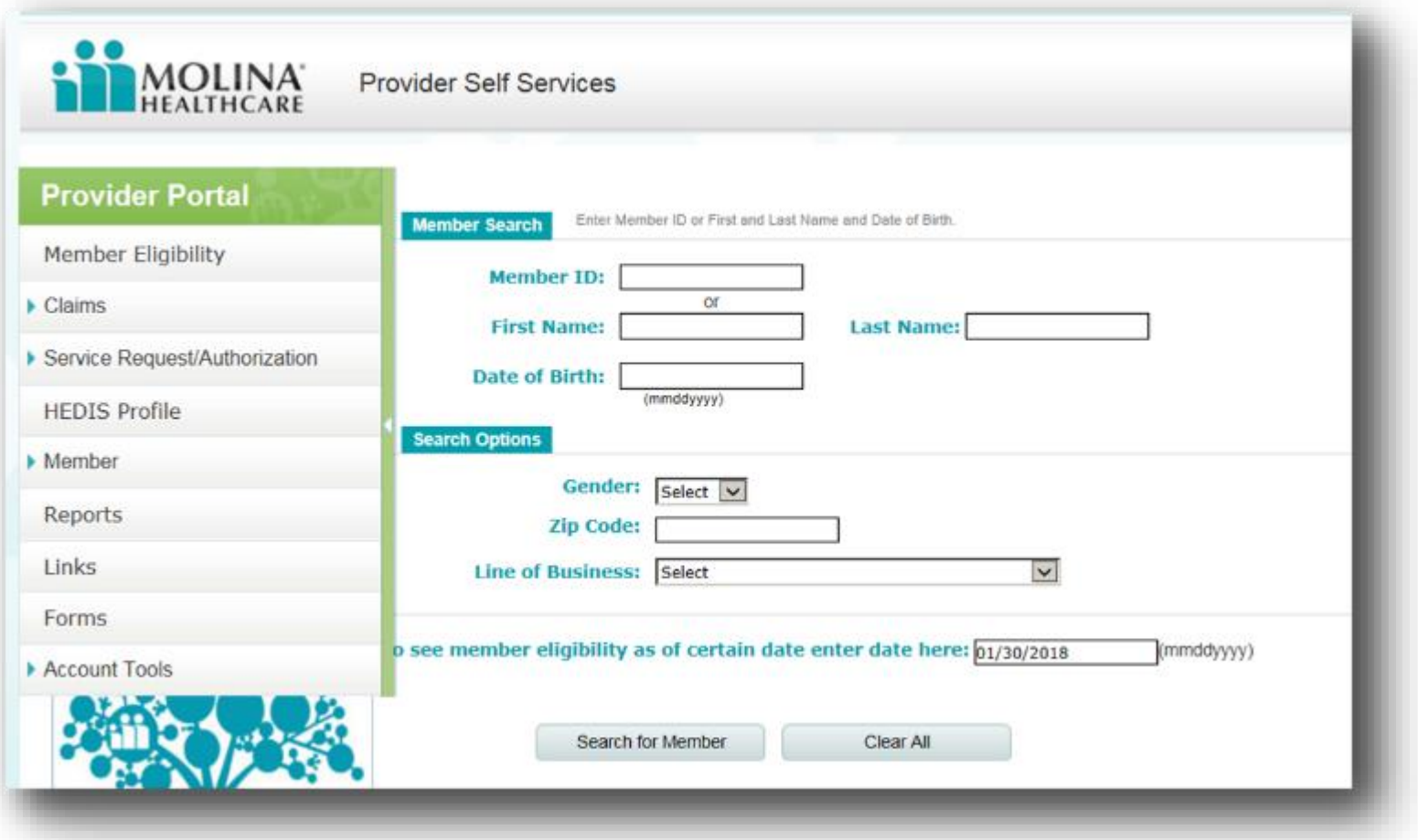
Provider Portal



Create new or track previously submitted claims and prior authorizations.

Customize your favorites for quick access.

Member Eligibility Search



Click ***Member Eligibility*** from the main menu. Search for a member using Member ID, First Name, Last Name and/or Date of Birth. When a match is found, the Provider Portal will display the member's eligibility and benefits page.

Verifying Member Eligibility

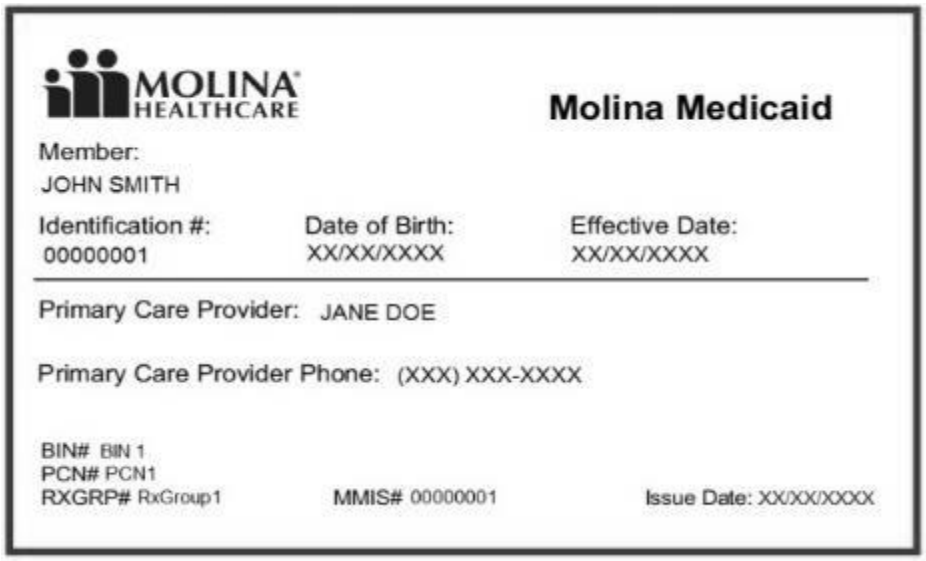
Molina Healthcare offers various tools to verify member eligibility. Providers may use our online self-service Provider Portal, integrated voice response (IVR) system, eligibility rosters or speak with a customer service representative.

Please note: At no time should a member be denied services because his or her name does not appear on the eligibility roster. If a member does not appear on the eligibility roster, please contact Molina Healthcare for further verification.

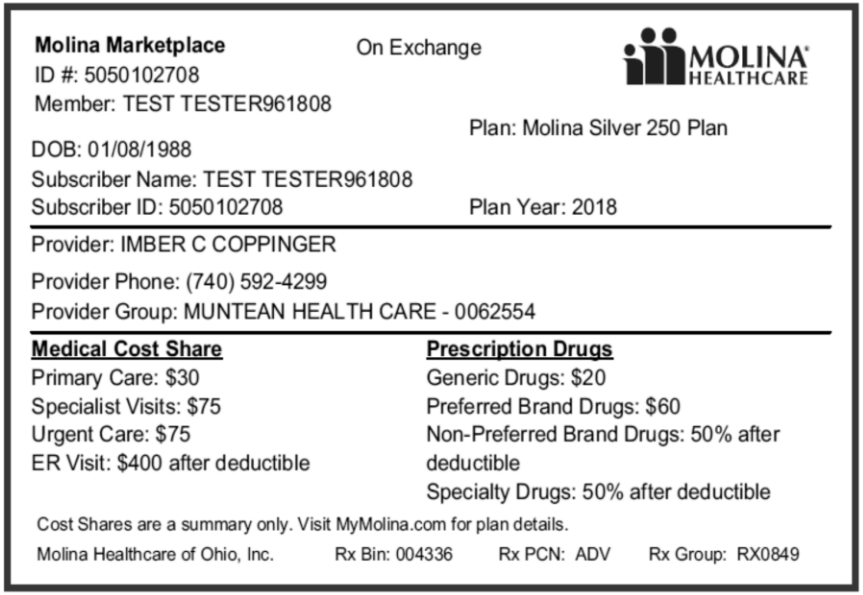
Provider Portal: http://Provider.MolinaHealthcare.com

Provider Services/24-hour IVR Automated System: (855) 322-4079

Molina Healthcare Medicaid ID Card



Molina Healthcare Marketplace ID Card



Molina Marketplace On Exchange

ID #: 5050102708

Member: TEST TESTER961808

Plan: Molina Silver 250 Plan

DOB: 01/08/1988

Subscriber Name: TEST TESTER961808

Subscriber ID: 5050102708 Plan Year: 2018

Provider: IMBER C COPPINGER

Provider Phone: (740) 592-4299

Provider Group: MUNTEAN HEALTH CARE - 0062554

Medical Cost Share	Prescription Drugs
Primary Care: $30	Generic Drugs: $20
Specialist Visits: $75	Preferred Brand Drugs: $60
Urgent Care: $75	Non-Preferred Brand Drugs: 50% after deductible
ER Visit: $400 after deductible	Specialty Drugs: 50% after deductible

Cost Shares are a summary only. Visit MyMolina.com for plan details.

Molina Healthcare of Ohio, Inc. Rx Bin: 004336 Rx PCN: ADV Rx Group: RX0849

This card is for identification purposes only and does not prove eligibility for service.

Member: Emergencies (24 hrs): when a medical emergency might lead to disability or death, call 911 immediately or get to the nearest emergency room. No prior authorization is required for emergency care.

Miembro: Emergencias (24 horas al día): si una emergencia médica puede resultar en muerte o discapacidad, llame al 911 inmediatamente o acuda a la sala de emergencias más cercana. No necesita autorización previa para los servicios de emergencia.

Remit claims to: Molina Healthcare, P.O. Box 22712, Long Beach, CA 90801

Member Services: (888) 296-7677 (TTY/TTD: 711)

24 Hour Nurse Advice Line: (888) 275-8750

Línea de Consejos de Enfermeras 24 horas al día (español): (866) 648-3537

CVS Caremark Pharmacy Help Desk: (800) 364-6331

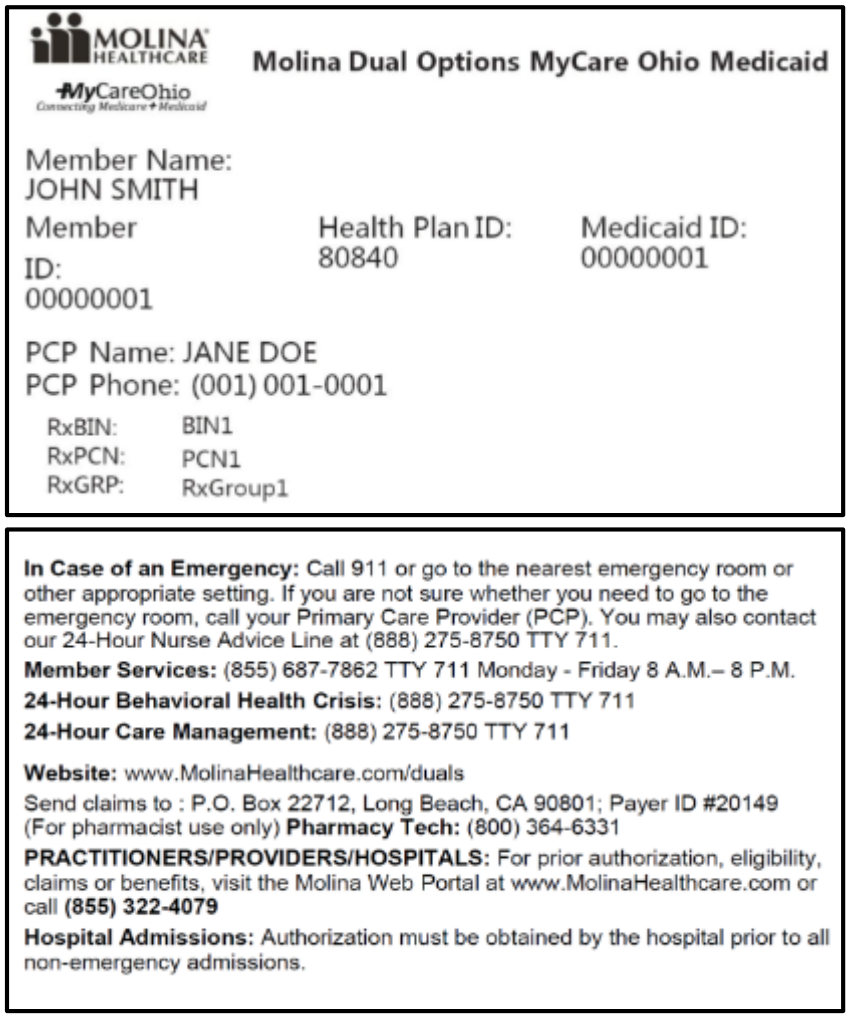
Provider: Notify the health plan within 24 hours of any inpatient admission at the hospital admission notification phone number.

Prior Authorization/Notification of Hospital Admission and Covered Services: (855) 322-4079

MHO-1366 MolinaMarketplace.com

Molina Dual Options MyCare Ohio ID Cards

Molina MyCare Ohio Medicaid (opt-out)



MOLINA HEALTHCARE
MyCareOhio
Connecting Medicare + Medicaid

Molina Dual Options MyCare Ohio Medicaid

Member Name:
JOHN SMITH

Member ID:
00000001

Health Plan ID:
80840

Medicaid ID:
00000001

PCP Name: JANE DOE
PCP Phone: (001) 001-0001

RxBIN: BIN1
RxPCN: PCN1
RxGRP: RxGroup1

In Case of an Emergency: Call 911 or go to the nearest emergency room or other appropriate setting. If you are not sure whether you need to go to the emergency room, call your Primary Care Provider (PCP). You may also contact our 24-Hour Nurse Advice Line at (888) 275-8750 TTY 711.

Member Services: (855) 687-7862 TTY 711 Monday - Friday 8 A.M.– 8 P.M.

24-Hour Behavioral Health Crisis: (888) 275-8750 TTY 711

24-Hour Care Management: (888) 275-8750 TTY 711

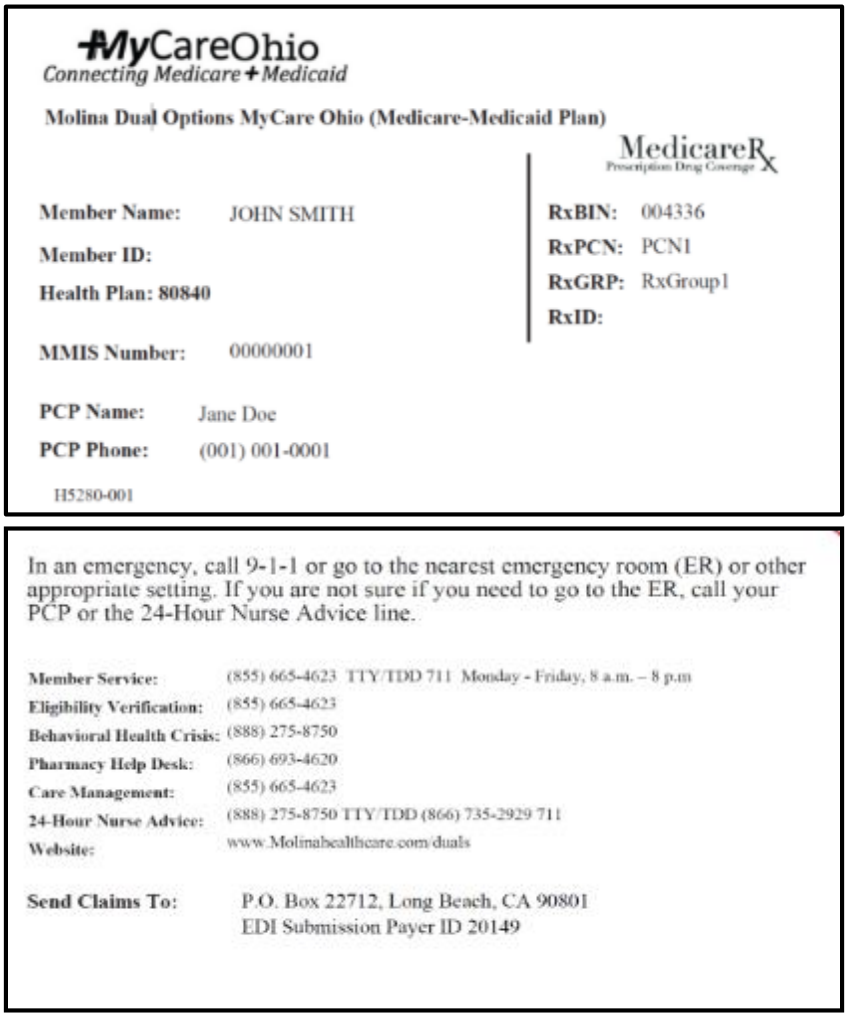
Website: www.MolinaHealthcare.com/duals

Send claims to : P.O. Box 22712, Long Beach, CA 90801; Payer ID #20149
(For pharmacist use only) **Pharmacy Tech:** (800) 364-6331

PRACTITIONERS/PROVIDERS/HOSPITALS: For prior authorization, eligibility, claims or benefits, visit the Molina Web Portal at www.MolinaHealthcare.com or call **(855) 322-4079**

Hospital Admissions: Authorization must be obtained by the hospital prior to all non-emergency admissions.

Molina Dual Options MyCare Ohio Medicare-Medicaid Plan (full benefits)



MyCareOhio
Connecting Medicare + Medicaid

Molina Dual Options MyCare Ohio (Medicare-Medicaid Plan)

MedicareRx
Prescription Drug Coverage

Member Name: JOHN SMITH
Member ID:
Health Plan: 80840
MMIS Number: 00000001
PCP Name: Jane Doe
PCP Phone: (001) 001-0001

H5280-001

RxBIN: 004336
RxPCN: PCN1
RxGRP: RxGroup1
RxID:

In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

Member Service:	(855) 665-4623 TTY/TDD 711 Monday - Friday, 8 a.m. – 8 p.m
Eligibility Verification:	(855) 665-4623
Behavioral Health Crisis:	(888) 275-8750
Pharmacy Help Desk:	(866) 693-4620
Care Management:	(855) 665-4623
24-Hour Nurse Advice:	(888) 275-8750 TTY/TDD (866) 735-2929 711
Website:	www.Molinahealthcare.com/duals

Send Claims To: P.O. Box 22712, Long Beach, CA 90801
EDI Submission Payer ID 20149

Molina Healthcare Medicare ID Card

Prior Authorizations (PA)

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

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

Requests for services on the Molina Healthcare Prior Authorization Guide are evaluated by licensed nurses and trained staff.

A list of services and procedures that require PA is in the Provider Manual, listed on the Molina Healthcare Prior Authorization Request Form and on our website at www.MolinaHealthcare.com/OhioProviders.

Prior Authorizations (PA)

Information generally required to support decision making includes:

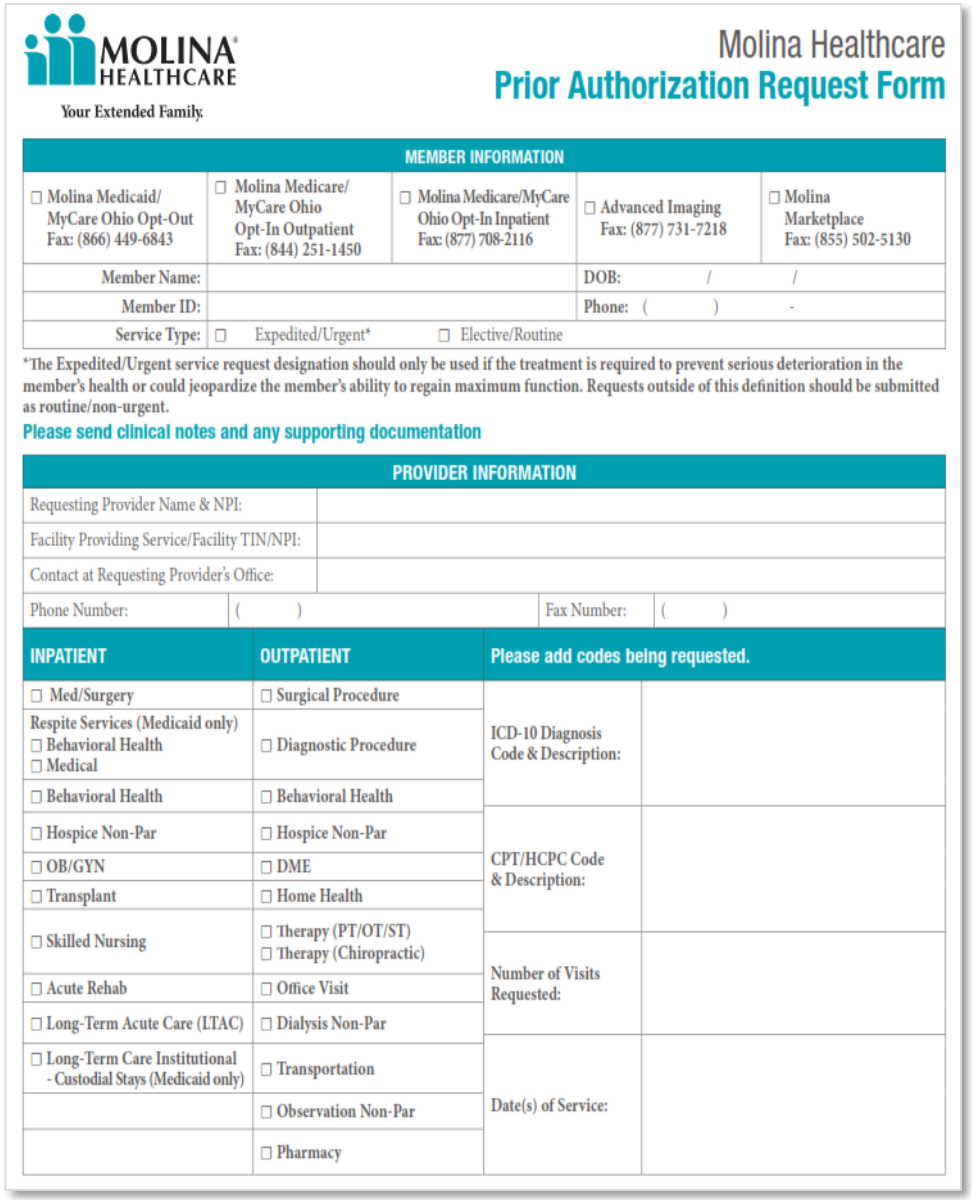
- Current (up to six months), adequate patient history related to the requested services
- Copy of current and existing treatment plan that identifies all services (medical and behavioral)
- Physical examination that addresses the problem
- Laboratory or radiology results to support the request (including previous MRI, CT, lab or X-ray report/results)
- PCP or specialist progress notes or consultations
- Any other information or data specific to the request

Molina Healthcare will process all "non-urgent" requests in no more than 10 calendar days from the initial request. "Urgent" requests will be processed within 48 hours of the initial request.

Waiver Services are requested verbally or in writing by the member or their representative and are authorized on the Waiver Service Plan.

If we require additional information, we will contact you.

Prior Authorization Form



MOLINA HEALTHCARE
Your Extended Family.

Molina Healthcare
Prior Authorization Request Form

MEMBER INFORMATION				
☐ Molina Medicaid/ MyCare Ohio Opt-Out Fax: (866) 449-6843	☐ Molina Medicare/ MyCare Ohio Opt-In Outpatient Fax: (844) 251-1450	☐ Molina Medicare/MyCare Ohio Opt-In Inpatient Fax: (877) 708-2116	☐ Advanced Imaging Fax: (877) 731-7218	☐ Molina Marketplace Fax: (855) 502-5130
Member Name:			DOB: / /	
Member ID:			Phone: ( ) -	
Service Type:	☐ Expedited/Urgent*	☐ Elective/Routine		

*The Expedited/Urgent service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.

Please send clinical notes and any supporting documentation

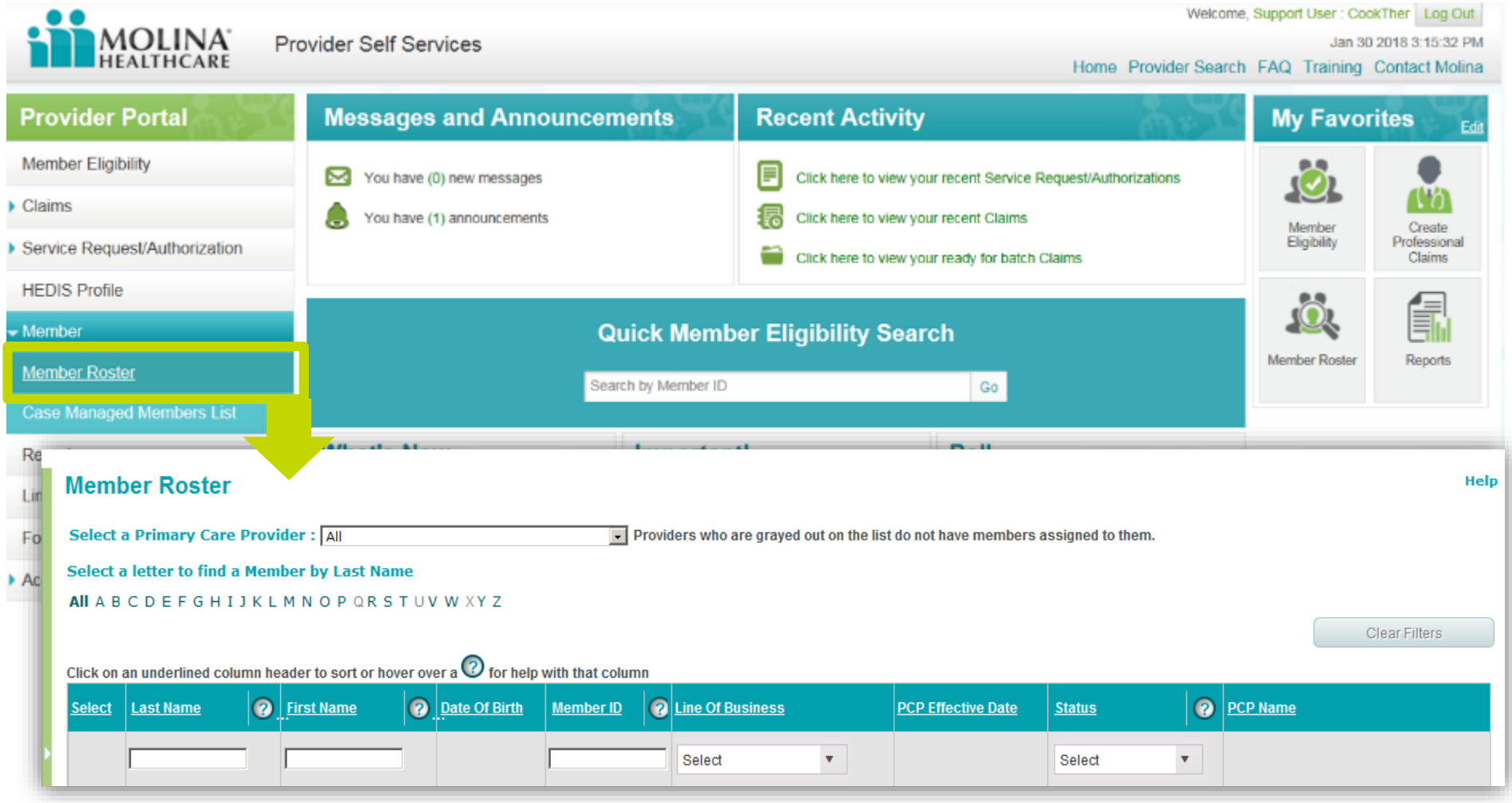
PROVIDER INFORMATION			
Requesting Provider Name & NPI:			
Facility Providing Service/Facility TIN/NPI:			
Contact at Requesting Provider's Office:			
Phone Number:	( )	Fax Number:	( )

INPATIENT	OUTPATIENT	Please add codes being requested.	
☐ Med/Surgery	☐ Surgical Procedure	ICD-10 Diagnosis Code & Description:	
Respite Services (Medicaid only) ☐ Behavioral Health ☐ Medical	☐ Diagnostic Procedure		
☐ Behavioral Health	☐ Behavioral Health		
☐ Hospice Non-Par	☐ Hospice Non-Par	CPT/HCPC Code & Description:	
☐ OB/GYN	☐ DME		
☐ Transplant	☐ Home Health		
☐ Skilled Nursing	☐ Therapy (PT/OT/ST) ☐ Therapy (Chiropractic)	Number of Visits Requested:	
☐ Acute Rehab	☐ Office Visit		
☐ Long-Term Acute Care (LTAC)	☐ Dialysis Non-Par		
☐ Long-Term Care Institutional - Custodial Stays (Medicaid only)	☐ Transportation	Date(s) of Service:	
	☐ Observation Non-Par		
	☐ Pharmacy		

You can submit PAs:

- On the **Provider Portal:** **http://Provider.MolinaHealthcare.com**
- By faxing the Prior Authorization Request Form to the appropriate Line of Business (LOB)
  - The PA Request Form is available at **www.MolinaHealthcare.com/OhioProvider** under the "Forms" tab

PCP Member Roster



PCP Member Roster

The Member Roster application is a flexible tool that makes your member management easier by helping you:

1. View an up-to-date member list.

No more monthly member lists. Knowing your member roster in real-time helps reconcile accounts. This list applies to any provider with assigned Molina Healthcare members.

2. Customize your search with built-in filters.

Search for members any way you like – by the line of business, first name, last name and more.

3. View various statuses for multiple members.

Be informed about new members and if any member has missing services through HEDIS® alerts.

4. Check member eligibility directly from the roster.

Click on your member's name and view member details at a glance.

5. Have easier access to other applications.

Jump directly from the roster to claims and service request/authorizations.

HEDIS® and Quality

MOLINA HEALTHCARE

HEDIS® Profile

View your HEDIS® scores and compare your performance against peers and national benchmarks
Retrieve/print list of patients who need HEDIS® services completed
Search/filter for patients with HEDIS® services needed
Submit HEDIS® chart documentation online for services completed to update our system

- If you registered multiple lines of business under one username you can view information specific to that account.
- Click on the drop-down arrow to toggle between your Medicare, Medicaid, MyCare Ohio and Marketplace accounts.

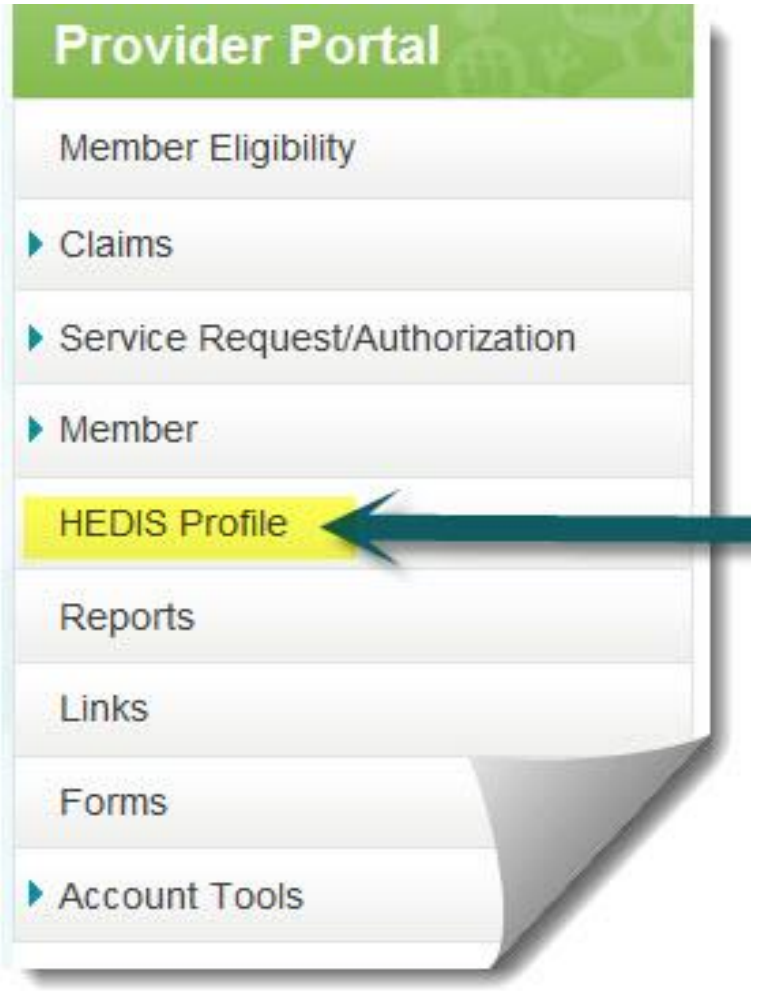
HEDIS® Profile

To access your HEDIS® Profile, log in to your Provider Portal account.

Select “HEDIS® Profile” on the right menu bar.

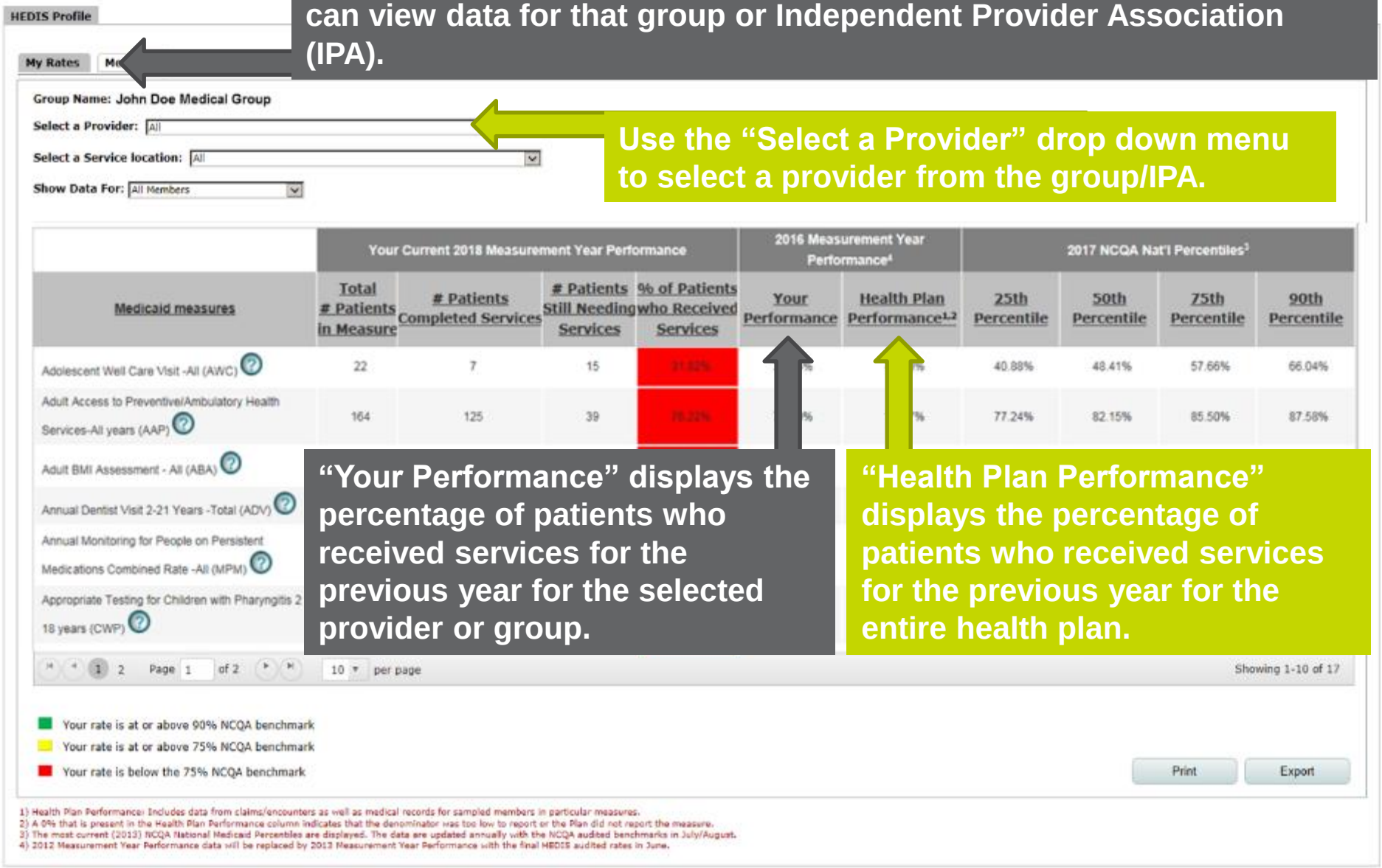
The HEDIS® Profile is accessible to the “Admin,” “All Access,” and “Clinical” Provider Portal user roles.

Billers and non-clinical portal user roles will not be able to access the HEDIS® Profile from their Provider Portal account.



HEDIS® Profile

The "My Rates" tab will display. Users registered as a Facility/Group can view data for that group or Independent Provider Association (IPA).

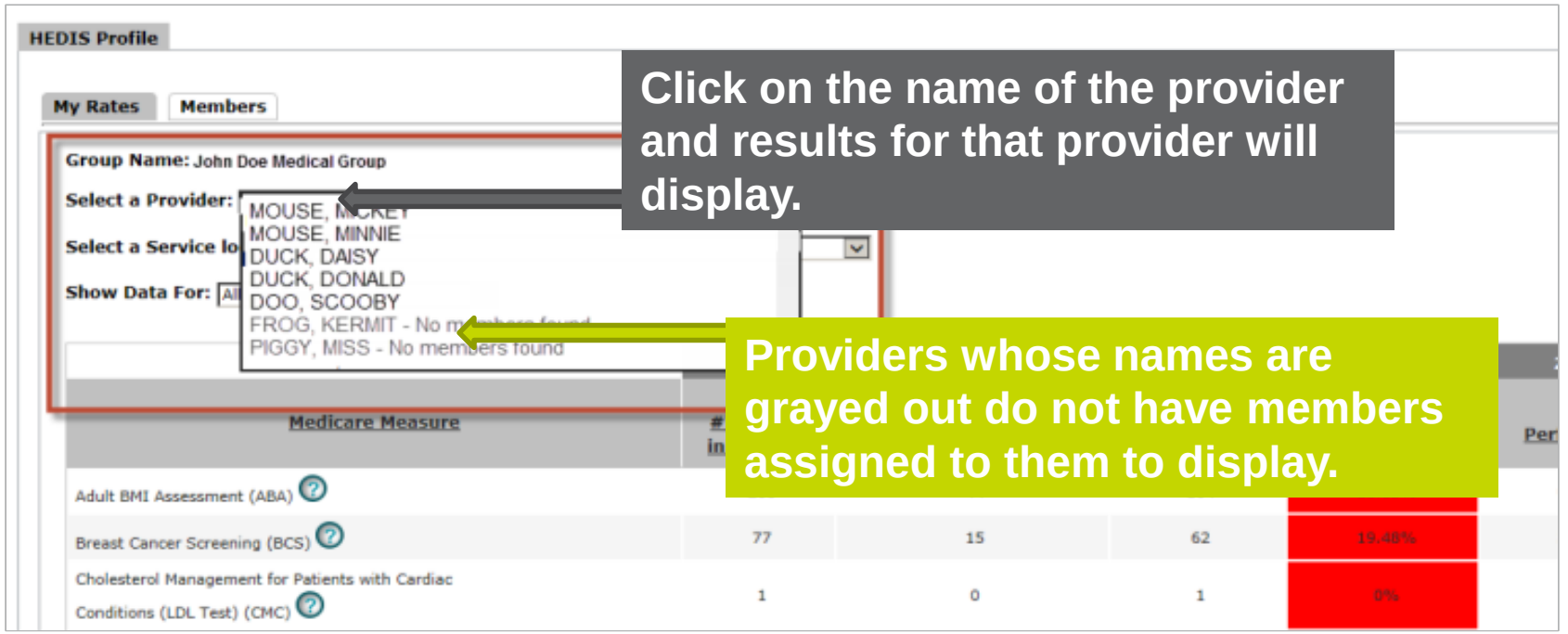


Use the "Select a Provider" drop down menu to select a provider from the group/IPA.

"Your Performance" displays the percentage of patients who received services for the previous year for the selected provider or group.

"Health Plan Performance" displays the percentage of patients who received services for the previous year for the entire health plan.

HEDIS® Profile



<u>Please note</u> that for the selected provider, you will only see members assigned within the group/IPA account.

HEDIS® Profile

NCQA National Medicaid, Marketplace Percentiles (Shown on the Medicaid HEDIS® Profile only)

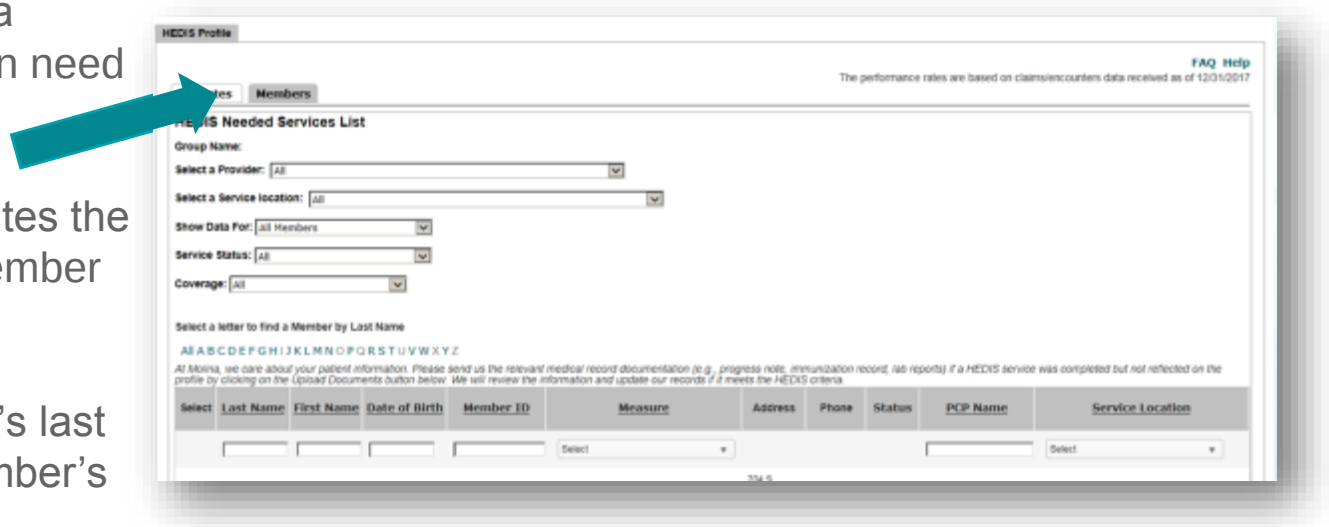
- The 50th, 75th and 90th national Medicaid percentiles are included for comparison purposes.
- The "% of Patients who Received Service" column will change color based on the NCQA benchmarks.
- If your rate is below the 75 percent NCQA benchmark, it will be highlighted in red.
- If your rate is at or above 75 percent, it will be highlighted in yellow.
- If your rate is at or above 90 percent, it will be highlighted in green.

Medicare Star Ratings (Shown on the Medicare HEDIS® Profile only)

- The Medicare 3, 4, and 5 star thresholds are included for comparison purposes.
- The "% of Patients who Received Service" column will change color based on the Medicare Star Ratings.
- If your rate is below the 4 Star Rating, it will be highlighted in red.
- If your rate is at or above the 4 Star Rating, it will be highlighted in yellow.
- If your rate is at or above the 5 Star Rating, it will be highlighted in green.

HEDIS® Profile – Members Tab

The “Members” tab displays a detailed list of members still in need of a HEDIS® service.



The “Measure” column indicates the HEDIS® measure that the member needs to complete.

You can click on the member’s last name to take you to that member’s “Eligibility Details” page.

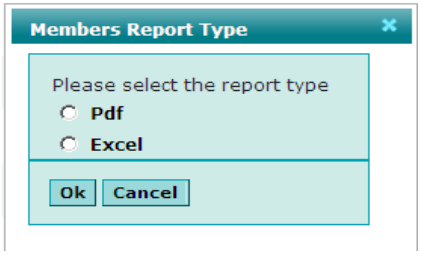
To view documents for a specific member, first select a member by clicking on the check box on the first column. Then click on “View Documents.”

A pop-up will display with a list of documents submitted for this member.

Print and Export HEDIS® Needed Services List for your patients.

To print a report, click on “Print” and a print-ready version of the report will display in a new window.

To export a report, click on “Export” and a pop-up will display to choose between two formats, PDF or Excel.



Quality Improvement

Facilitating & encouraging preventive care for healthy members and those with chronic conditions

Member Programs

- Pregnancy Rewards and Motherhood Matters℠ for new and expecting moms
- Focused diabetes, hypertension and asthma programs
- Prenatal care

Provider Programs

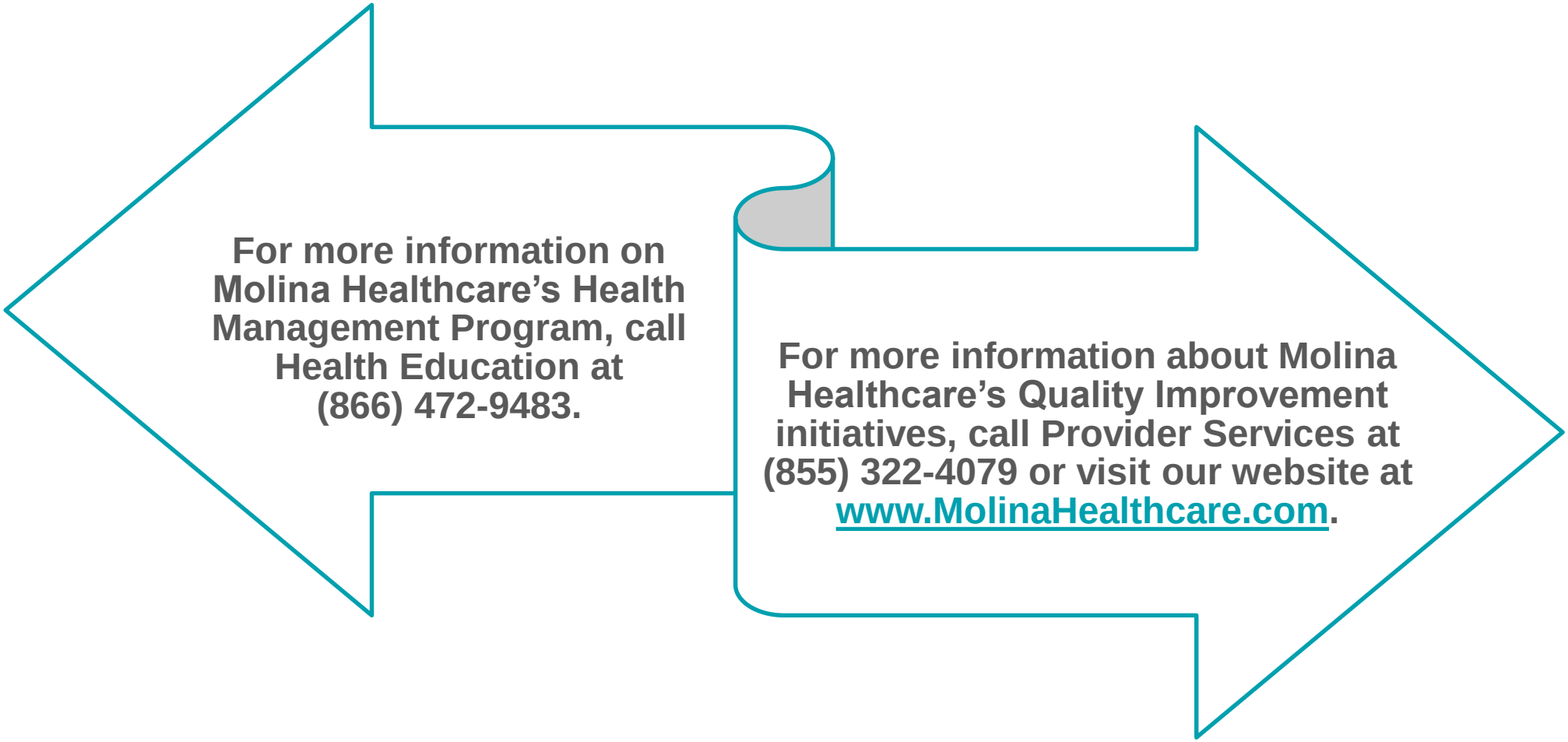
- Targeted provider incentives
- Focused diabetes, hypertension and asthma programs
- Comprehensive support and educational material

CAHPS® Surveys

- HEDIS® and CAHPS® education and awareness
- Post-appointment member survey for feedback on member satisfaction with provider services

Quality Improvement

Molina Healthcare's Quality Improvement Department maintains key processes and continues initiatives to ensure measurable improvements in the care and service provided to our members.



Access to Care Standards

In applying access standards, you agree not to discriminate against any member on the basis of age, creed, color, marital status, national origin, place of residence, physical, mental or sensory handicap, race, religion, military status, sex, sexual orientation, socioeconomic status, or status as a recipient of Medicaid benefits.

You may not limit the practice because of a member's medical (physical or mental) condition or the expectation of frequent or high-cost care. If you choose to close your panel to new members, you must give Molina Healthcare 30 days' advance written notice.

Office Wait Times

- Not to exceed 30 minutes
- PCPs are required to monitor waiting times and adhere to standards

After Hours Care

- Providers must have backup (on call) coverage 24/7
- May be an answering service or recorded message
- Must instruct members with an emergency to hang up and call 911 or go to the nearest emergency room

Access to Care Standards

Category	Type of Care	Access Standard*
Primary Care Physicians (PCPs):	Emergency Needs	Immediately upon presentation
	Urgent Care	No later than the end of the following business day after the patient's initial contact with the PCP site
	Regular and routine care	Not to exceed six weeks
OB/GYN	Pregnancy (initial visit)	Within two weeks
	Routine Visit	Within six weeks
Non-PCP Specialist	Emergency Needs	Immediately upon presentation
	Urgent Care	Not to exceed 24 hours
	Regular and routine care	Not to exceed eight weeks
Behavioral Health Specialists	Emergency needs	Immediately upon presentation
	Non-life threatening emergency	Not to exceed six hours
	Urgent Care	Not to exceed 48 hours
	Initial visit for routine care	Not to exceed ten business days
	Follow-up routine care	Not to exceed ten calendar days based off the condition

***Ohio CPC Access To Care Standards – Ohio CPC practices should consult their agreements for additional requirements.**

Drug Formulary

- The Molina Healthcare Drug Formulary was created to help manage the quality of our members' pharmacy benefit.
- The Formulary is the cornerstone for a progressive program of managed care pharmacotherapy.
- Prescription drug therapy is an integral component of your patient's comprehensive treatment program.
- The Formulary was created to ensure that members receive high-quality, cost-effective and rational drug therapy.
- The Molina Healthcare of Ohio Drug Formulary is available on our website at: www.MolinaHealthcare.com/OhioProviders.

Pharmacy

Prescriptions for medications requiring prior authorization or for medications not included on the Molina Healthcare Drug 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.

PA Fax – Medicaid/MyCare Ohio Opt-Out:
(866) 449-6843

PA Fax – Medicare/MyCare Ohio Opt-In Outpatient:
(844) 251-1450

PA Fax – Medicare/MyCare Ohio Opt-In Inpatient:
(877) 708-2116

PA Fax – Marketplace:
(855) 502-5130

MyCare Care Management

MOLINA HEALTHCARE

MyCare Ohio Care Management

Integrated Care Management Program

IDENTIFYING
AT-RISK
MEMBERS

ASSESSING
NEEDS
& PRIORITIES

ONGOING
CARE
COORDINATION

Care Management Roles

CARE MANAGEMENT:
MEMBER-CENTERED
PROBLEM-SOLVERS

INTERDISCIPLINARY CARE TEAM:
COLLABORATIVE
EFFORTS FOR BEST OUTCOMES

TRANSITIONS OF CARE:
HIGH-TOUCH
CARE FOLLOWING DISCHARGE

Care Management Levels

1 LEVEL 1: FACE-TO-FACE
CARE MANAGEMENT
FOR LOW/MONITORING MEMBERS

2 LEVEL 2: FACE-TO-FACE
CARE MANAGEMENT
FOR MEDIUM-RISK MEMBERS

3 LEVEL 3: FACE-TO-FACE
CARE MANAGEMENT
FOR HIGH-RISK MEMBERS

4 LEVEL 4: FACE-TO-FACE
CARE MANAGEMENT
FOR COMPLEX/INTENSIVE MEMBERS

MyCare Ohio Model of Care

Molina Healthcare uses an integrated system of care that:

Provides comprehensive services across the continuum of Medicare and Medicaid benefits
Strives for full integration of physical health, behavioral health, long-term care services, and social support services
Eliminates fragmentation of care
Provides a single, individualized care plan
Emphasizes a high-touch, member-centric care environment
Focuses on activities that support better health outcomes and reduce the need for institutional care

All members will have initial and annual health risk assessments and integrated care plans based on identified needs. Members are placed in the appropriate level of care management based on assessment, their utilization history and current medical and psycho-social-functional needs.

MyCare Ohio Provider Support of Care Management

As a network provider you play a **critical role** in providing quality services to our members, including:

Identifying members in need of services
Making appropriate and timely referrals
Collaborating with Molina Care Managers on the Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT), if needed
Reviewing and responding to patient-specific communication
Maintaining appropriate documentation in the member's medical record
Participating in ICT and Model of Care provider training
Ensuring that our members receive the right care, in the right setting, at the right time

Please call our Care Management department at (855) 665-4623 when you identify a member who needs or might benefit from such services.

MyCare Ohio Interdisciplinary Care Team

Molina Healthcare's ICT may include:

Member and/or designee	Registered nurse (RN)	Molina Care Manager
Social Worker	Molina Medical Director	Pharmacy
Member's PCP	Utilization management staff	Care Transition Coach
Service providers	Community health worker	Waiver Service Coordinator
Family members and/or caregivers	Other entities that member selects	

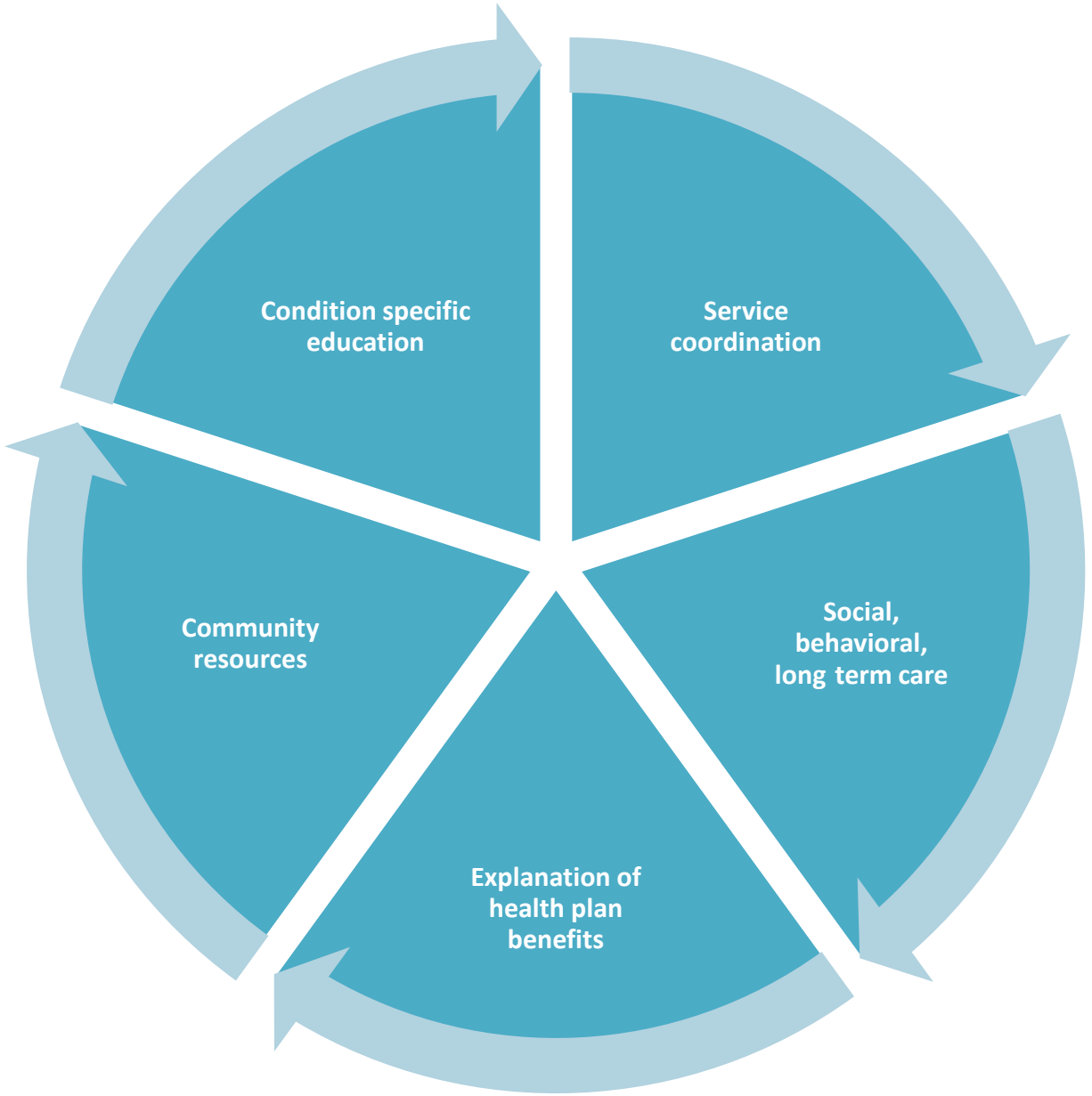
Note: Molina Healthcare's ICT is built around the member's preferences, and decisions are made collaboratively and with respect to the member's right to self-direct care. Members have the right to limit or may decline to participate in:

- Care management
- ICT membership or approval of all ICT participants
- ICT meetings or brief telephonic communications

MyCare Ohio Care Management Design: Level 1

Level 1: Health Management

- For members whose lower acuity conditions, behavioral, or unmet needs put them at increased risk
- Focus on disease prevention and health promotion
- Members receive educational materials and telephone-based health coaching
- **Goal:** Member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation



MyCare Ohio Care Management Design: Level 2

Level 2: Care Management

- For members with medium-risk chronic illness
- Designed to improve member's health status and reduce burden of disease
- Members receive direct telephone contact with Care Manager
- Care Manager may enlist help from community health worker or connector
- **Goal:** Assess unique needs, create ICP with prioritized goals and minimize barriers to care for optimal health outcomes

MyCare Ohio Care Management Design: Level 3

Level 3: Complex Care Management

- For members who have experienced a critical event or diagnosis
- Provides help in navigating the health care system
- Care Managers monitor, follow up and evaluate effectiveness of services
- Community Connectors support within the member's community with social services access and coordination
- **Goal:** Improve functional capacity and regain optimum health

MyCare Ohio Care Management Design: Level 4

Level 4: Imminent Risk

- For members at imminent risk of an emergency room visit, inpatient admission or institutionalization
- Members may face loss of living arrangement, deterioration of mental or physical condition, insufficient informal caregiver arrangements or terminal illness
- Focus on keeping member in least restrictive environment possible
- **Goal:** Identify potential transition from facility, Long Term Support Services (LTSS), participation in ICT meetings, ICP with prioritized goals and minimize barriers to care for optimum health outcomes

MyCare Ohio Care Management Design

Based on the level of Care Management needed, outreach is made to determine the best plan to achieve short- and long-term goals. At the higher levels, this includes building an ICP. These assessments include the following elements based on NCQA, state and federal guidelines:

Health status and diagnosis	Clinical history and medications
Cultural and linguistic needs	Visual and hearing needs
Caregiver resources	Available benefits and community resources
Body mass index, smoking	Confidence
Communication barriers with providers	Treatment and medication adherence
Emergency department and inpatient use	PCP visits
Psychosocial needs	Durable medical equipment
Health goals	Activities of daily living, functional status, or use of LTSS
Chemical dependency	Readiness to change and member's desire and interest in self-directing care
Life-planning activities	Mental health

The resulting care plan is approved by the member, may be reviewed by the ICT, and maintained and updated by the Care Manager as needed.

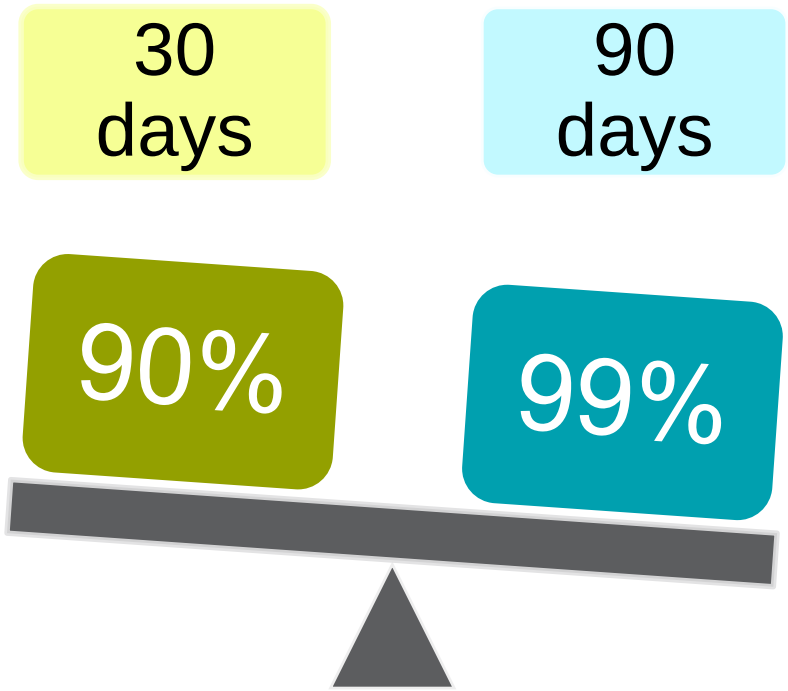
Billing and Claims

MOLINA HEALTHCARE

Claims Processing Standards

Claims Processing Standards: Claim payment will be made to contracted providers in accordance with the provisions set forth in the provider's contract. Further, payment is subject to the following minimum standards as set forth by the Ohio Department of Medicaid (ODM):

- 90 percent of the monthly volume of clean claims will be adjudicated within 30 calendar days of receipt by Molina Healthcare.
- 95 percent of the monthly volume of claims shall be paid or denied within 60 calendar days of receipt by Molina Healthcare.
- 99 percent of all claims shall be paid or denied within 90 calendar days of receipt by Molina Healthcare.



Claims Submission Options

Clearinghouse

- Change Healthcare is the outside vendor used by Molina Healthcare
- Providers may use any clearinghouse. Note that fees may apply.
- Use payer ID: 20149
- Change Healthcare phone: (877) 389-1160

Provider Portal

- Online submission is available through the Provider Portal at http://Provider.MolinaHealthcare.com.

Claims Customer Service

Corrected Claims	EDI Submission Issues	Claim Reconsideration
Use the Corrected Claims Guide on our website	Call the EDI customer service line at (866) 409-2935	Use the Claims Reconsideration Form on our website
Providers have 365 days from the date of original remittance advice	Email to: EDI.Claims@MolinaHealthcare.com	Requests must be received within 120 days from the date of original remittance advice
Submit completed forms through the Molina Healthcare Provider Portal	Contact your Provider Services Representative	Use the Provider Portal to submit Claim Reconsiderations

If you have any questions about the claim process, contact Provider Services at (855) 322-4079.

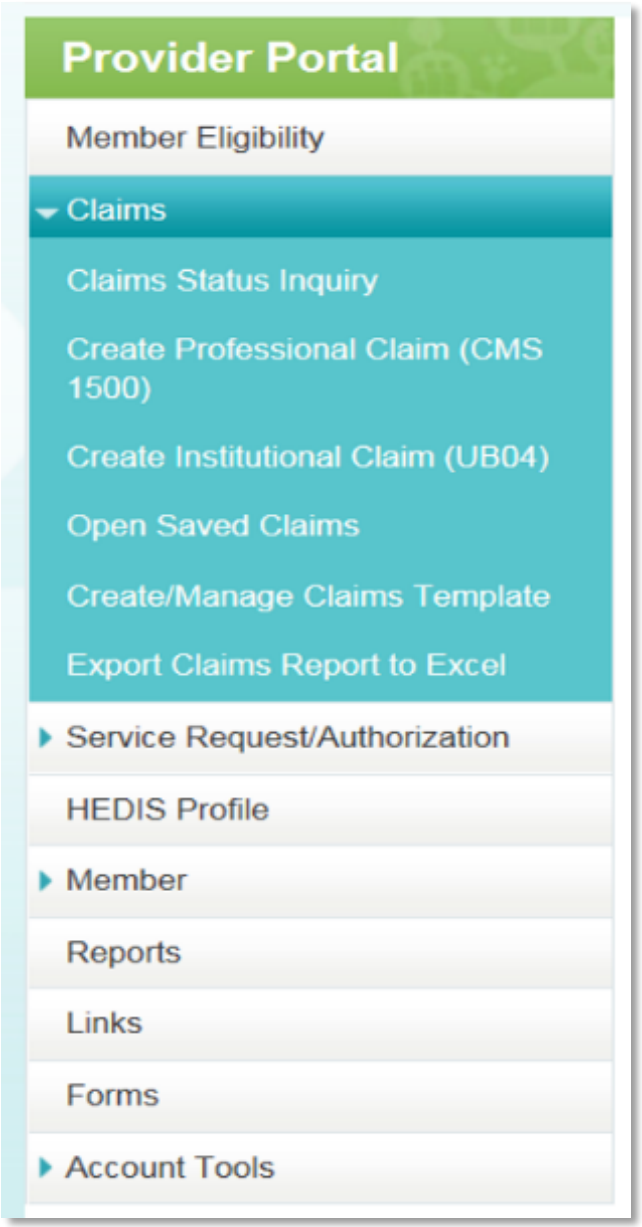
Provider Portal: Claims

The Provider Portal is secure and available 24 hours a day, seven days a week.
Register for access to our Provider Portal for self-services, including:

Provider Portal Claim Features	
Submit new professional claims	Submit new facility claims
Online claim reconsideration	Void a claim
Submit a corrected claim	Save claims for batch submission
Check the status of a claim	Add supporting documents to your claim
Create a claims template	

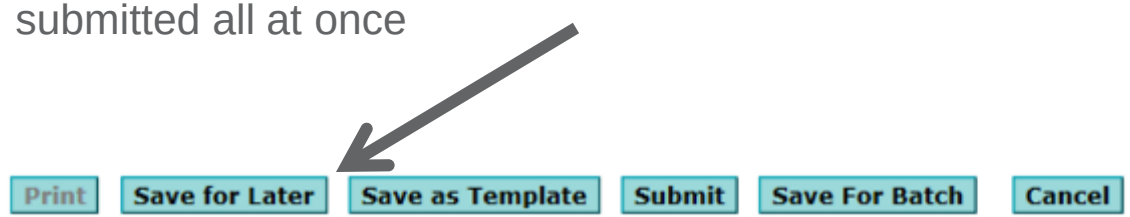
Self-service tools are on the Provider Portal.
Register online at https://Provider.MolinaHealthcare.com.

Provider Portal: Claims



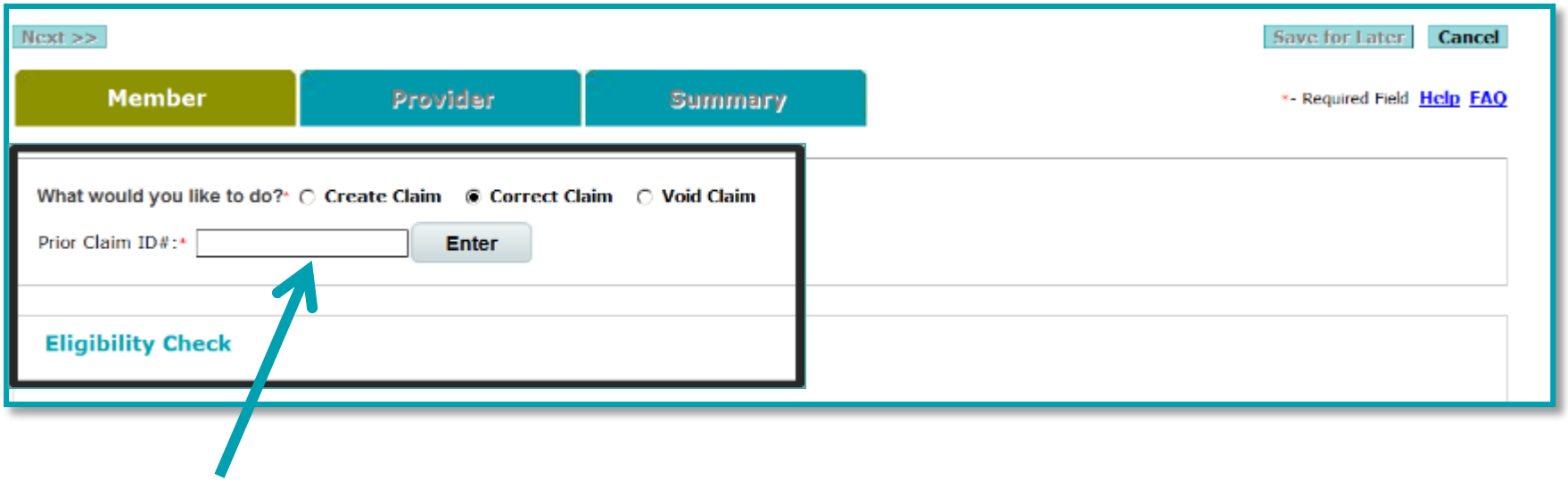
You can build claims and submit a batch of claims all at once:

- Complete a claim following the normal process
- Then, instead of submitting, select “Save for Batch”
- Claims saved for a batch can be found in the “Saved Claims” section in the side menu
- Ready-to-batch claims need to be selected and then can be submitted all at once



You will still receive an individual claim number for each claim submitted.

Provider Portal: Claims



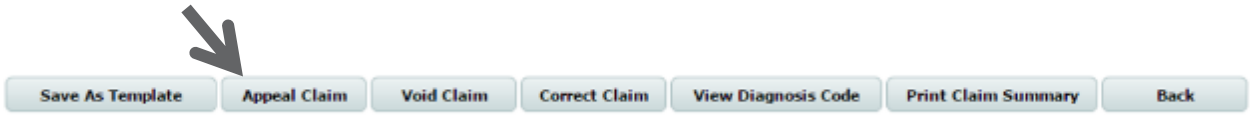
Enter Claim ID number here.

Submit corrected claims or void a claim through the Provider Portal. First select “Create Claim,” then select the “Correct Claim” or “Void Claim” feature and enter the previously-assigned Claim ID number.

Provider Portal: Claims

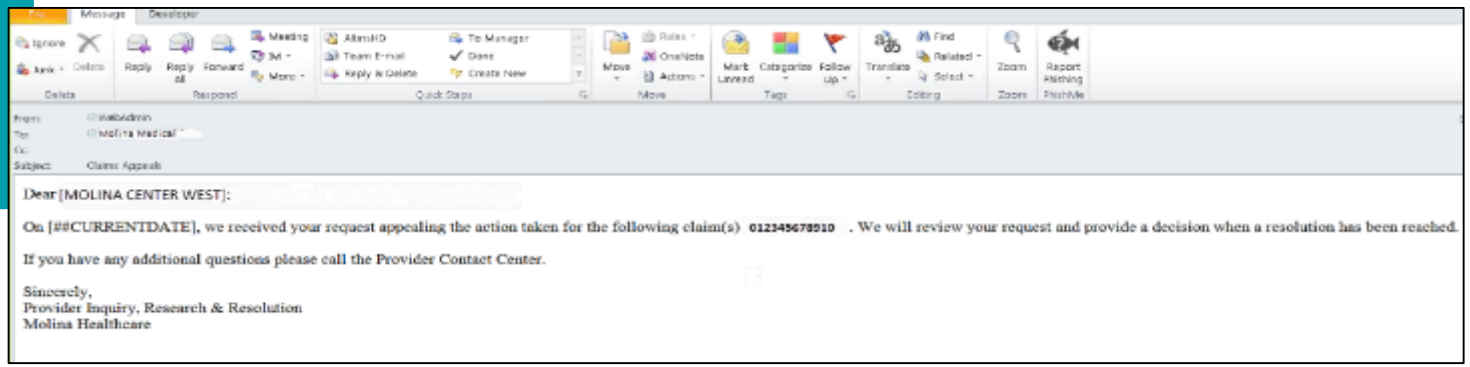
You can also request a claim reconsideration online:

- Select “Claims Status Inquiry”
- Search for the desired claim by using the available search filters (claim status, claim number or date of service)
- Select the desired claim ID to access the claim details
- Once routed to the “Claims Details” page, you can access the Provider Appeal Request Form by selecting the “Appeal Claim” button



- The information will auto populate
- Attach any supporting documents
- Agree to the Terms and Conditions by typing your name into the “Submitter Name” field

You will receive an email confirmation, which serves as an electronic acknowledgement letter



Dear [MOLINA CENTER WEST]:

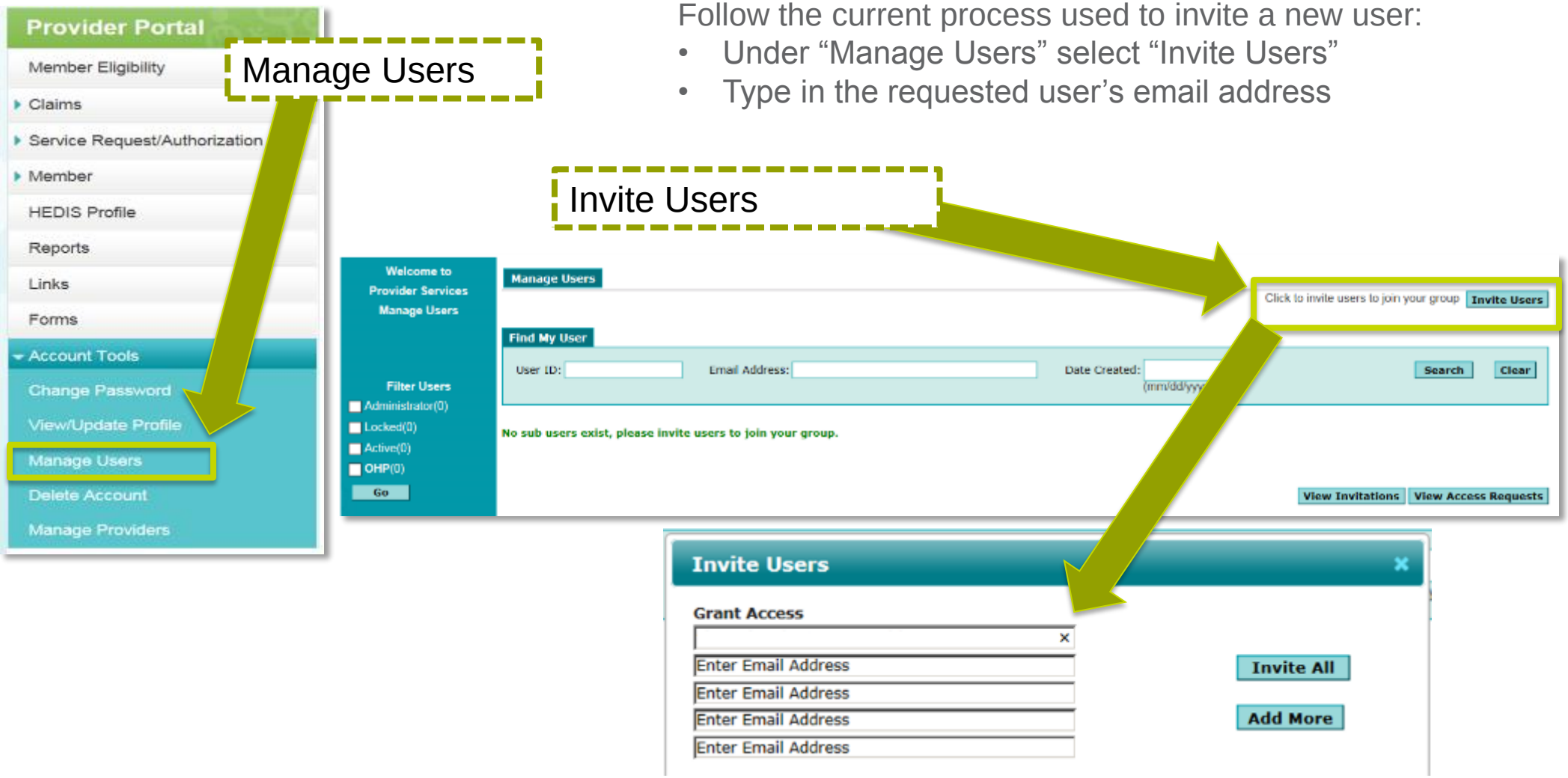
On [##CURRENTDATE], we received your request appealing the action taken for the following claim(s) 012345678910 . We will review your request and provide a decision when a resolution has been reached.

If you have any additional questions please call the Provider Contact Center.

Sincerely,
Provider Inquiry, Research & Resolution
Molina Healthcare

Provider Portal: Third Party Biller

Third Party Biller functionality is available on the Provider Portal and allows the administrator to grant access to third party billers outside of the provider's organization.



Follow the current process used to invite a new user:

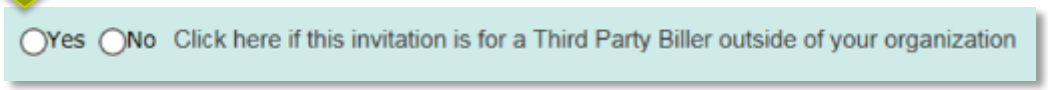
- Under "Manage Users" select "Invite Users"
- Type in the requested user's email address

Provider Portal: Third Party Biller

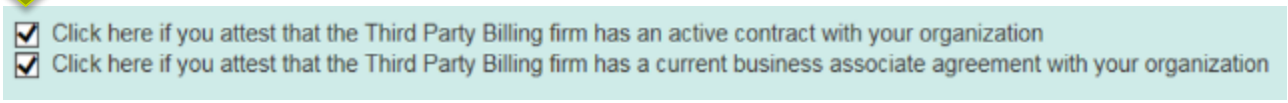
Select Roll: Biller

- Select “Biller” for the type of role
- Confirm the invitation is for a Third Party Biller outside of your organization
- Both of the attestation boxes have to be selected for the invitation to be sent successfully
- An invitation will be sent to the specified email address

Click “Yes” if the invitation is for a Third Party Biller outside of your organization



Confirm both attestations are correct



To remove a Third Party Biller’s access, follow the same process used to remove any other user.

Electronic Payments and Remittance Advice

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

Access to Change Healthcare is **FREE** to our providers. We encourage you to register after receiving your first check from Molina Healthcare. Here's how:

Register for Change Healthcare online

- Go to: https://providernet.adminisource.com
- Click "Register"
- Accept the terms

Verify your information

- Select Molina Healthcare from the payers list
- Enter your primary NPI
- Enter your primary Tax ID
- Enter recent claim and/or check number

Enter your User Account Information

- Use your email address as the username
- Strong passwords are enforced (eight or more characters of letters/ numbers)

Verify payment information

- Bank account and payment address
- Changes to payment address may interrupt EFT process
- Add additional addresses, accounts and Tax IDs after login

Electronic Payments and Remittance Advice

If you are associated with a clearinghouse

- Go to “Connectivity” and click the “Clearinghouses” tab
- Select the Tax ID for this clearinghouse
- Select a clearinghouse (if applicable, enter your Trading Partner ID)
- Select the File Types you would like to send and click “Save”

If you are a registered Change Healthcare user

- Log in to Change Healthcare and click “Provider Info”
- Click “Add Payer” and select Molina Healthcare
- Enter recent check number

Benefits of Change Healthcare

- Administrative rights to sign up/manage your own EFT account
- Ability to associate new providers within your organization to receive EFT/835s
- View/print/save PDF versions of your Explanation of Payment (EOP)
- Historical EOP search by various methods (i.e. claim number, member name)
- Ability to route files to your FTP and/or clearinghouse

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

EPSDT Billing Requirements

- Molina Healthcare **requires** the referral field indicator (field 24h) be populated on Early Periodic Screening, Diagnosis and Treatment (EPSDT) claims.
- If this field is incomplete, claims could be rejected.

- Ohio Department of Medicaid (ODM) requires managed care plans, including Molina Healthcare, to submit the referral field indicator on EPSDT encounters.

- ODM is federally required to report how many EPSDT visits and referrals for follow-up or corrective treatment occurred for Medicaid-eligible recipients ages 0 to 20 years.

Balance Billing

Molina Healthcare shall pay the provider for clean claims for covered services provided to members, including emergency services, in accordance with applicable law and regulations and in accordance with the compensation schedule.

- Providers contracted with Molina cannot bill the member for any covered benefits. The provider is responsible for verifying eligibility and obtaining approval for services that require prior authorization.
- Providers may not charge members fees for covered services beyond copayments or coinsurance.
- Providers agree that under no circumstance shall a member be liable to the provider for any sums owed by Molina to the provider. Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State or another payer such as a Medicaid Managed Care Plan is responsible for paying such amounts. Balance billing a Medicare and/or Medicaid Member for Medicare and/or Medicaid covered services is prohibited by law. This includes asking the member to pay the difference between the discounted and negotiated fees, and the provider's usual and customary fees.

Balance billing is prohibited by State and Federal Regulations.

Refer to Ohio Administrative Code 5160-26-05(D) (10), which prohibits subcontracting providers from charging members.

Refer to Ohio Administrative Code 5160-26-05(D) (9) (b) (i-iii) for circumstances when it is appropriate to bill a member for non-covered services.

Medicare – Cost Sharing

Medicare cost-sharing includes:

- Medicare Part A and Part B premiums
- Medicare Part A and Part B deductibles
- Coinsurance
- Copayments

All duals get help paying for some or all of their Medicare cost-share.

Contact Molina Member Services to verify member's cost-sharing responsibility.

Member Services

MOLINA HEALTHCARE

Member Rights

Molina Healthcare has outlined the rights and responsibilities for members participating in our managed care programs. These are listed in our online Provider Manual at www.MolinaHealthcare.com/OhioProviders.

These rights include, but are not limited to:

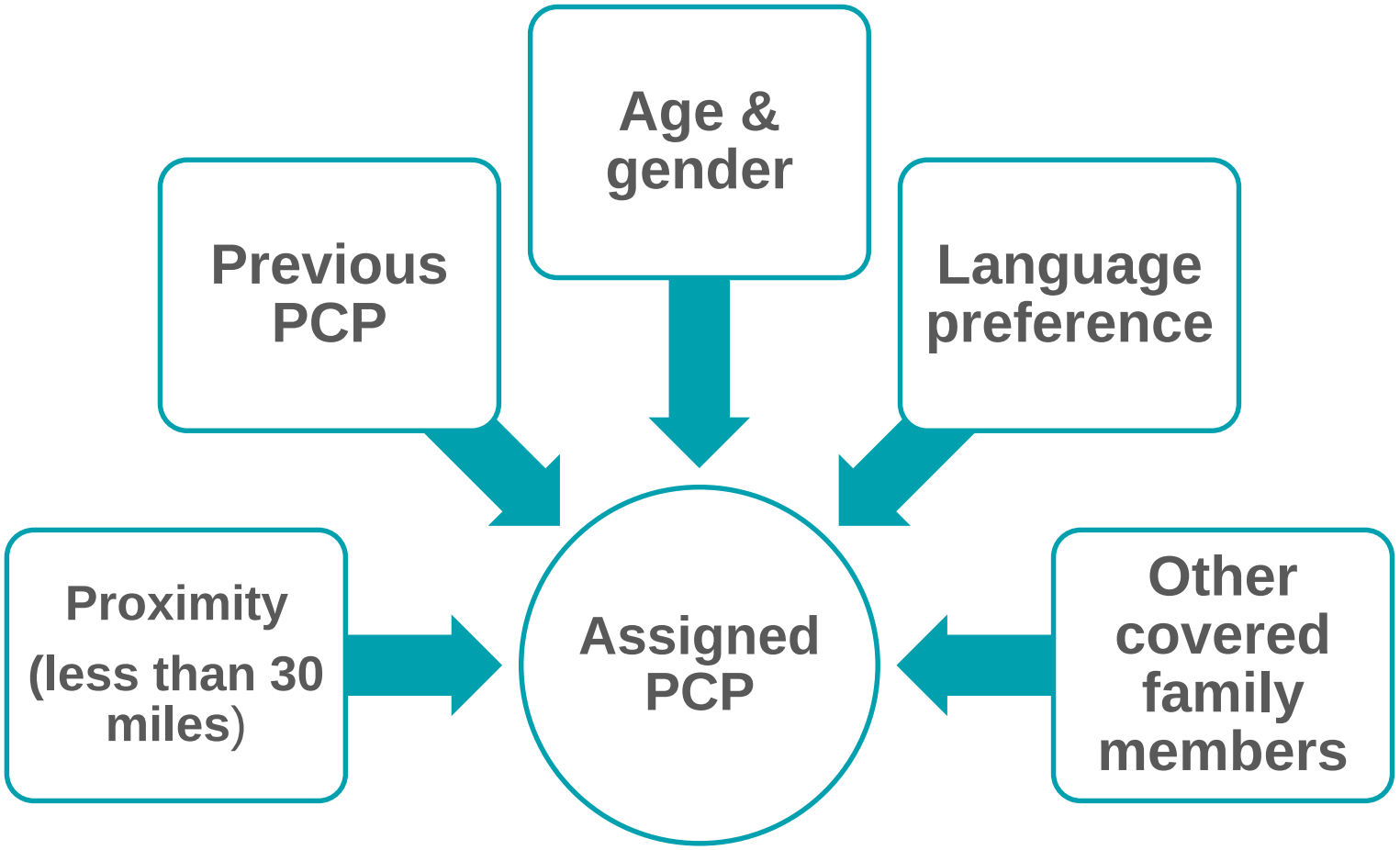
Receive information about Molina Healthcare, covered benefits and the providers contracted to provide services
Openly discuss their treatment options, regardless of cost or benefit coverage, in a way that is easy to understand
Receive information about their member rights and responsibilities
Make recommendations about Molina Healthcare's member rights and responsibilities
Get a second opinion from a qualified provider on Molina Healthcare's panel. Molina Healthcare must set up a visit with a provider not on our panel at no cost to the member if the qualified panel provider is not able to see the member

Member Responsibilities

Always carry their Molina Healthcare ID card and not let anyone else use their ID card.
Keep appointments, and be on time.
If a member requires transportation, call Molina Healthcare at least 2 business days in advance, whenever possible.
Call their provider 24 hours in advance if they are going to be late or if they cannot keep their appointment.
Share important health information (to the extent possible) with Molina Healthcare and their providers so that providers can give them appropriate care.
Understand their health conditions (to the degree possible) and be active in decisions about their health care.
Work with a provider to develop treatment goals and follow the care plan that the member and provider have developed.
Ask questions if they do not understand their benefits.
Call Molina Healthcare within 24 hours of a visit to the emergency department or an unexpected stay in the hospital.
Inform Molina Healthcare if they would like to change their PCP. Molina Healthcare will verify that the PCP the member selects is contracted with Molina Healthcare and is accepting new patients.
Inform Molina Healthcare and their county caseworker if they change their name, address or telephone number or if they have any changes that could affect their eligibility.
Let Molina Healthcare and their providers know if they or any of the members of their family have other health insurance coverage.
Report any fraud or wrongdoing to Molina Healthcare or the proper authorities.

Primary Care Physician Assignment

Primary Care Physician (PCP) Assignment – Members have the right to choose their PCPs. If the member or his/her designated representative does not choose a PCP, one will be assigned using:



Changing Primary Care Providers

Members may change their PCP at any time through:

Member Services

- **Molina Medicaid**: (800) 642-4168 (TTY/Ohio Relay use (800) 750-0750 or 711) – 7 a.m. to 7 p.m., Monday through Friday
- **Molina Dual Options (full benefits)**: (855) 665-4623 (TTY 711) – 8 a.m. to 8 p.m., Monday through Friday
- **Molina MyCare Ohio Medicaid (opt-out)**: (855) 687-7862 (TTY 711) – 8 a.m. to 8 p.m., Monday through Friday
- **Medicare**: (866) 472-4584 (TTY711) – 8 a.m. to 8 p.m., Monday through Sunday
- **Marketplace**: (888) 296-7677 (TTY711) – 8 a.m. to 7 p.m., Monday through Friday

Member Web Portal

- Register or log on at www.MyMolina.com
- Members can change a PCP, request a new ID card, check eligibility and more.

Changing Primary Care Providers

All changes completed by the 25th of the month will be in effect on the first day of the following calendar month.

Any changes on or after the 26th of the month will be in effect on the first day of the second calendar month.

A member should not be turned away because the PCP name on the member ID card does not match the provider he or she wishes to see.

The member can call Molina Healthcare at the time of the appointment to change the PCP. Claims will not be denied because of provider assignment mismatch.

Primary Care Referrals

Referrals are made when medically necessary services are beyond the scope of the PCP's practice.

Molina Healthcare does not require referrals for our members to be seen by any specialty providers.

However, some specialty providers do require a referral in order to see patients. In this case, information should be exchanged between the PCP and specialist to coordinate care for the member.

Self-Referrals

Molina Healthcare members can self-refer for the following:

Services from Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)
Family planning services from Qualified Family Planning Providers (QFPP)
Services from Certified Nurse Practitioners (CNP)
Services from Certified Nurse Midwives (CNM)
Routine and preventive services from a women's health specialist contracted with Molina Healthcare, which is in addition to the member's designated PCP if that PCP is not a woman's health specialist.
Behavioral health services from Community Mental Health Centers (CMHC)
Substance abuse services from Ohio Department of Alcohol and Drug Addiction Services (ODMHAS) - certified Medicaid providers

FQHC and RHC facilities or QFPP services are not required to be contracted with Molina Healthcare.

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Appeals and Grievances

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

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

Members may authorize a designated representative to act on their behalf. Members must provide their written consent for someone to act on their behalf during the appeal or grievance process. This representative may be a friend, a family member, health care provider or an attorney.

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

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

Appeals and Grievances

Appeals

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

Receipt of Standard Appeal requests:

- 15 calendar days of receipt for Medicaid and MMP Appeals
- 30 calendar days of receipt for Marketplace Appeals

Receipt of Expedited Appeal requests:

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

In general, members must exhaust the internal appeals process prior to filing an external appeal (e.g. State Fair Hearing or Independent External Review).

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

Appeals and Grievances

Grievances

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

Receipt of Grievance:

- Two working days of receipt of a grievance related to accessing medically-necessary covered services in the Medicaid or Molina Dual Options MyCare Ohio lines of business
- 30 calendar days of receipt for grievances that are not claims related in Medicaid, Medicare or Molina Dual Options MyCare Ohio lines of business

Grievance regarding bills or claims:

- 60 calendar days for grievances regarding bills or claims in the Medicaid line of business
- 30 calendar days for grievances regarding bills or claims in the Molina Dual Options MyCare Ohio lines of business

Appeals and Grievances

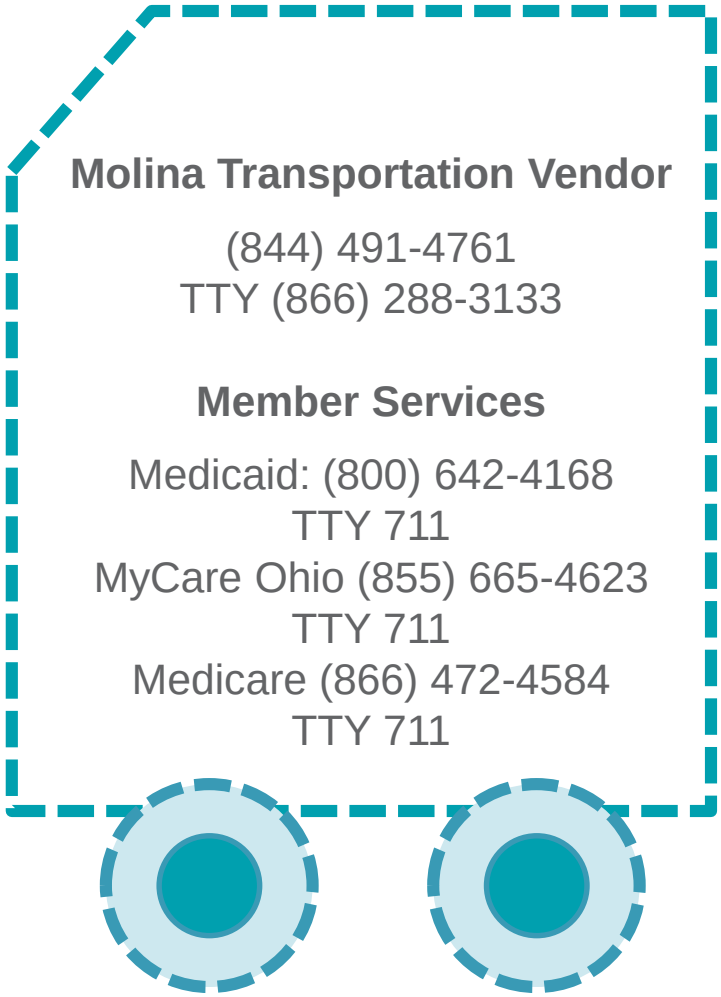
Member may file a grievance by calling Molina Healthcare's Member Services Department:

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

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

Transportation Services

- Molina Healthcare provides non-emergent medical transportation for our members. If your patients are in need of this service, please have them contact Molina Healthcare's Member Services department to see if they qualify.
- We also provide transportation for our members who must travel a distance **greater than 30 miles** one-way.
- As an added benefit for members, we offer a supplemental transportation benefit of **30 one-way rides (15-round trips)** each calendar year to provider, WIC or CDJFS re-determination appointments.
- Note: It is important to have your patient(s) call at least **2 business days in advance**.



Compliance

MOLINA HEALTHCARE

Medicaid ID Number

In order to comply with Federal Rule 42 CFR 438.602:

- providers are required to be fully enrolled with the Ohio Department of Medicaid (ODM) with an active Medicaid ID to receive payment for submitting clean claims to Molina Healthcare
- providers must revalidate their Medicaid ID number every three years

Molina Healthcare may not pay a network provider on or after Jan. 1, 2019, if the provider has not begun the process with ODM.

Providers without a Medicaid ID number will need to submit a new application to ODM to continue as a contracted provider with Molina Healthcare and receive payment for submitted clean claims.

The enrollment process is electronic and only takes a few minutes to complete. Enrollment is available through the Medicaid Information Technology System (MITS) portal or providers can start the process at http://Medicaid.Ohio.gov.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) requires providers to implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability and integrity of a member's **protected health information (PHI)**. Providers should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

Molina Healthcare strongly supports the use of electronic transactions to streamline health care administrative activities. Providers are encouraged to submit claims and other transactions using electronic formats.

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

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

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to the HIPAA Transactions on our website under the "HIPAA" tab at www.MolinaHealthcare.com/OhioProviders

Cultural & Linguistic Competency

Molina Healthcare has a 30-year 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.

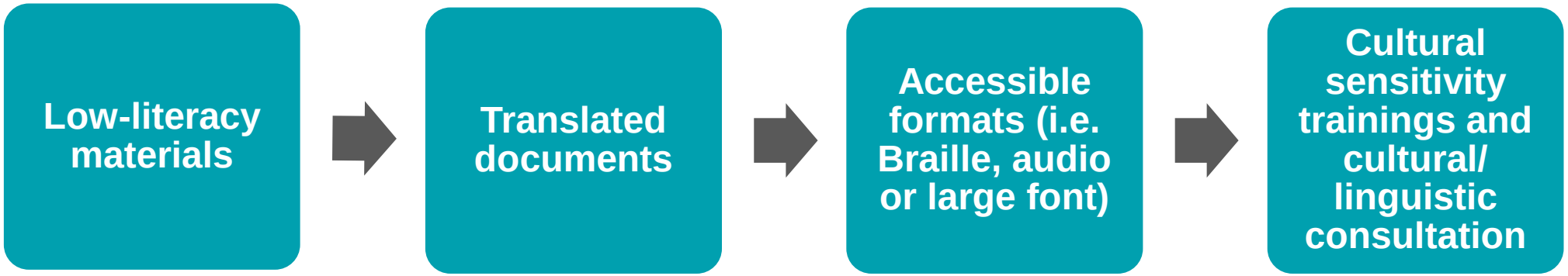
Developing member education material in a variety of media and languages and ensure that the literacy level is appropriate for our target audience.

Providers are required to participate in and cooperate with Molina Healthcare's provider education and training efforts as well as member education efforts.

Providers must comply with all health education, cultural and linguistic, and disability standards, policies and procedures.

Cultural & Linguistic Competency

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



If your patient is deaf or hard of hearing, he or she can contact us through our dedicated TTY/Ohio Relay line, toll-free, at (800) 750-0750 or 711.

Molina Healthcare's 24-Hour Nurse Advice Line provides advice to members 24 hours a day, seven days a week. Members may call the Nurse Advice Line at:

English: (888) 275-8750
TTY: 711
Spanish: (866) 648-3537

The 24-Hour Nurse Advice Line telephone numbers are also printed on member ID cards.

Cultural Competency training is required to be completed by providers on an annual basis.

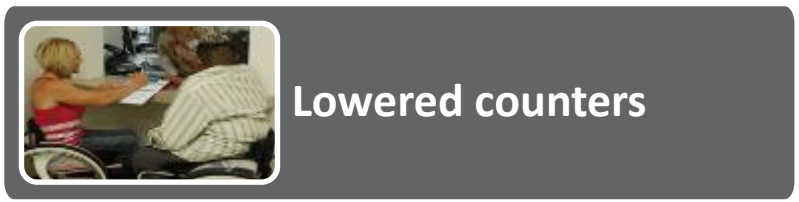
Cultural & Linguistic Competency

Providers are required to participate in Molina Healthcare's provider education and training efforts and member education and efforts. Providers are to comply with all health education; cultural, linguistic and disability standards; policies; and procedures.

Arranging for Interpreter Services
Pursuant to Title VI of the Civil Rights Act of 1964, services provided for members with LEP, LRP or limited hearing or sight are the financial responsibility of the provider; not the member.
Molina Healthcare members are never responsible for the cost of such services.
Written Procedures are to be maintained by each office or facility regarding their process for obtaining such services.
Providers using interpreter services shall document such services.
Documentation of these services shall be kept in the member's medical record which may be audited by Molina Healthcare at any time.

Molina Healthcare is available to assist providers with locating these services if needed. Call (855) 322-4079. Providers with members who cannot hear or have limited hearing ability may use TTY 711.

Disability, Literacy & Competency Training



Prejudices

- Be aware not only of the causes, consequences and treatment of disabling health conditions, but also the incorrect assumptions that result from stigmatized views about people with disabilities.

Barriers

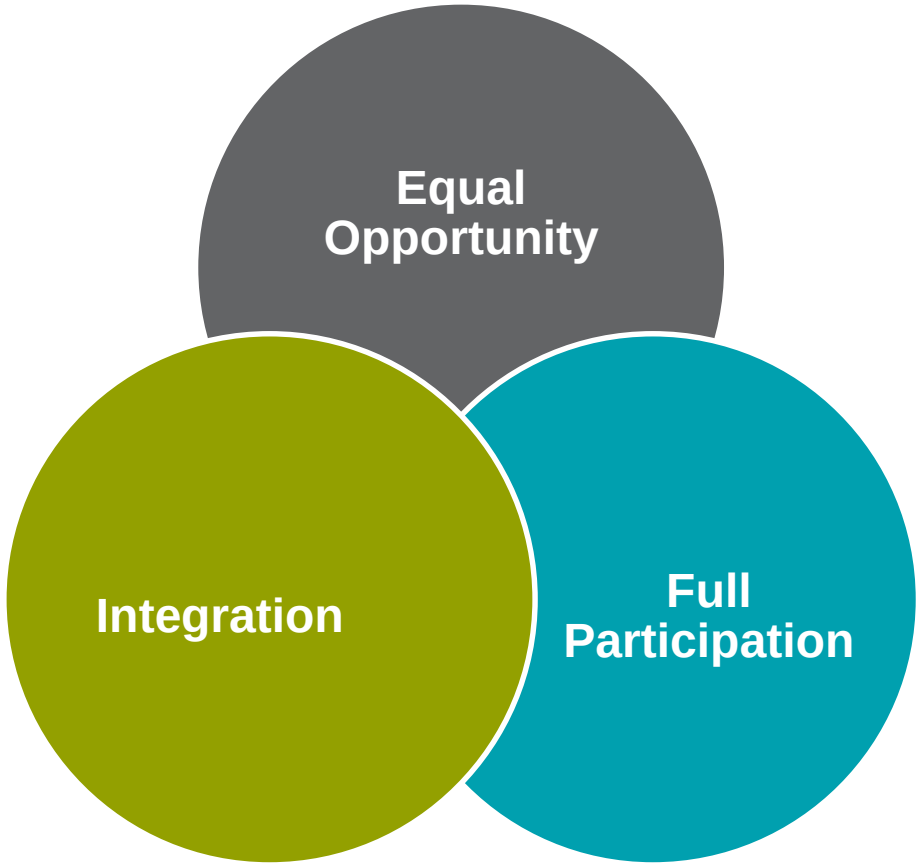
Some of the most prevalent barriers for seniors and people with disabilities are:

- Physical access: Ability to get to, in to, and through buildings
- Communication access: Ensuring that an interpreter is present
- Medical equipment access: Safe transfer to tables, access to diagnostic equipment
- Attitudinal: Prejudices about a person's quality of life; embracing the idea that disability, chronic conditions and wellness exist together

Americans with Disabilities Act (ADA)

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

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



Anti-Discrimination Regulations

The Rehabilitation Act of 1973 is a civil rights law that prohibits discrimination on the basis of disability in programs and activities, public and private, that receive federal financial assistance.

Section 504 forbids organizations and employers, such as hospitals, nursing homes, mental health centers and human service programs from excluding or denying individuals with disabilities an equal opportunity to receive program benefits and services.

Protected individuals under this law include any person who:

- Has a physical/mental impairment that substantially limits one or more major life activities
- Has a record of such an impairment
- Is regarded as having such an impairment

Participating providers or contracted medical groups/IPAs may not limit their practices because of a member's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care. Providers must not discriminate against enrollees based on their payment status and cannot refuse to serve members because they receive assistance with Medicare cost sharing from a State Medicaid Program.

A Person-Centered Model of Care is a team-based approach in which providers partner with patients and their families to identify and meet all of a patient's comprehensive needs. The purpose of a Person-Centered Model of Care is to provide continuous and coordinated care to maximize health outcomes while involving the patient in his or her own health care decisions.

Ownership Disclosure Form

As of Feb. 6, 2017, providers are required to complete the Ownership Disclosure Form during the contracting process and re-attest every 36 months during the recredentialing process, or at any time disclosure needs to be made to the plan.

The **Ownership Disclosure Form** is available under the “Forms” tab at **www.MolinaHealthcare.com/OhioProviders**

Fraud, Waste & Abuse

Molina Healthcare 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.

Abuse

Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicare and Medicaid programs, 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 Medicare and Medicaid programs. (42 CFR § 455.2)

Fraud

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

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

Examples of Fraud, Waste & 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 services.

Member

- Lending an ID card to someone who is not entitled to it
- Altering the quantity or number of refills on a prescription
- Making false statements to receive medical or pharmacy services
- Using someone else's insurance card
- Including misleading information on or omitting information from an application for health care coverage or intentionally giving incorrect information to receive benefits
- Pretending to be someone else to receive services
- Falsifying claims

Provider

- Billing for services, procedures or supplies that have not actually been rendered
- Providing services to patients that are not medically-necessary
- Balance billing a Medicaid member for Medicaid covered services
- Double billing or improper coding of medical claims
- Intentional misrepresentation of benefits payable, dates rendered, medical record, condition treated/diagnosed, charges or reimbursement, provider/patient identity, "unbundling" of procedures, non-covered treatments to receive payment, "upcoding," and billing for services not provided
- Concealing patient's misuse of ID card
- Failure to report patient's forgery/alteration of a prescription

Molina Healthcare Contact Information

MOLINA HEALTHCARE

Frequently Used Phone Numbers

Department	Medicaid	MyCare Ohio	Marketplace	Medicare
Member Services	(800) 642-4168 TTY (800) 750-0750 or 711 7 a.m. to 7 p.m. Monday-Friday	(855) 687-7862 TTY 711 8 a.m. to 8 p.m. Monday - Friday	(888) 296-7677 8 a.m. to 7 p.m. Monday - Friday	(866) 472-4584 TTY 711 8 a.m. to 8 p.m. 7 days a week
Care Management	(855) 322-4079			(866) 472-4584
Provider Services	(855) 322-4079 Fax (888) 296-7851			(866) 472-4584
	8 a.m. to 6 p.m. MyCare Ohio; 8 a.m. to 5 p.m. all other lines of business OHProviderRelations@MolinaHealthcare.com			
Claims Inquiry – Customer Service	(855) 322-4079			(866) 472-4584
Claims Reconsideration	(855) 322-4079 Fax (800) 499-3406			(866) 472-4584
Prior Authorization	(855) 322-4079			(866) 472-4584
Provider Portal Help	(855) 322-4079			(866) 472-4584
Pharmacy	(855) 322-4079 Fax (800) 961-5160			(866) 472-4584
Community Outreach	(800) 642-4168			
Fraud, Waste & Abuse Tip Line	(866) 606-3889			
24 Hour Nurse Advice Line	(888) 275-8750 English (866) 648-3537 Spanish 771 TTY			
Member Eligibility	(800) 686-1516			

To receive our Provider Bulletin via email sign up at www.MolinaHealthcare.com/ProviderEmail

Questions and Comments