Provider Orientation

Molina Healthcare of Ohio, Inc.

Agenda

Molina Healthcare Overview

- Ohio Managed Care Overview

Molina Healthcare Members

- Eligibility
- Enrollment
- Benefits

Health Care Services

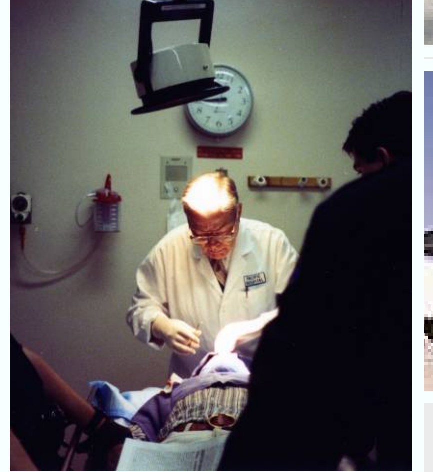
- Prior Authorization
- Access Standards
- Care Management

Molina Healthcare Providers

- Quality Improvement
- Member Appeals and Grievances
- Fraud, Waste and Abuse

Our Story

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



Vision Statement

Molina Healthcare is an innovative national health care leader, providing quality care and accessible services in an efficient and caring manner.

Mission Statement

Our mission is to provide quality health services to financially vulnerable families and individuals covered by government programs.

Core Values

We strive to be an exemplary organization.

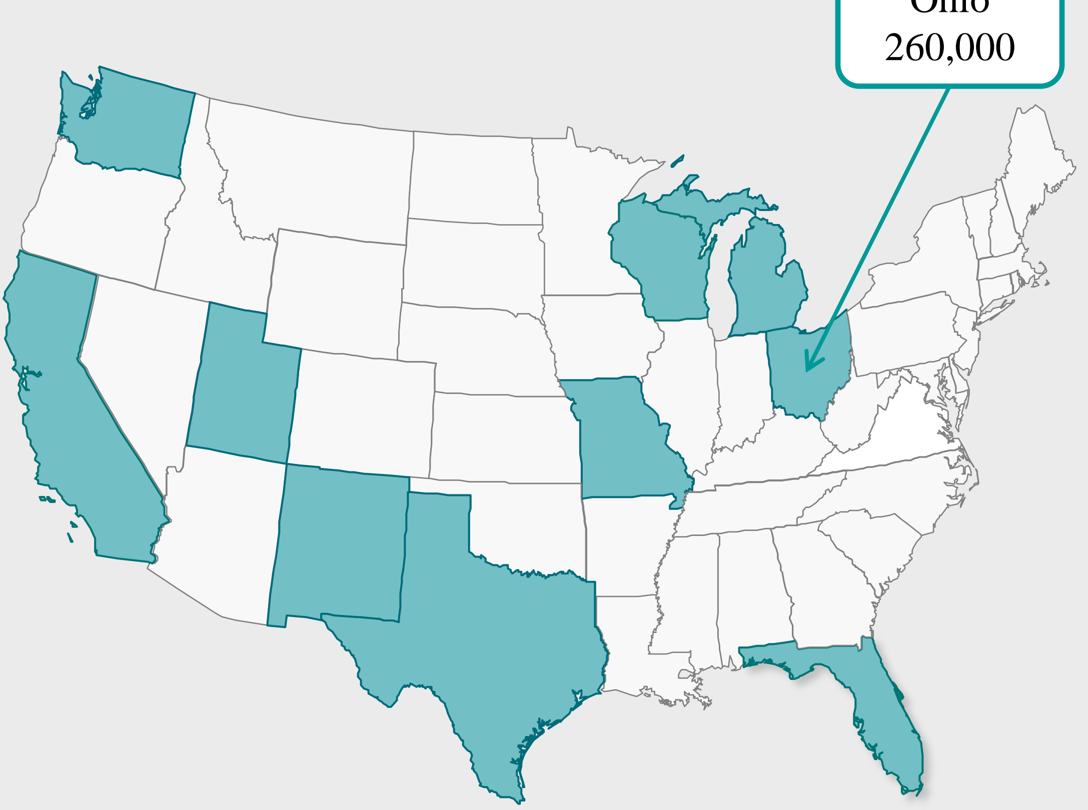
- We care about the people we serve and advocate on their behalf.
- We provide quality service and remove barriers to health services.
- We are health care innovators and embrace change quickly.
- We respect each other and value ethical business practices.
- We are careful in the management of our financial resources and serve as prudent stewards of the public’s funds.

Business Snapshot

As of 06/30/2012

Markets and Members Served

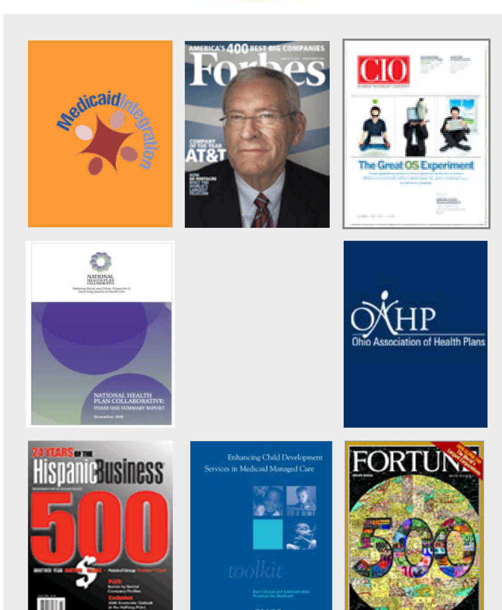
Total Medicare & Medicaid Membership



California	350,000	Missouri	79,000	Utah	86,000
Florida	70,000	New Mexico	89,000	Washington	356,000
Michigan	220,000	Texas	301,000	Wisconsin	42,000

- **Founded in 1980** by Dr. C. David Molina who opened primary care clinics in Long Beach, CA, to serve the uninsured and underinsured
- Celebrating **over 30 years** of managed care experience
- Over **1.8 million members nationwide**
- Medicaid operations in **10 states**
- 20 **primary care clinics** in California, Virginia and Washington. We are both insurers and providers of health care.
- Molina Healthcare is a **leader in NCQA Accreditations**, with eight accredited health plans

Recognized for Quality, Innovation and Success



Molina Healthcare, Inc.

- **America's Top 100 Medicaid health plans** by NCQA for six years for all state plans
- **FORTUNE 500** Company by Fortune Magazine
- *Business Ethics* magazine **100 Best Corporate Citizens**
- Alfred P. Sloan Award for Business Excellence in Workplace Flexibility in 2011
- Ranked Largest Hispanic-owned business by *Hispanic Business* magazine in 2009
- Recognized for **innovation in multi-cultural health care** by The Robert Wood Johnson Foundation

Molina Healthcare of Ohio, Inc.

- **NCQA Accredited** since January 2009
- Recipient of two 2012 Ohio Association of Health Plans Pinnacle Awards and two 2011 OAHP Pinnacle Awards
- ***Columbus Business First* Corporate Caring Award** recipient in 2012, finalist in 2008, 2009, 2010

Molina Healthcare of Ohio began serving Ohio's **Covered Families and Children** Medicaid population in 2005. Molina Healthcare began serving the **Aged, Blind or Disabled** population in 2007.

Molina Healthcare serves over **256,000 members** in 4 of the Medicaid Managed Care regions – 50 of Ohio's 88 counties.

Molina Healthcare's Regions include Central, Southwest, Southeast and West Central.

In 2008, Molina Medicare of Ohio was awarded a contract from the Centers for Medicare and Medicaid Services. Molina Medicare currently serves the **Medicare** population in 15 counties.

Medicaid Service Area

Medicaid & Medicare Service Area

Medicaid and Medicare Eligibility

Medicaid Eligibility

- A person must qualify for Medicaid before they can enroll with Molina Healthcare. The County Departments of Job and Family Services (CDJFS) accept applications and make eligibility determinations. Applications are accepted online, in person and by mail.

Medicare Eligibility

- A person must qualify for Medicare before they can enroll with Molina Medicare. Molina Options Plus members must have full Medicaid before qualifying.

Eligibility

To Verify Eligibility for Medicaid

- Molina Healthcare Provider Self Services Portal
    - www.MolinaHealthcare.com
    - Web Help Desk 1-866-449-6848
- Molina Healthcare IVR 1-866-402-3467
- ODJFS IVR 1-800-686-1516

Medicaid Newborn Coverage

- 90 days (end of the month)
- Temporary identification number
- State assigns a permanent number

To Verify Eligibility for Medicare

- Molina Medicare Provider Services 1-866-472-4584

Medicaid Enrollment

Medicaid Managed Care is mandatory in the state of Ohio.* Medicaid consumers are notified that they are **required to choose a Managed Care Plan (MCP)** when they receive their eligibility notice from ODJFS.

- Consumers may change their MCP for any reason within the first 90 days of their initial selection
- After 90 days, consumers must wait until the Open Enrollment Period to change MCPs
- Annual open enrollment is during the month of November

**Medicaid Managed Care is mandatory in the state of Ohio; however, a few exceptions to the rule exist for specific populations.*

Medicare Enrollment

Members who wish to enroll in Molina Medicare must meet the following criteria:

- Be entitled to Medicare Part A and enrolled in Medicare Part B
- Not be medically determined to have end-stage renal disease (ESRD) prior to completing the enrollment form
- Reside in the Molina Medicare service area
- Meet income requirements (for Options Plus members only)
- Annual Election Period is October 15 through December 7

Identification (ID) Cards

Medicaid

MOLINA HEALTHCARE

CFC

Member
VINCENT TEST

Identification#	Date of Birth:	Effective Date:
108123499099	02/02/1962	07/01/2009

Primary Care Provider: LEROY B. TEST

Primary Care Provider Phone: (937)223-1781

MMIS # **108123499099** BIN **#610473** Issue Date: **06/25/2009**

MEMBERS: To reach Member Services please call **(800) 642- 4168** or for hearing impaired, call the TTY/Ohio Relay Service at **(800) 750-0750 or (711)** Monday to Friday, 7 a.m. to 7 p.m.

To schedule transportation please call **(866) 642-9279**.

Emergency Services: Call **911** (if available) 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) at the number on the front of this card for instructions. You may also contact our 24-Hour Molina Healthcare Nurse Advice Line at **(888) 275-8750** or **(866) 648-3537 (Español)**. For hearing impaired, call TTY **(866) 735-2929**. Follow up with your PCP after all emergency room visits.

PRACTITIONERS/PROVIDERS/HOSPITALS: For prior authorization, post stabilization, eligibility, claim or benefit information call **(800) 642-4168**.
Hospital Admissions: Authorization must be obtained by the hospital prior to all non-emergency admissions.

PHARMACISTS: For pharmacy questions, please call **(800) 642-4168**.

Claims Submission: P.O. Box 22712, Long Beach, CA 90801 - EDI Claims: WebMD-Payor #20149

www.MolinaHealthcare.com

Medicare

Molina Medicare Options (HMO) NM
Member: CHAVEZ, ENRIQUE I
Member # 8000880006574

Primary Care Provider: ARAGON, JOSEPH R
Primary Care Provider Phone: (505)865-3373
Medical Group: LOS LUNAS FAMILY PRACTICE
Medical Copays:
Office Visits: $5
Specialist Visits: $20
ER Visits: $50

RxBIN: 012189
RxPCN: 5037
RxGrp:

Issue ID: 80840
Issued Date: 10/06/2009

H9082 PBP

Member Services: 1-866-440-0127; TTY: 1-800-346-4128
24-Hour Nurse Advice Line: 1-888-275-8750;
TTY: 1-866-735-2922; For Spanish please call 866-648-3537.
Days & Hours of operation: Mon — Sun, 8:00 AM to 8:00 PM local time
Providers/Hospitals: Notify Molina Medicare Options (HMO) within 24 hours of any inpatient admission. For prior authorization, eligibility and general information, please call Molina Medicare Options at 1-866-440-0127 or TTY at 1-800-346-4128 Mon — Sun, 8:00 AM to 8:00 PM local time.
Claims Submission information:
Medical/Hospital: Molina Medicare Options (HMO), PO Box 22811, Long Beach, CA 90801
Pharmacy: Molina Medicare Options (HMO),
7050 Union Park Ave, Suite 200, Midvale, Utah 84047

www.molinamedicare.com

Resources

- Provider Manuals
- Member Rights & Responsibilities
- Preventative & Clinical Care Guidelines
- Provider Directory
- Frequently Used Forms
- Advanced Directives
- Medicaid Web Portal
- Medicare SNP Model of Care Training

www.MolinaHealthcare.com

www.MolinaMedicare.com

Provider Self Services for Medicaid

Individualized Training on Provider Self Services Functionalities

- Member eligibility inquiry
- Search for contracted providers for referrals
- Submit online authorizations
- Submit claims
- Check status of authorizations
- Claim status inquiry
- Update provider profile
- Coordination of benefits

Benefits Summary

Benefit	Description
Transportation	**Medicaid**: 30 one-way trips (15 round trips) **Medicare Options Plus**: 60 one-way trips **Medicare Options**: 16 one-way trips Must call 48 hours in advance
Vision	**Medicaid**: 0 to 20 years old: Covered eye exam every 12 months 21+ years old: Covered eye exam every 24 months New glasses provided every 24 months **Medicare Options Plus**: Covered eye exam per year; contact lenses or eye glasses, covered up to $200 every two years **Medicare Options**: Covered eye exam per year; contact lenses or eye glasses, covered up to $100 every two years
Care Management	Focuses on member education, integration of service, connection to community resources and ancillary services and coordination between medical, prescription drug and behavioral health services
24-Hour Nurse Advice Line	Receives inbound calls from members and providers with questions about medical care and after-hour issues that need to be addressed, gives protocol-based medical advice to members, anddirects after-hour transitions in care.

A full list of benefits can be found in your Medicaid and Medicare Provider Manuals.

For questions about whether a service is covered or requires prior authorization, please visit our website at www.MolinaHealthcare.com or www.MolinaMedicare.com or call Provider Services at 1-800-642-4168.

Medical Home

The Medical Home approach is a basic tenet of care coordination.

- A primary care provider (PCP) is designated for each member.
- Members are educated to make better health care decisions.
- Specialty care providers need to work with PCPs to coordinate care.

Health Care Services

Medicaid Services Requiring Prior Authorization

Ancillary/DME Services
- Ambulatory & Ambulette Services (except emergency)
- Durable Medical Equipment (per ODJFS Medicaid Supply List)
- Hearing Aids
- Home Health Services
- Select Ingestible Medications & Immunoglobulins Administered in an office setting or other outpatient setting.
- Orthodontia
- Orthotics (per ODJFS Medicaid Supply List)
- Prosthetics (per ODJFS Medicaid Supply List)
- Physical Therapy greater than 30 visits
- Non-emergent Transportation greater than 30 miles or exceeding 15 rounds trips per calendar year
- Wound Vacs/Outpatient Only

Inpatient Services
- Hospital Admissions
- Hospital Inpatient Rehab Admissions
- Hospice Inpatient Admissions
- Nursing Facility Admissions

Outpatient Services
- Chiropractic Services exceeding benefit limit
- PET/SPECT/MRI/MRA
- Enteral Nutrition (infant formula and oral nutrition/if it does not meet OAC requirements)
- Genetic Testing for congenital abnormalities
- Out of Network Facility Services
- Out of Network Specialty Referrals
- Outpatient Procedures
- Pain Management
- Respiratory Therapy
- Second Medical Opinion from out-of-plan provider
- Transplant Evaluation & Admissions
- Treatment of Varicose/Spider Veins

Surgeries
- Abortions, Bariatric, Blepharopasty, Cosmetic/Plastic Surgery
- Hysterectomy, Mammoplasty, Oral Surgery, Otoplasty
- Rhinoplasty/Septoplasty, Scar Revisions, Tubal Ligations
- Vasectomy

PLEASE NOTE: Abortions, hysterectomies and **sterilizations** do not require clinical review; however, claims for these services cannot be paid until the appropriate **ODJFS Consent Form** is received.

*Elective admissions require prior authorization. All urgent admissions require notification within 24 hours of admission or next business day.**

**Urgent situations are those that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or in the opinion of the practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.*

Health Care Services

Medicaid Services Requiring Prior Authorization

- All Non-Par Providers/Services
- Alcohol and Chemical Dependency Treatment
- All Elective Inpatient Admissions (Acute Care, SNF, Rehab, LTAC)
- Behavioral Health Services
- Cardiac Rehabilitation, Pulmonary Rehabilitation, and Certified Outpatient Rehabilitation Facility (CORF)
- Chiropractic Services (covers treatment of subluxation only)
- Cosmetic, plastic and reconstructive procedures in any setting
- Dialysis (notification only)
- Durable Medical Equipment/Orthotics/Prosthetics
  - >$500 billed charges per line item
  - C-PAP and Bi-PAP
  - All customized orthotics, prosthetics, wheelchairs and braces
- Enteral Formulas & Nutritional Supplements
- Potentially experimental/investigational procedures
- Genetic counseling and testing
- Hearing Aids
- Home Healthcare (after 3 skilled nursing visits)
- Home Infusion
- Hospice Care (notification only)
- Imaging (CT, MRI, MRA, PET, SPECT, Cardiac Nuclear Studies, informal media thickness testing and 3D imaging)
- Neuropsychological testing
- Occupational Therapy, Psychical Therapy and Speech Therapy (after initial evaluation plus 2 visits)
- Office Based Procedures such as
  - Removal of benign skin lesions, skin tags and lipomas
  - Brachytherapy
  - Mohs Surgery
- Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures except cardiac cath, sterilizations, tonsillectomies, myringotomies, tympanoplasties, cataract surgeries, and endoscopic procedures
- Pain Management Procedures
- Plastic and Reconstructive Procedures in any setting
- Podiatry Office Based Surgical Services
- Sleep Studies
- Specialty Pharmacy
- Transplant Services
- Transportation non-emergent ground or air ambulance
- Unlisted procedures (all)
- Voluntary Termination of Pregnancy
- Wound Vacs and Hyperbaric Wound Therapy

A detailed list of CPT Codes requiring prior authorization can be found at www.MolinaHealthcare.com.

Prescription Drug Services

- In an effort to simplify the process for the provider community, Ohio Medicaid and the Medicaid Managed Care Plans have collaborated to develop a more standardized Prior Authorization (PA) list, a single PA Form for all health plans and a similar Preferred Drug List (PDL).
- CMS/Caremark is the Pharmacy Benefit Manager (PBM) for Molina Healthcare.

Health Care Services

Primary Care Providers (PCP) Access to Care Standards

Type of Care	**Appointment Wait Time**
Preventive Care Appointment	Within 6 weeks of request
Routine Primary Care	Within 6 weeks of request
Acute Care	Members with persistent symptoms must be treated no later than the end of the following working day after their initial contact with the PCP site
Emergency Care	Member with emergency care needs must be triaged and treated immediately upon presentation at the PCP site
After-Hours Care	Available by phone 24/7
Office Waiting Time	Should not exceed 30 minutes

Non-Primary Care Access to Care Standards

Routine Consultation Appointment	Within 8 weeks of request
Pregnancy (for initial visit)	Within 2-6 weeks of request

Behavioral Health Access to Care Standards

Routine Care	Within 10 business days of request
Urgent Care	Within 48 hours of request
Non-life threatening emergency	Within 6 hours

Care Management

Members are identified for participation in the program through various methods:

- Internal and External Referrals (e.g. PCP/Specialist referrals)
- Utilization patterns identified through claim submission
- Predictive Modeling

Care Management Initiatives

- Member education
- Integration of behavioral health and medical services
- Coordination of resources and services to ensure utilization in a timely and cost effective manner

Provider Responsibilities

- Identify and refer members who may benefit from care coordination to improve health outcomes
- Collaborate with the care manager to identify specific desired outcomes
- Encourage member participation with care management including state required face to face visits

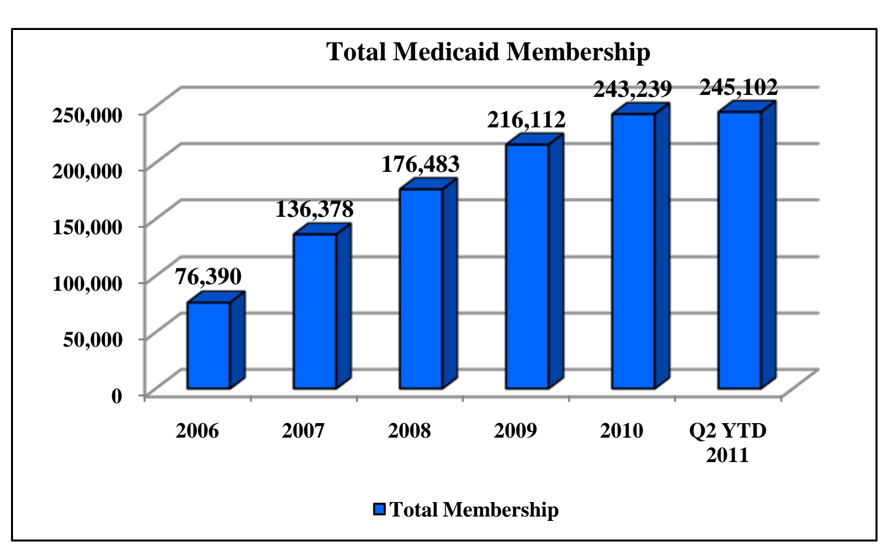
Care Management Triggers

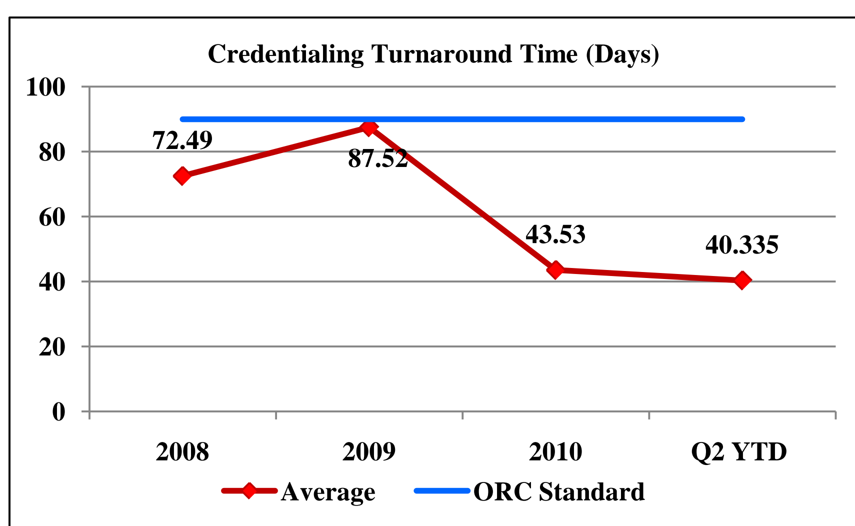
- Multiple co-morbid conditions
- High-risk chronic illness with clinical instability
- Avoidable or inappropriate utilization of ED services (indicative of lack of a Medical Home)
- Unsuccessful or failed discharge which resulted in readmission

Referrals to the Molina Care Management Team can be made by calling:

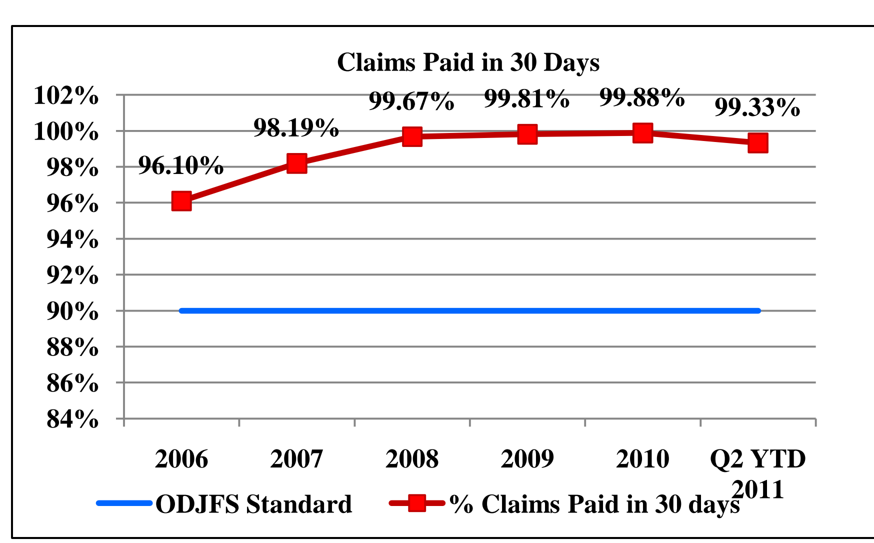
- 1-866-774-1510

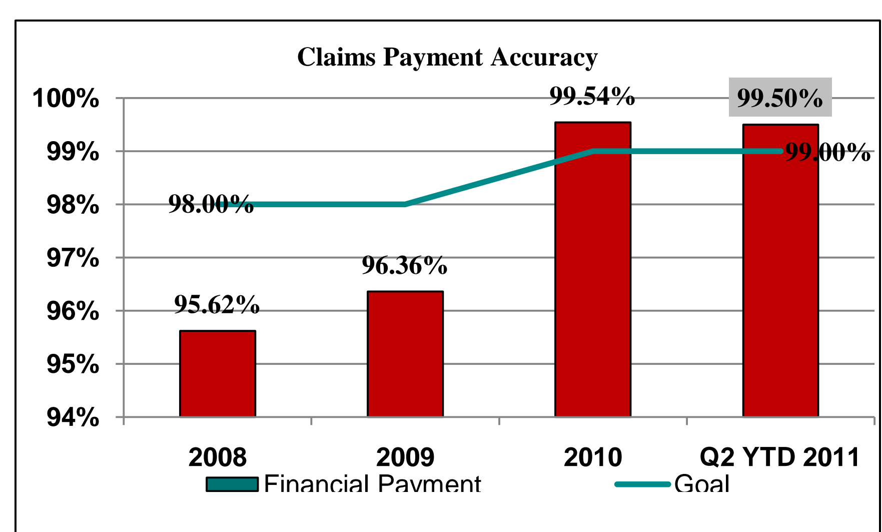
Total Membership and Credentialing Turnaround Time



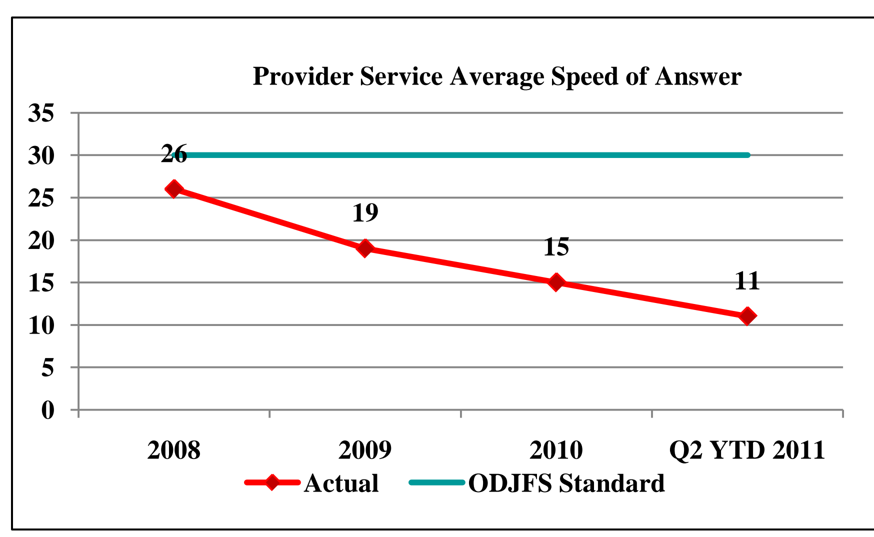


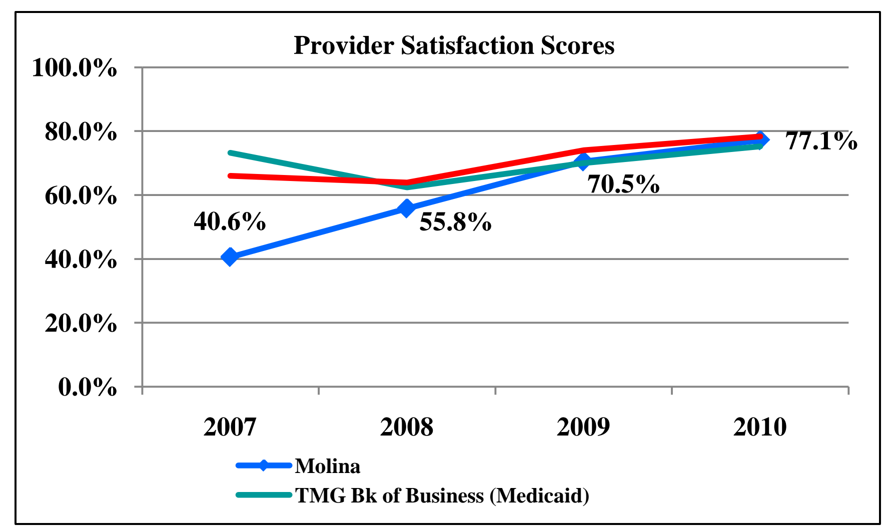
Claims Paid Turnaround Time and Claims Payment Accuracy





Average Speed of Answer and Provider Satisfaction Scores





We Care About Quality

The **Healthcare Effectiveness Data and Information Set (HEDIS®)** from NCQA is a well-known and respected tool used by more than 90 percent of American health plans to report performance on quality of care and service. Molina Healthcare is in the process of collecting this data, and appreciates your cooperation in our efforts to improve the health of our members and communities.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CAHPS is a survey of both members and providers about their satisfaction with their health plan.

Molina Healthcare CAHPS scores is consistently above the state's benchmark.

National Committee for Quality Assurance (NCQA)

Molina Healthcare of Ohio has received NCQA New Health Plan accreditation, a rigorous and comprehensive process for evaluating health care plan quality. NCQA accreditation is not a requirement. It is a step **above and beyond** that Molina Healthcare takes to ensure quality health care for our members.

Quality Improvement

HEDIS®

- The QI Department compiles health service data to support annual reporting of HEDIS rates to NCQA.

Health Education

- Based on HEDIS rates and other clinical performance measure results, health education initiatives are implemented for both providers and members to improve the quality of health services received by our members.

Credentialing

- In compliance with HB125, NCQA and ODJFS standards, all providers' qualifications are verified to ensure eligibility for participation in the Molina Healthcare of Ohio network.

Quality of Care

- All potential quality of care issues are investigated and resolved by trained registered nurses in collaboration with the Medical Director and Clinical Quality Improvement Committee. This may require office site assessment.

Quality of Service

- All potential quality of service issues are investigated and resolved by QI staff. This may require office site assessment.

NCQA

- The QI Department is responsible for ensuring that all plan processes are in compliance with current NCQA standards.

Member Appeals and Grievances

Molina Healthcare members, member representatives and participating providers have the right to voice a complaint or submit an appeal through a formal process or request a Denied Claims Review. Providers may file an appeal or grievance on behalf of the member.

Appeals

- An appeal is the request for review of an action. The member has the right to appeal Molina Healthcare's decision to deny a service.
- A member will receive Notice of Action (NOA) letter whenever a service is denied, reduced, suspended or terminated in whole or part.
- When a provider appeals on behalf of a member, an appeal representative authorization form must be completed by the member.

Grievances (Complaints)

- A grievance is an expression of dissatisfaction with any aspect of Molina Healthcare's provision of health care services, activities or behaviors.
- Molina Healthcare members have the right to submit a grievance (complaint) by calling Member Services
- Members may also submit their grievance in writing.

Details regarding the process are located in the Provider Manual.

Fraud, Waste and Abuse

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

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

Molina Healthcare is a contractor to both federal and state government agencies. We are, in essence, "stewards of government funds." As such, it is incumbent upon the corporation to prevent, detect and investigate insurance fraud.

The Anti-Fraud Plan was developed to prevent and detect fraud, waste and abuse in the delivery of Molina Healthcare medical and business related services.

Examples of Provider Fraud and Abuse

By a Provider
Billing for services, procedures or supplies that have not actually been rendered
Provider 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 or manipulation of the benefits payable for services, procedures or supplies, dates on which services or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of provider or the recipient of services, “unbundling” of procedures, non-covered treatments to receive payment, “upcoding,” and billing for services not provided
Concealing patients misuse of Molina Healthcare ID card
Failure to report a patient’s forgery or alteration of a prescription

You make us great:

Satisfied providers are Molina Healthcare's most valuable resource and our best reference.

Let us know what we can do to sustain and improve our valued partnerships with you.

Contact Us

Molina Healthcare of Ohio, Inc.

P.O. Box 349020

Columbus, OH 43234-9904

Provider Services

1-800-642-4168