Agenda

- Molina Healthcare Overview
- Provider Online Resources
- Molina Dual Options MyCare Ohio Overview
- Provider Manual, Online Directories and Web Portal Highlights
- Member Eligibility and Member ID
- PCP Assignment
- Referrals and Prior Authorization, including Service Request Form
- Transition of Services
- Service Request Forms and Clear Coverage
- Care Management/Model of Care
- Interdisciplinary Care Team
- Quality Improvement
- Access Standards
- Pharmacy
- Claims
- EFT
- Transportation Services
- Disability, Literacy and Competency Training
- Cultural and Linguistic Competency
- Members Rights and Responsibilities
- Fraud, Waste, & Abuse
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. This commitment to providing access to quality care continues to be our mission today, just as it has been for the last 30 years.

**Mission Statement**

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

**Vision Statement**

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

**Core Values**

We strive to be an exemplary organization:

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

*This is the Molina Way*
Who We Are

Three Decades of Delivering Access to Quality Care

Molina Healthcare has evolved over the years, but the mission has remained the same—providing those most in need with access to high quality health care services. It is our story that makes us proud to call ourselves an extended family, to the members, partners and communities we serve.

1980
FIRST PATIENT
Molina Healthcare is born. Originally named Molina Medical Centers, our primary care clinics begin serving communities in southern California.

1994
160,000 MEMBERS
Molina Healthcare is licensed as a health plan in California.

2000
250,000 MEMBERS

1997
110,000 MEMBERS
Molina Healthcare begins serving communities in Utah.

2004
750,000 MEMBERS
Molina Healthcare begins serving communities in New Mexico.

2005
900,000 MEMBERS
Molina Healthcare begins serving communities in Texas.

2006
1 MILLION MEMBERS
Molina Healthcare begins offering services to people with Medicare.

2008
1.25 MILLION MEMBERS
Molina Healthcare begins operating Fairfax County clinics in Virginia.

2011
1.7 MILLION MEMBERS
Molina Medicaid Solutions’ system in Maine receives full federal certification.

2012
1.8 MILLION MEMBERS
Molina Healthcare is awarded dual eligible contracts in California, Illinois and Ohio.

Molina Healthcare is named a FORTUNE 500 company.

Molina Medicaid Solutions’ system in Idaho receives full federal certification.

Molina Healthcare begins serving communities in Wisconsin.
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
• 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
• NCQA Accredited since January 2009
• Ohio Association of Health Plans Pinnacle (OAHP) Awards
  o One 2013 OAHP Pinnacle Award
  o Two 2012 OAHP Pinnacle Awards
  o Two 2011 OAHP Pinnacle Awards
• Columbus Business First Corporate Caring Award recipient in 2012, finalist in 2010, 2009, 2008
• Columbus Business First 2012 Best Places to Work Award
• 2013 Ohio Hispanic Coalition Padrino Award
• 2014 Medical Mutual Pillar Award in Community Service
Molina Healthcare began serving Ohio’s Covered Families and Children Medicaid population in 2005, and Aged, Blind or Disabled members in 2007.

In 2008, Molina Healthcare was awarded a contract from the Centers for Medicare and Medicaid Services (CMS) to serve the Medicare population.

In July 2013, Molina began offering Medicaid services statewide and for Children with Special Health Care Needs.

Molina began serving members through the Health Insurance Marketplace on Jan. 1, 2014.

On Jan. 1, 2014, the Ohio Department of Medicaid expanded to serve childless adults and parents up to 138% FPL through Adult Extension.

Molina Healthcare will provide services for beneficiaries who are eligible for both Medicaid and Medicare in May 2014 as part of MyCare Ohio.

Membership: 255,000*  
Employees: 512  
Provider Network:
- 16,793 network primary care and specialist providers
- 189 hospitals
- All six of Ohio’s children’s hospitals
- Network includes providers statewide

*As of Dec. 31, 2013
Molina Dual Options MyCare Ohio is…

- **Dual Options (MMP)** is the name of Molina’s Medicare-Medicaid Program.
- The Dual Options plan was designed for Members who are dual eligible:
- In order to provide quality healthcare coverage and service with little out-of-pocket costs.
- Dual Options (MMP) embraces Molina’s longstanding mission to serve those who are the most in need and traditionally have faced barriers to quality healthcare.
- Operated by both the Center for Medicare and Medicaid Services (CMS) and the Ohio Department of Medicaid (ODM)
- Combines the benefits of Medicare and Medicaid
- Coordinates the physical, behavioral, waiver and long-term care services for individuals eligible for both Medicare and Medicaid
- Offered to individuals in 13 counties divided into 3 regions
Benefits At A Glance

- Inpatient Services
- Outpatient Services
- Rural Health Clinics (RHCS) and Federally Qualified Health Centers (FQHC)
- Physician Service (in office, home, hospital or elsewhere)
- Laboratory and X-Ray Services
- Screening, diagnosis, and treatment services to children under the age of twenty-one (21) under the Healthchek, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program
- Family Planning Services and Supplies
- Home Health and Private Duty Nursing Services
- Podiatry
- Chiropractic Services
- Physical Therapy, Occupational Therapy, Developmental Therapy, and Speech Therapy
- Nurse –Midwife, Certified Family Nurse Practitioner, and Certified Pediatric Nurse Practitioner Services
- Free-Standing Birth Center Services in free-standing birth centers as defined in OAC 5160-18-01
- Prescription Drugs
- Ambulance and Ambulette Services
- Dental Services
- Durable Medical Equipment and Medical Supplies including expedited wheelchair fitting, purchase, maintenance and repair, professional evaluation, home assessment, the services of skilled wheelchair technicians, pick-up and delivery, timely repairs, training, demonstration
  and loaner chairs.
- Vision Care Services, including eyeglasses
- Nursing Facility Services
- Hospice Care
Benefits At A Glance Continued…

- Behavior Health Services, including the following behavior health services provided by the Ohio Department of Mental Health and Addiction Services (MHAS)
  - Behavioral Health Assessment
  - Behavioral Health Counseling and Therapy (Individual and Group)
  - Crisis Intervention (24-hour availability)
  - Partial Hospitalization
  - Inpatient psychiatric hospitalization in free-standing and state-operated psychiatric hospitals (see limitations in section G.2.b.iii of this appendix)
  - Community Psychiatric Support Treatment (Individual and Group)
  - Ambulatory Detoxification
  - Targeted Case Management for AOD
  - Intensive Outpatient Programs (IOP)
  - Laboratory Urinalysis
  - Medication/Somatic Treatment Services
  - Methadone Administration

- Immunizations
- Screening and Counseling for obesity provided during an evaluation and management or preventive medicine visit per: OAC 5160-4-34
- Home and Community-Based Waiver Service provided by providers certified by the Ohio Department of Aging (ODA) or approved by ODM and meet the requirements in Chapters 173-39 or 5160-45 of the OAC:
Who is Eligible?

Consumers are eligible to join a MyCare Ohio managed care plan if:

- They are receiving full benefits from both Medicare and Medicaid
- They are 18 years of age or older
- They reside in a MyCare Ohio service region

Eligible consumers will receive an Enrollment Letter from ODM. As soon as the consumer receives his or her letter, he or she can choose a managed care plan.

<table>
<thead>
<tr>
<th>MyCare Ohio Regions</th>
<th>Enrollment Letter Distribution Date</th>
<th>Enrollment Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NW</td>
<td>February 28, 2014</td>
<td>May 1, 2014</td>
</tr>
<tr>
<td>NE, NEC, SW</td>
<td>March 28, 2014</td>
<td>June 1, 2014</td>
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<tr>
<td>C, WC, EC</td>
<td>April 30, 2014</td>
<td>July 1, 2014</td>
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Enrollment Process

Consumers will receive an Enrollment Letter from ODM telling them:

- From which managed care plans they can choose
- How long they have to choose a MyCare Ohio Medicaid plan
  - If a consumer does not choose a plan by the date in the letter, ODM will choose a plan for that consumer to cover Medicaid benefits
- Their options for Medicare coverage
  - Consumers have until Jan. 1, 2015 to make a decision about their Medicare coverage
- How to enroll in the MyCare Ohio managed care plan they choose

Consumers can call the Ohio Medicaid Consumer Hotline to select Molina MyCare Ohio!

(800) 324-8680
TTY (800) 292-3572
http://www.ohiomh.com
Provider Online Resources

- Provider Manuals
- Provider Online Directories
- Web Portal
- Preventive & Clinical Care Guidelines
- Prior Authorization Information
- Advanced Directives
- Claims Information
- Pharmacy Information
- HIPAA
- Fraud, Waste and Abuse Information
- Frequently Used Forms
- Communications & Newsletters
- Member Rights & Responsibilities
- Contact Information

www.MolinaHealthcare.com
www.MolinaHealthcare.com/Medicare
Molina Healthcare’s Provider Manual is written specifically to address the requirements of delivering health care services to our members, including your responsibilities as a participating provider. The Molina Provider Manuals are located on the following websites:


### Provider Manual Highlights

<table>
<thead>
<tr>
<th>Benefits and Covered Services Overview</th>
<th>Long Term Supports and Services</th>
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<tbody>
<tr>
<td>Claims, Encounter Data and Compensation (including no member billing requirements)</td>
<td>Member Grievances and Appeals</td>
</tr>
<tr>
<td>Compliance and Fraud, Waste, and Abuse Program</td>
<td>Member’s Rights and Responsibilities</td>
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<tr>
<td>Contacts</td>
<td>Model of Care</td>
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<tr>
<td>Credentialing and Re-credentialing</td>
<td>Pharmacy</td>
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<tr>
<td>Delegation Oversight</td>
<td>Preventive Health Guidelines</td>
</tr>
<tr>
<td>Eligibility, Enrollment, and Disenrollment</td>
<td>Provider Responsibilities</td>
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<tr>
<td>Healthcare Services</td>
<td>Quality Improvement</td>
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<tr>
<td>Health Insurance Portability and Accountability Act (HIPAA)</td>
<td>Transportation Services</td>
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<tr>
<td>Interpreter Services</td>
<td>Utilization Management, Referral and Authorization</td>
</tr>
</tbody>
</table>
Molina Healthcare providers may request a copy of our Provider Directory from your Provider Services Representative. Providers may also use the Online Provider Directory on our website.

To find a Molina Healthcare Medicare and/or Medicaid provider, visit us at www.MolinaHealthcare.com, and click Find a Provider, or Find a Hospital, or Find a Pharmacy.
Molina Healthcare participating providers may register for access to our Web Portal for self-service member eligibility, claims status, provider searches and to submit requests for authorization and professional claims. The Web Portal is a secure website that allows providers to perform many self-service functions 24 hours a day, 7 days a week. Some of the services available on the Web Portal include:

<table>
<thead>
<tr>
<th>Web Portal Highlights</th>
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<tbody>
<tr>
<td>▪ Member eligibility verification and history</td>
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<tr>
<td>▪ View Coordination of Benefits (COB) information</td>
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<tr>
<td>▪ Update provider profile</td>
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<tr>
<td>▪ View PCP Member Roster</td>
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<tr>
<td>▪ Submit online service/prior authorization requests</td>
</tr>
<tr>
<td>▪ Claims status inquiry</td>
</tr>
<tr>
<td>▪ View Nurse Advice Line call reports for members</td>
</tr>
<tr>
<td>▪ View HEDIS® missed service alerts for members</td>
</tr>
<tr>
<td>▪ Status check of authorization requests</td>
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<tr>
<td>▪ Submit claims online</td>
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Register online at [https://eportal.molinahealthcare.com/Provider/login](https://eportal.molinahealthcare.com/Provider/login).
Member Eligibility Information (refer to next slide)
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 web portal will display the member’s eligibility and benefits page.
Molina Healthcare offers various tools to verify member eligibility. Providers may use our online self-service Web 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/her name does not appear on the eligibility roster. If a member does not appear on the eligibility roster please contact the Plan for further verification.

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

Duals Member Customer Service: (855) 665-4623 Monday-Friday 8AM-8PM

Medicare Customer Service/24 HR-IVR Automated System: (866) 472-4584

Duals Provider Service/24 HR-IVR Automated System: (855) 322-4079
PCP Assignment and Changes

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

- Proximity of the provider must be within 30 miles
- Member’s last PCP, if known
- Member’s age, gender and PCP needs
- Member’s language preference
- Member’s covered family members, in an effort to keep family together and maintain established relationships

**PCP Changes** – Members may change their PCP at any time. 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.
Referrals and Prior Authorization

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

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

- Assist in benefit determination
- Prevent unanticipated denials of coverage
- Create a collaborative approach to determining the appropriate level of care for Members receiving services
- Identify 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 that have authority to approve services.

A list of services and procedures that require prior authorization is in our Provider Manual, and also on our website at:

Request for Authorization

- Authorization should be requested with supporting clinical documentation at least 5 business days prior to the date of the requested service. When the request is for emergent services, Molina Healthcare should receive the request and clinical documentation within one business day of the qualifying event. Information generally required to support decision making includes:
  - Current (up to 6 months), adequate patient history related to the requested services
  - Copy of current and existing treatment plan that identifies all services (Medical and Behavior Health)
  - Physical examination that addresses the problem
  - Lab or radiology results to support the request (including previous MRI, CT, Lab or X-ray report/results)
  - PCP or Specialist progress notes or consultations and any other information or data specific to the request

- Molina Healthcare will process all “non-urgent” requests in no more than 14 business days of the initial request. “Urgent” requests will be processed within 72 hours of the initial request. If we require additional information we will pend the case and provide written communication to you and the Member on what we need.

- Providers who request prior authorization approval for patient services and/or procedures can request to review the criteria used to make the final decision. Providers may request to speak to the Medical Director who made the determination to approve or deny the service request.

- Upon receipt of prior authorization, Molina Healthcare will provide you with a Molina Healthcare unique authorization number. This authorization number can be used on all claims related to the service authorized.

- Our goal is to ensure our members are receiving the Right Services at the Right Time AND in the Right Place. You can help us meet this goal by sending all appropriate information that supports the member’s need for Services when you send us your authorization request. Please contact us for any questions/concerns.
The same prior authorization requirements used for Medicaid services will be utilized for the Molina Dual Options Plan with the exception of an extended list for Behavioral Health, Nursing Facilities, and Waiver services.

When checking to see if a service requires a prior authorization we **strongly recommend** first viewing the service request form and then proceeding to verify if the specific CPT code is requires a PA or is a non-covered service. The most up to date version of these items can be found under the forms section of the Molina Provider website at: [http://www.molinahealthcare.com](http://www.molinahealthcare.com)

**The following are examples of services that require Prior Authorization:**

- Nutritional Supplements & Enteral Formulas
- Durable Medical Equipment
- Inpatient Admissions: Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility, Hospice
- Chiropractic Services
- Imaging
- Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures

**Please note:** prior authorizations are **not** required for the following services: emergency and post-stabilization services including emergency behavioral health care, urgent care crisis stabilization, including mental health, urgent support for home and community services, family planning services, preventive services, basic OB / prenatal care, communicable disease services including STI and HIV testing and out-of-area renal dialysis.
Transition of Service

Molina is committed to implementing the ICDS Waiver in a manner that allows for the safe transition of individuals while adhering to minimal service disruption. The State has developed the following requirements to aid in the transition process. This process allows the member to continue services while transitioning into the MCP:

- In order to minimize service disruption, the MCP will honor the individual’s existing service levels and providers for a pre-determined amount of time, depending upon the type of service

- The Plans will receive files of all existing authorized waiver services

- Providers can use the MITS provider portal to see if a consumer is enrolled in MyCare Ohio and which plan they have selected. MITS will also indicate if the member is a Molina Duals Option MyCare Ohio member or if they are a Molina Duals Medicaid only member.
Direct Care Waiver Services: Personal care, Waiver Nursing, Home Care Attendant, Choices Home Care Attendant, Out-of-Home Respite, Enhanced Community Living, Adult Day Health Services, Social Work Counseling, Independent Living Assistance.

- Services will be maintained at current level and with current providers at the current Medicaid reimbursement rates for 365 days.

Assisted Living Waiver:

- Provider will be retained at current rate for the life of Demonstration.


- Services will be maintained at current level for 365 days, and existing provider at existing rate for 90 days.

To view the MyCare Ohio Plan Transition Requirements, go to: http://www.insurance.ohio.gov/Consumer/OSHIIP/Documents/MyCare_Ohio_Plan_Transition_Requirements.pdf
Service Request Form

Providers should send requests for prior authorizations to the Utilization Management Department using the Molina Healthcare Service Request Form, which is available on our website, at:


Service Request Forms may be faxed to the Utilization Management Department to the numbers listed below, or submitted via our Provider Web Portal.

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

MyCare Ohio:  Fax (866) 449-6843
To improve the prior authorization process for our providers, Molina Healthcare implemented Clear Coverage, a web-based application that can be accessed through the Molina Web Portal. Clear Coverage does not support Waiver Services, Inpatient Hospitalization, Sterilization, and Specialty Drugs.

As a Molina Healthcare provider, you are able to enter a prior authorization service request which may result in an automatic authorization for specific services. The process includes an interactive, real time medical review based on Molina Healthcare specific guidelines and InterQual® clinical criteria. You also can upload medical records as needed, verify member eligibility and benefits, view authorization status, and print proof of authorization.

Clear Coverage is available to our entire provider network, and you are able to access self-training materials for the application within the Molina Web Portal or request in-person training from your External Provider Relations Representative. Clear Coverage brings a wide range of benefits, including lower administrative costs, more consistent policy adherence, and time savings.

Provider Web Portal: https://eportal.molinahealthcare.com/Provider/Login
To ensure that members receive high quality care, Molina Healthcare uses an integrated system of care that provides comprehensive services to all members across the continuum of Medicare and Medicaid benefits. Molina Healthcare strives for full integration of physical health, behavioral health, long-term care services and support and social support services to eliminate fragmentation of care and provide a single, individualized plan of care for members. Molina Healthcare’s Care Management program consists of four programmatic levels. This approach emphasizes high-touch, member-centric care environment and focuses on activities that support better health outcomes and reduce the need for institutional care.

As a network provider, you play a critical role in providing quality services to our members. This includes identifying members in need of services, making appropriate/timely referrals, collaborating with Molina Healthcare care managers on the Individualized Care Plan (ICP) and Interdisciplinary Care Team meetings (ICT; if needed), reviewing/responding to patient-specific communication, maintaining appropriate documentation in member’s medical record, participating in ICT/ Model of Care provider training and 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/might benefit from such services.

For additional Model of Care information, please visit our website at www.MolinaHealthcare.com/Duals.
Interdisciplinary Care Team (ICT)

Molina Healthcare’s ICT may include:

- Registered Nurse (RN)
- Social Worker
- Case Manager
- Utilization Management Staff
- Molina Medical Director
- Pharmacy
- Member’s Primary Care Provider
- Member and/or Designee
- Care Transition Coach
- Service Providers
- Community Health Worker
- Waiver Service Coordinator
- Other entity that member selects

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

- Case management
- Participate in ICT and/or approve all ICT participants
- ICT meetings; brief telephonic communications
Care Management Design

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 the assessment, their utilization history and current medical and psycho-social-functional needs. Molina Healthcare’s Care Management program consists of four programmatic levels as follows:

**Level 1 – Health Management**

Health Management is focused on disease prevention and health promotion. It is provided for members whose lower acuity chronic conditions; behavior (e.g., smoking or missing preventive services) or unmet needs (e.g., transportation assistance or home services) put them at increased risk for future health problems and compromise independent living. The goal of Health Management is to achieve member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation throughout the continuum of care.

At this level, members receive educational materials via mail about how to improve lifestyle factors that increase the risk of disease onset or exacerbation. Topics covered include smoking cessation, weight loss, nutrition, exercise, hypertension, hyperlipidemia, and cancer screenings, among others. Members are given the option, if they so choose, to engage in telephone-based health coaching with Health Management staff, which includes nurses, social workers, dieticians, and health educators.

**Level 1: Health Management**

- Condition specific health education management
- Service coordination: transportation, scheduling appointments
- Community Resources
- Social, Behavioral, LTC Support
- Explanation of health plan benefits and services

Your Extended Family

MOLINA HEALTHCARE
Care Management Design

Level 2 – Care Management

Care Management is provided for members who have medium-risk chronic illness requiring ongoing intervention. These services are designed to improve the member’s health status and reduce the burden of disease through education and assistance with the coordination of care including LTSS. The goal of Care Management is to collaboratively assess the member’s unique health needs, create individualized care plans with prioritized goals, and facilitate services that minimize barriers to care for optimal health outcomes.

Care Managers have direct telephonic access with members. In addition to the member, Care Management teams also include pharmacists, social workers, and behavioral health professionals who are consulted regarding patient care plans. In addition to telephonic outreach to the member, the Care Manager may enlist the help of a Community Health Worker or Community Connector to meet with the member in the community for education, access, or information exchange.

Level 2: Case Management

- Multidisciplinary approach with assessment/care plans/member centered-goals
- Service coordination
- Medical, Social, Behavioral, LTC Support
- Condition specific education/management
- Explanation of health plan benefits and services
Level 3 – Complex Care Management

Complex Care Management is provided for members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the health care system to facilitate the appropriate delivery of care and services.

The goal of Complex Care Management is to help members improve functional capacity and regain optimum health in an efficient and cost-effective manner. Comprehensive assessments of member conditions include the development of a care management plan with performance goals and identification of available benefits and resources. Care Managers monitor, follow-up and evaluate the effectiveness of the services provided on an ongoing basis. Complex Care Management employs both telephonic and face-to-face interventions.

Community Connector program will also be available for members receiving Level 3 & 4 – Complex Care Management. Community Connectors support Molina Healthcare’s most vulnerable members within their home and community with social services access and coordination. Community Health Workers serve as patient navigators and promote health within their own communities by providing education, advocacy and social support.

Level 3: Complex Case Management

- Multidisciplinary approach utilizing Interdisciplinary Care Team
- Utilize comprehensive and condition specific assessment(s)
- Member-centered prioritized goals
- Medical, Social, Behavioral, LTC Support
- Service coordination
- Incorporate home visits as appropriate
- Enlist Community Connector Focus on condition specific member education/self management skills
- Explanation of health plan benefits and services
Level 4 – Imminent Risk

Level 4 focuses on members at imminent risk of an emergency department visit, an inpatient admission, or institutionalization, and offers additional high intensity, highly specialized services. Level 4 also includes those members who are currently institutionalized but qualify to transfer to a home or community setting. Services are designed to improve the member’s health status and reduce the burden of disease through education as described in Level 1.

These criteria include meeting an intensive skilled nursing (ISN) level of care, facing an imminent loss of current living arrangement, deterioration of mental or physical condition, having fragile or insufficient informal caregiver arrangements, having a terminal illness, and having multiple other high risk factors.

Comprehensive assessments of Level 4 conditions include assessing the member’s unique health needs utilizing the comprehensive assessment tools, identifying potential transition from facility and need for LTSS referral coordination, participating in ICT meetings, creating individualized care plans with prioritized goals, and facilitating services that minimize barriers to care for optimal health outcomes.

Level 4: Imminent Risk Case Management

- Multidisciplinary approach
- Utilize detailed assessment(s)
- Prioritized Goals
- Medical, Social, Behavioral, LTC Support
- Service coordination
- Incorporate home visits as appropriate
- Enlist Community Connector
- Focus on keeping the member in the least restrictive environment possible
- Focus on condition specific member education/self management
- Explanation of health plan benefits and services
Based on the level of Care Management needed, outreach is made to the member to determine the best plan to achieve short and long-term goals. Each level utilizes a health assessment to determine interventions that support member achievement of short- and long-term goals. At the higher levels, this includes building an individualized care plan with the member and/or representative. These assessments include the following elements based on NCQA, state and federal guidelines:

- Health status and diagnoses
- Cultural and linguistic needs
- Caregiver resources
- Body Mass Index, Smoking
- Communication barriers with providers
- Emergency Department and inpatient use
- Psychosocial needs (e.g., food, clothing, employment)
- Health goals
- Chemical dependency
- Readiness to change and Member’s desire / interest in self-directing their care
- Life-planning activities (e.g., health care power of attorney, advance directives)
- Activities of daily living, functional status, need for or use of LTSS
- Clinical history, Medications prescribed
- Visual and hearing needs
- Available benefits and community resources
- Confidence
- Treatment and medication adherence
- Primary Care Physician visits
- Durable medical equipment needs
- Mental health

The resulting care plan is approved by the member, maybe reviewed by the ICT and maintained and updated by the Case Manager as the member’s condition changes. The Case Manager also addresses barriers with the member and/or caregiver, and collaborates with providers to ensure the member is receiving the right care, in the right setting, with the right provider.
Quality Improvement

Quality is a Molina Healthcare core value and ensuring members receive the right care in the right place at right time is everyone's responsibility. Molina Healthcare’s quality improvement department maintains key processes and continuing initiatives to ensure measurable improvements in the care and service provided to our members. Clinical and service quality is measured/evaluated/monitored through the following programs:

- Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Health Plan Survey (CAHPS®), CMS STARs, Health Outcomes Survey (HOS) data and other quality measures
- Provider Satisfaction Survey
- Health Management Programs:
  - Molina Breathe with Ease™ asthma program, Healthy Living with Diabetes, Chronic Obstructive Pulmonary Disease program, Heart Healthy Living Cardiovascular program, Motherhood Matters® pregnancy program to support and educate members and to provide special care to those with high risk pregnancy
  - For more information on Molina Healthcare’s Health Management Program, please call: Health Education (800) 526-8196, ext. 127532
- Preventive Care and Clinical Practice Guidelines

For additional information about Molina Healthcare’s Quality Improvement initiatives, you can Provider Services at (855) 322-4079 or visit our website: www.MolinaHealthcare.com.
Molina Healthcare monitors compliance and conducts ongoing evaluations regarding the availability and accessibility of services to Members. Please ensure adherence to these regulatory standards:

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<thead>
<tr>
<th>Category</th>
<th>Type of Care</th>
<th>Access Standard</th>
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<tbody>
<tr>
<td><strong>Primary Care Provider</strong></td>
<td>Routine Needs</td>
<td>Within 6 weeks</td>
</tr>
<tr>
<td></td>
<td>Persistent Symptoms</td>
<td>No later than the end of the following day after their initial contact with the PCP site</td>
</tr>
<tr>
<td></td>
<td>Emergent Needs</td>
<td>Triaged and treated immediately upon presentation at the PCP site</td>
</tr>
<tr>
<td></td>
<td>After Hours Care</td>
<td>Available by phone 24 hours a day, 7 days a week</td>
</tr>
<tr>
<td><strong>Non-Primary Care</strong></td>
<td>Routine Needs</td>
<td>Within 6-8 weeks</td>
</tr>
<tr>
<td></td>
<td>Persistent Symptoms</td>
<td>Within 2-4 weeks</td>
</tr>
<tr>
<td></td>
<td>Emergent Needs</td>
<td>Triaged and treated immediately upon presentation</td>
</tr>
<tr>
<td></td>
<td>Pregnancy (initial visit)</td>
<td>Within 2-4 weeks</td>
</tr>
<tr>
<td><strong>Behavioral Health</strong></td>
<td>Routine Needs</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td></td>
<td>Persistent Symptoms</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td></td>
<td>Non-Life Threatening Emergency</td>
<td>Treated within 6 hours</td>
</tr>
<tr>
<td></td>
<td>Emergent Needs</td>
<td>Triaged and treated immediately upon presentation</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td>Office Wait Time</td>
<td>Maximum of 30 minutes</td>
</tr>
</tbody>
</table>
Access Standards

Office Wait Time – For scheduled appointments, the wait time in offices should not exceed 30 thirty minutes from appointment time until the time seen by the PCP. All PCPs are required to monitor waiting times and to adhere to this standard.

After Hours – All providers must have back-up (on call) coverage after hours or during the provider’s absence or unavailability. Molina Healthcare requires primary care providers to maintain a 24-hour telephone service, seven (7) days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an emergency to hang up and call 911 or go immediately to the nearest emergency room.

Appointment Scheduling – Each provider must implement an appointment scheduling system. The following are the minimum standards:

• The provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments;
• A process for documenting missed appointments must be established. When a member does not keep a scheduled appointment, it is to be noted in the member’s record and the provider is to assess if a visit is still medically indicated. All efforts to notify the member must be documented in the medical record. If a second appointment is missed, the provider is to notify the Molina Dual Options Member Services Department toll-free at (855) 665-463 or 711 for TTY/TDD;
• When the provider must cancel a scheduled appointment, the member is given the option of seeing an associate or having the next available appointment time. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to, wheelchair-bound Members and Members requiring language translation;
• A process for member notification of preventive care appointments must be established. This includes, but is not limited to, immunizations and mammograms; and process must be established for member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, participating providers have agreed that they will not discriminate against any member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, and place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Additionally, a participating provider or contracted medical group/IPA may not limit his/her practice because of a member’s medical (physical or mental) condition or the expectation for the need of frequent or high cost care. If a PCP chooses to close his/her panel to new Members, Molina Healthcare must receive thirty (30) days advance written notice from the provider.

Additional information on appointment access standards is available from the Molina Dual Options QI Department toll-free at (855) 665-4623.
Pharmacy/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 Molina Healthcare members receive high quality, cost-effective, rational drug therapy. Molina Healthcare Drug Formularies are available on our website, at:

**Medicaid Formulary:** [Drug Formulary](#)  
**Medicare Formulary:** [Drug Formulary](#)

Prescriptions for medications requiring prior approval, most injectable medications or for medications not included on the Molina 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.

**Medicaid Phone:** (855) 322-4079  
**Medicare Phone:** (888) 290-1309  
**Prior Authorization Fax:** (888) 858-3090  
**Prior Authorization Fax:** (866) 290-1309

The Prior Authorization/Medication Exception Request is available on our website, at:

**Medicaid:** [Molina Medicaid](#)  
**Medicare:** [Molina Medicare](#)
Claims Submission Options
1. Submit paper claims directly to Molina Healthcare of Ohio
2. Clearinghouse (Emdeon)
   - Emdeon is an outside vendor that is used by Molina Healthcare
   - When submitting EDI Claims (via a clearinghouse) to Molina Healthcare, please utilize the following: payer ID 20149.
   - EDI or Electronic Claims get processed faster than paper claims
   - Providers can use any clearinghouse of their choosing. Note that fees may apply

Claims Address
- EDI Claims Submission – Medicaid & Medicare
  Emdeon Payor ID# 20149
  Emdeon Telephone (877) 469-3263
- Medicaid Claims Submission Address
  Molina Healthcare of Ohio
  P.O. Box 27712
  Long Beach, CA 90801
- Medicare Claims Submission Address
  Molina Medicare
  P.O. Box 22811
  Long Beach, CA 90801
- Molina Dual Options Claims Submission Address
  Molina Dual Options Claims
  P.O. Box 22712
  Long Beach, CA 90801

EDI Claim Submission Issues
- Please call the EDI customer service line at (866) 409-2935 and/or submit an email to EDI.Claims@molinahealthcare.com
- Contact your provider services representative

Note: Online submission is also available through Web Portal Services at: www.MolinaHealthcare.com
Claims

Claims Processing Standards:

- In accordance with 42 C.F.R. § 447.46, Molina Healthcare must pay ninety percent (90%) of all submitted Clean Claims within thirty (30) days of the date of receipt and ninety-nine percent (99%) of such claims within ninety (90) days of the date of receipt.

- The clean pharmacy and non-pharmacy claims will be separately measured against the thirty (30) and ninety (90) day prompt pay standards. The prompt pay requirement applies to the processing of both electronic and paper claims for contracting and non-contracting providers by Molina Healthcare and delegated claims processing entities.

These standards have to be met in order for Molina Healthcare to remain compliant with State requirements and ensure providers are paid timely.
Claims Customer Service

For assistance with any claims related process, please contact Provider Services at (855) 322-4079 (follow phone prompts).

- **Corrected Claims**
  - The Corrected Claims form can be found on our website [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com)
  - Participating providers have 120 days from the date of the original remittance advice to submit corrected claims.
  - The completed form and corrected claim may be mailed to:
    Molina Healthcare
    PO Box 22712
    Long Beach, CA 90801

- **Claims Reconsiderations**
  - The Claims Reconsideration Form can be found on our website [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com)
  - Requests must be received within 120 days of date of original remittance advice.
  - The completed form and documentation can be faxed to: (800) 499-3406; or mailed to:
    Molina Healthcare of Ohio
    Attn: Provider Services
    PO Box 349020
    Columbus, Ohio 43234-9020
Electronic Funds Transfer & Remittance Advice (EFT & ERA)

Molina Healthcare has partnered with our payment vendor, FIS ProviderNet, for Electronic Funds Transfer and Electronic Remittance Advice. Access to the ProviderNet portal is FREE to our participating providers and we encourage you to register after receiving your first check from Molina Healthcare.

**New ProviderNet User Registration:**
1. Go to https://providernet.adminisource.com
2. Click “Register”
3. Accept the Terms
4. Verify your information
   a. Select Molina Healthcare from Payers list
   b. Enter your primary NPI
   c. Enter your primary Tax ID
   d. Enter recent claim and/or check number associated with this Tax ID and Molina Healthcare
5. Enter your User Account Information
   a. Use your email address as user name
   b. Strong passwords are enforced (8 or more characters consisting of letters/numbers)
6. Verify: contact information; bank account information; payment address
   a. Note: any changes to payment address may interrupt the EFT process
   b. Add any additional payment addresses, accounts, and Tax IDs once you have logged in.

**If you are associated with a Clearinghouse:**
1. Go to “Connectivity” and click the “Clearinghouses” tab
2. Select the Tax ID for which this clearinghouse applies
3. Select a Clearinghouse (if applicable, enter your Trading Partner ID)
4. Select the File Types you would like to send to this clearinghouse and click “Save”

**If you are a registered ProviderNet user:**
1. Log in to ProviderNet and click “Provider Info”
2. Click “Add Payer” and select Molina Healthcare from the Payers list
3. Enter recent check number associated with your primary Tax ID and Molina Healthcare

**BENEFITS**
- 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 associated Clearinghouse

If you have questions regarding the actual registration process, please contact ProviderNet at: (877) 389-1160 or email: Provider.Services@fisglobal.com.
Molina Healthcare of Ohio provides non-emergent medical transportation for our members for distances greater than 30 miles. Transportation can be scheduled on a recurring basis ahead of time.

If one of your patients is in need of this service, please have them contact our Logisticare or our Member Services Department to see if they qualify. Note: It is important to have your patient(s) call three (3) days in advance of the appointment to schedule the transportation. One additional passenger or escort is allowed to accompany the member if there is space availability.

**Logisticare**: (888) 475-5423; TTD/TTY – (866)288-3133

**Member Services – Duals**: (855) 665-4623
Prejudices
Physicians and other health professionals who encounter people with disabilities in their professional practice should be aware not only of the causes, consequences, and treatment of disabling health conditions, but also of the incorrect assumptions about disability that result from stigmatized views about people with disabilities that are common within society.

Barriers
By reducing or eliminating barriers to health care access, we can improve health and quality of life for people with disabilities. 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 a sign language or foreign language interpreter is present
- Medical Equipment Access: Ability to safely transfer on tables, access to diagnostic equipment
- Attitudinal: opinions and/or prejudices about a person’s quality of life; embracing the idea that disability, chronic conditions and wellness exist simultaneously

Providers shall not differentiate or discriminate in providing Covered Services to any Member because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, disability, physical, sensory or mental health handicap, socioeconomic status, chronic medical condition or participation in publicly financed programs of health care.
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: equal opportunity, integration, and full participation. 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.

- Each provider office service location deemed ADA compliant will receive a special designation in the Molina MyCare Ohio Provider Directory. Showing our members that your office is ADA friendly is a testament to your continued commitment to providing quality health care.
- For additional information or questions on ADA, please refer to Molina Healthcare Provider Education Series document – Americans with Disabilities Act (ADA) Questions & Answers for Healthcare Providers brochure.
- To Have your service location assessed for ADA compliance please contact Provider Services at: (855) 322-4079
Section 504 of the Rehabilitation Act of 1973
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 or mental impairment that substantially limits one or more major life activities
- has a record of such an impairment or
- is regarded as having such an impairment.
Major life activities include walking, seeing, hearing, speaking, breathing, learning, working, caring for oneself, and performing manual tasks. Some examples of impairments which may substantially limit major life activities, even with the help of medication or aids/devices, are: AIDS, alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease, and mental illness.

Person-Centered Model of Care
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.
Planning

- Services and supports should be planned and implemented with each member’s individual needs, preferences and health care decisions in mind. Member’s should be given the authority to manage their health care and supports as they wish with as much or as little assistance as they need. All necessary information should be given to the member so that they can make the best decision for themselves. Individuals should also have the freedom of choice when it comes to Provider selection.

Self-Determination

- Self-determination can be defined as the process when individuals with disabilities and their families control decisions about their health care and have a say in what resources are used to support them. Self-determination can foster independent living for dual eligible members and can also improve quality of life.

Social Model vs. Medical Model of Disability

- There is a fundamental difference between how people with disabilities are seen by society and how the disability community sees themselves.

<table>
<thead>
<tr>
<th>Medical Model of Disability</th>
<th>Social Model of Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability is a deficiency or abnormality</td>
<td>Disability is only a difference</td>
</tr>
<tr>
<td>Being disabled is negative</td>
<td>Being disabled, in itself is neutral</td>
</tr>
<tr>
<td>Disability resides in the individual</td>
<td>Disability derives from interaction between the individual &amp; society</td>
</tr>
<tr>
<td>The remedy for disability-related problems is a cure or normalization of the individual</td>
<td>The remedy for disability-related problems are a change in the interaction between the individual and society</td>
</tr>
<tr>
<td>The agent of the remedy is the professional</td>
<td>The agent of remedy can be the individual, an advocate or anyone who affects the arrangements between the individual and society</td>
</tr>
</tbody>
</table>
Independent Living Philosophy

Developed by a group of students in Berkley, CA who were frustrated by the degree to which control over their lives had been taken over by medical and rehabilitation professionals. Their experiences gave birth to the philosophy that “The freedom to make choices and the ability to live in the community is a basic civil right that should be extended to all people – regardless of disability”.

The students believed that they didn’t need to change to become integrated, but rather the environment and the attitudes toward persons with disabilities needed to change.

This is the philosophy of the Independent Living Centers (ILCs), a network of statewide, consumer-controlled, community-based, cross disability, non-residential private nonprofit agencies. ILC staff work with consumers to promote independence in the community contrary to other agencies that may take on a caretaker or protector role. ILCs believe that the freedom to make choices, including mistakes, empowers people to further their involvement in their life and community.
The Recovery Model

The mental health Recovery Model is a treatment concept wherein a service environment is designed such that individuals have primary control over decisions about their own care. This is in contrast to most traditional models of service delivery, in which individuals are instructed what to do, or simply have things done for them with minimal, if any, consultation for their opinions. The Recovery Model is based on the concepts of strengths and empowerment, saying that if individuals with mental illnesses have greater control and choice in their treatment, they will be able to take increased control and initiative in their lives. Providers should continue to provide members education about the possible outcomes that may result from various decisions and respect the value and worth of each individual as an equal and important member of society.

Evidence Based Practices & Quality Outcomes

Evidence-based practice involves identifying, assessing, and implementing strategies that are supported by scientific research and maximize three core principles: They are supported by the best research evidence available that links them to desired outcomes, they require clinical skill and expertise to select and apply a given practice appropriately, and they must be responsive to the individual desires and values of consumers, which includes consideration of individual problems, strengths, personality, sociocultural context and preferences.

Providers should strive for Quality Outcomes for each of their patients. Helping individuals achieve their highest level health and everyday function. Goals should be set for each patient and these goals should shape that patient’s treatment plan. Quality Outcomes can be measured by using key factors such as:

- Patient’s Satisfaction
- Level of Improvement concerning their condition or disease
- Functional Progress
What’s in it for Providers?

When patients increase understanding of symptoms and compliance with treatment plans and follow-up activities, providers may also experience increased:

- Job satisfaction from seeing better quality of life and health for patients
- Efficiency in practice operations and appointment availability resulting from fewer repeat calls or visits from patients for the same problems or symptoms
- Potential for higher quality scores
- Potential for financial rewards from managed care organizations’ quality incentive programs
National census data shows that the United States’ population is becoming increasingly diverse. 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. Providers are required to participate in and cooperate with Molina’s provider education and training efforts as well as member education and efforts. Providers are also to comply with all health education, cultural and linguistic, and disability standards, policies, and procedures.

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. Under no circumstances are Molina Healthcare members 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 utilizing 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.

* Please Note Molina Healthcare is available to assist providers with locating these services if needed. Please call 855-322-4079 or Providers with members who cannot hear or have limited hearing ability may use the Ohio Relay Service (TTY) TTY can be reached at 800-325-2223 or 711

If you have a deaf or hard of hearing members, please contact us through our dedicated TTY line, toll-free, at (800) 479-3310 or by dialing 711 for the Ohio Relay Service.

MHO provides twenty four (24) hours/seven (7) days a week Nurse Advice Services for members. The Nurse Advice Line provides access to 24 hour interpretive services. Members may call Molina Healthcare’s Nurse Advice Line directly (English line (888) 275-8750) or (Spanish line at (866) 648-3537) or for assistance in other languages. *The Nurse Advice TTY is (866) 735-2929. The Nurse Advice Line telephone numbers are also printed on membership cards.*
Member Rights and Responsibilities

Member Rights

- To receive all the services that Molina Healthcare must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally okayed to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To be able to take part in decisions about your health care, unless it is not in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure that others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in Federal regulations.
- To ask, and get a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To be able to say "yes" or "no" to having any information about you given out unless Molina Healthcare has to by law.
- To be able to say "no" to treatment or therapy. If you say "no", the doctor or MCP must talk to you about what could happen and they must put a note in your medical record about it.
- To be able to file an appeal, a grievance (complaint) or state hearing. See pages 29-31 of the Member Handbook for information.
Member Rights and Responsibilities

**Member Rights**

- To be able to get all MCP written member information from the MCP:
  - At no cost to you;
  - In the prevalent non-English languages of members in the MCP's service area;
  - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.

- To be able to get help free of charge from Molina Healthcare and its providers if you do not speak English or need help in understanding information.

- To be able to get help with sign language if you are hearing impaired.

- To be told of any experimental care and to be able to refuse to be part of the care.

- To make advance directives (a living will). See page 34 of the member handbook, which explains about advance directives. You can also contact Molina Healthcare Member Services for more information.

- To file any complaint about not following your advance directives with the Ohio Department of Health.

- To change your Primary Care Provider (PCP) to another PCP on Molina Healthcare’s panel at least monthly. Molina Healthcare must send you something in writing that says who the new PCP is and the date the change began.

- To be free to carry out your rights and know that the MCP, the MCP's providers or ODJFS will not hold this against you.

- To know that the MCP must follow all federal and state laws and other laws about privacy that apply.

- To choose the provider that gives you care whenever possible and appropriate.
Member Rights and Responsibilities

**Member Rights**

- If you are a female, to be able to go to a women’s health provider on Molina Healthcare’s panel for covered women’s health services.
- To be able to get a second opinion from a qualified provider on Molina Healthcare’s plan. If a qualified provider is not able to see you, Molina Healthcare must set up a visit with a provider not on our panel.
- To get information about Molina Healthcare from us.
- To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services Bureau of Civil Rights at the addresses listed below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran status, ancestry, health status, or need for health services.

**Office of Civil Rights**
United States Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, Illinois 60601
1-312-886-2359 1-312-353-5693 TTY

**Bureau of Civil Rights**
Ohio Department of Job and Family Services
30 East Broad Street, 37th Floor
Columbus, Ohio 43215-3414
1-614-644-2703, 1-866-227-6353
1-866-221-6700 TTY
Fax: 1-614-752-6381
Member Rights and Responsibilities

**Member Rights**

Members also have the right to:

- Receive information about Molina Healthcare, covered benefits and the providers contracted to provide services.
- Openly discuss your treatment options, regardless of cost or benefit coverage, in a way that is easy to understand.
- Receive information about your member rights and responsibilities.
- Make recommendations about Molina Healthcare’s member rights and responsibilities policies.
- 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 you, if a qualified panel provider is not able to see you.
Member Rights and Responsibilities

**Member Responsibilities**

- Always carry your Molina Healthcare ID card, and do not let anyone else use your ID card.
- Keep appointments, and be on time.
- If you require transportation, call Molina Healthcare at least 48 hours in advance whenever possible.
- Call your provider 24 hours in advance if you are going to be late or if you cannot keep your appointment.
- Share important health information with Molina Healthcare and your providers so that they can give you appropriate care.
- Understand your health conditions and be active in decisions about your health care.
- Work with your provider to develop treatment goals and follow the care plan that you and your provider have developed.
- Ask questions if you do not understand your 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 you would like to change your PCP. Molina Healthcare will verify that the PCP you select is contracted with Molina Healthcare and is accepting new patients.
- Inform Molina Healthcare and your county caseworker if you change your name, address or telephone number or if you have any changes that could affect your eligibility.
- Let Molina Healthcare and your health care providers know if you or any of the members of your family have other health insurance coverage.
- Report any fraud or wrongdoing to Molina Healthcare or the proper authorities.
Self-Referrals

Molina Healthcare members can self-refer for the following:

- Services provided at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).
- Family planning services provided by Qualified Family Planning Providers (QFPPs).
- Services provided by Certified Nurse Practitioners (CNPs)
- Services provided by Certified Nurse Midwives (CNMs)
- Women's routine and preventative health care services provided by any women's health specialist contracted with Molina Healthcare. This is in addition to the member's designated primary care provider (PCP) if that PCP is not a woman's health specialist.
- Behavioral health services offered through Community Mental Health Centers (CMHCs).
- Substance abuse services offered through Ohio Department of Alcohol and Drug Addiction Services (ODMHAS)-certified Medicaid providers.

Federally Qualified Health Center/Rural Health Clinic (FQHC/RHC) facilities or Qualified Family Planning Providers (QFPP) services are not required to be contracted with Molina Healthcare.
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” means 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” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)
The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

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

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

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.
On Feb. 8, 2006, President Bush signed into law the Deficit Reduction Act (“DRA”). The law, which became effective on Jan. 1, 2007, aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities like Molina Healthcare must comply with DRA. Providers doing business with Molina Healthcare, and their staff, have the same obligation to report any actual or suspected violation of Medicare and Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

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

The Federal False Claims Act and the Medicaid False Claims Act have Qui Tam language commonly referred to as “whistleblower” provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act(s). The whistleblower may also file a lawsuit on their own. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.
The Federal False Claims Act and the Medicaid False Claims Act contain some overlapping language related to personal liability. For instance, the Medicaid False Claims Act has the following triggers:

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

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in furthering a false claim are entitled to all relief necessary to make the employee whole including:

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

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

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

- Provider can report suspected fraud, waste and abuse by calling our tip line at (866) 366-5462.
# Frequently Used Phone Numbers

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>(855) 322-4079 (follow phone prompts)</td>
</tr>
<tr>
<td>Claims Reconsideration</td>
<td>(855) 322-4079 / fax (800) 499-3406</td>
</tr>
<tr>
<td>Claims Inquiry – Customer Service</td>
<td>(855) 322-4079 (follow phone prompts)</td>
</tr>
<tr>
<td>Community Outreach</td>
<td>(855) 665-4623</td>
</tr>
<tr>
<td>Fraud, Waste, and Abuse Tip Line</td>
<td>(866) 606-3889/ fax (888) 665-0860</td>
</tr>
<tr>
<td>Member Eligibility Ohio Medicaid</td>
<td>(800) 686-1516</td>
</tr>
<tr>
<td>Member Services – Duals</td>
<td>(855) 665-4623/fax: (855) 266-5462</td>
</tr>
<tr>
<td>Member Services – Medicare</td>
<td>(866) 472-4584</td>
</tr>
<tr>
<td>Pharmacy (Medicare/Duals)</td>
<td>(855) 322-4079 / fax: (888) 858-3090</td>
</tr>
<tr>
<td>Prior Authorization (Inpatient)</td>
<td>(855) 322-4079</td>
</tr>
<tr>
<td>Prior Authorization (Outpatient)</td>
<td>(855) 322-4079</td>
</tr>
<tr>
<td>Provider Services</td>
<td>(855) 322-4079 / fax: (866) 713-1893</td>
</tr>
<tr>
<td>Provider Services – Web Portal Help Desk</td>
<td>(866) 449-6848</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>(855) 322-4079 / fax: (866) 449-6843</td>
</tr>
<tr>
<td>24 Hour Nurse Advise Line</td>
<td>(888) 275-8750 / TTY: (866) 735-2929</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>(855) 322-4079 / fax(866) 553-9262</td>
</tr>
</tbody>
</table>

**Main Phone**  
(855) 665-4623  
TTY 711

**Member Services**  
8 a.m. to 8 p.m.  
Monday - Friday

**Provider Services**  
8 a.m. to 8 p.m.  
Monday - Friday
Questions and Comments