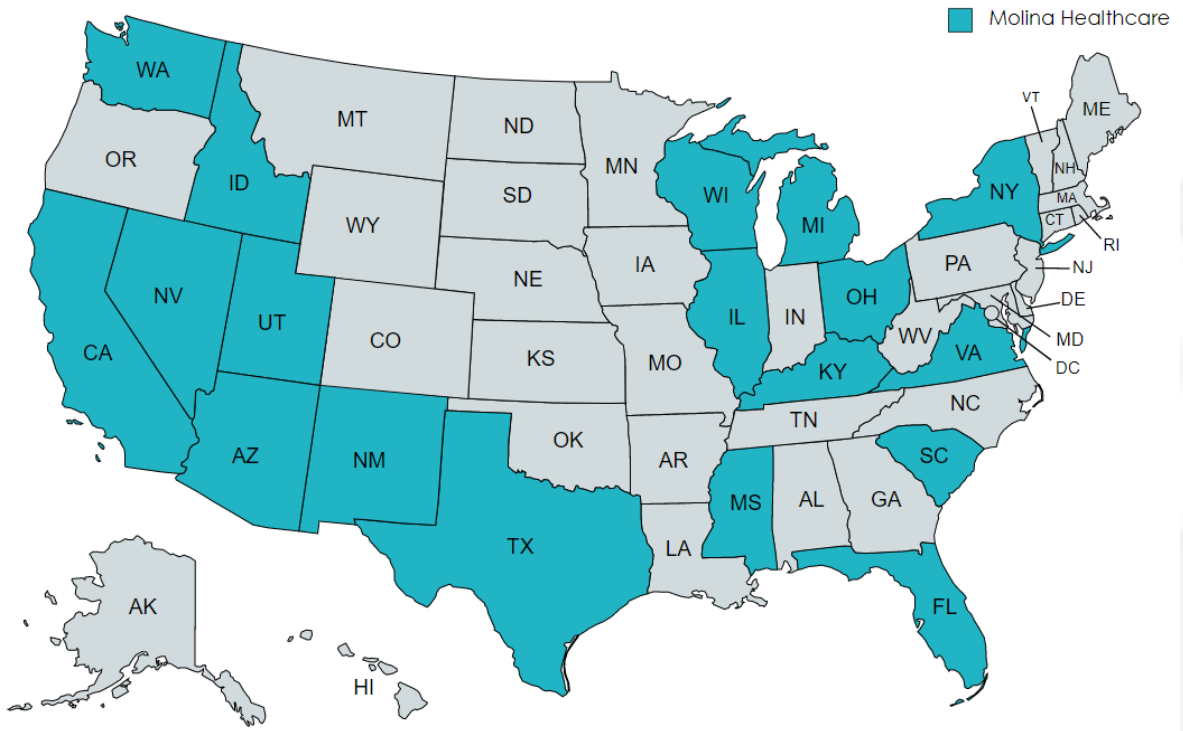
Molina Healthcare of Nevada Provider Orientation

| Presented by: MNV Provider Services

MOLINA HEALTHCARE

Agenda

1. Introduction to Molina Healthcare
2. Provider Resources
3. Quality
4. Healthcare Services
5. Claims
6. Appeals and Grievances
7. Compliance
8. Value Based Payments
9. Contact Provider Relations
10. Questions



MOLINA HEALTHCARE

Introduction to Molina Healthcare

| Provider Orientation

MOLINA® HEALTHCARE

About Molina Healthcare

Our Vision

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

Our Mission

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

Molina's Values

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

Molina Healthcare

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

Through its locally operated health plans, Molina served approximately 5.1 million members nationwide.

Medicaid: Provides a member-centered approach with a wide range of quality health care services to families and individuals who qualify for government-sponsored programs

Medicare: Medicare Advantage plans designed to meet the needs of individuals with Medicare

Marketplace: Offers plans that remove financial barriers to quality care and keep members' out-of-pocket expenses to a minimum

Senior Leadership

Rob Baughman,
Plan President

Sara Cooper, VP
Network Management & Ops

Cybil Fry, AVP
Quality Improvement &
Risk Adjustment

Kimberly Gahagan, AVP
Community Growth &
Engagement

Kyle Murphy, VP
Health Plan Operations

Nima Alinejad
Chief Medical Officer

Kristen Wall, VP
Healthcare Services

Provider Resources

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Molina Nevada - Provider Relations

Meet Our Team!

Southern Nevada:

LaDonna Washington, Sr. Provider Relations Representative

Melvin Goree, Sr. Provider Relations Representative

Nicole Spaight, Sr. Provider Relations Representative

Paris Graham, Provider Relations Representative

Northern Nevada:

Brittany Lloyd, Sr. Provider Relations Representative

Tyler Ranville, Provider Relations Representative

Alicia Simmons Lewis, Sr. Business Analyst

Leslie Brown, Director, Provider Relations

NVProviderRelations@MolinaHealthcare.com

Molina Healthcare Provider Relations

Satisfaction

- Provider Relations Representatives
- Annual Assessment of Provider Satisfaction
- You Matter to Molina Program

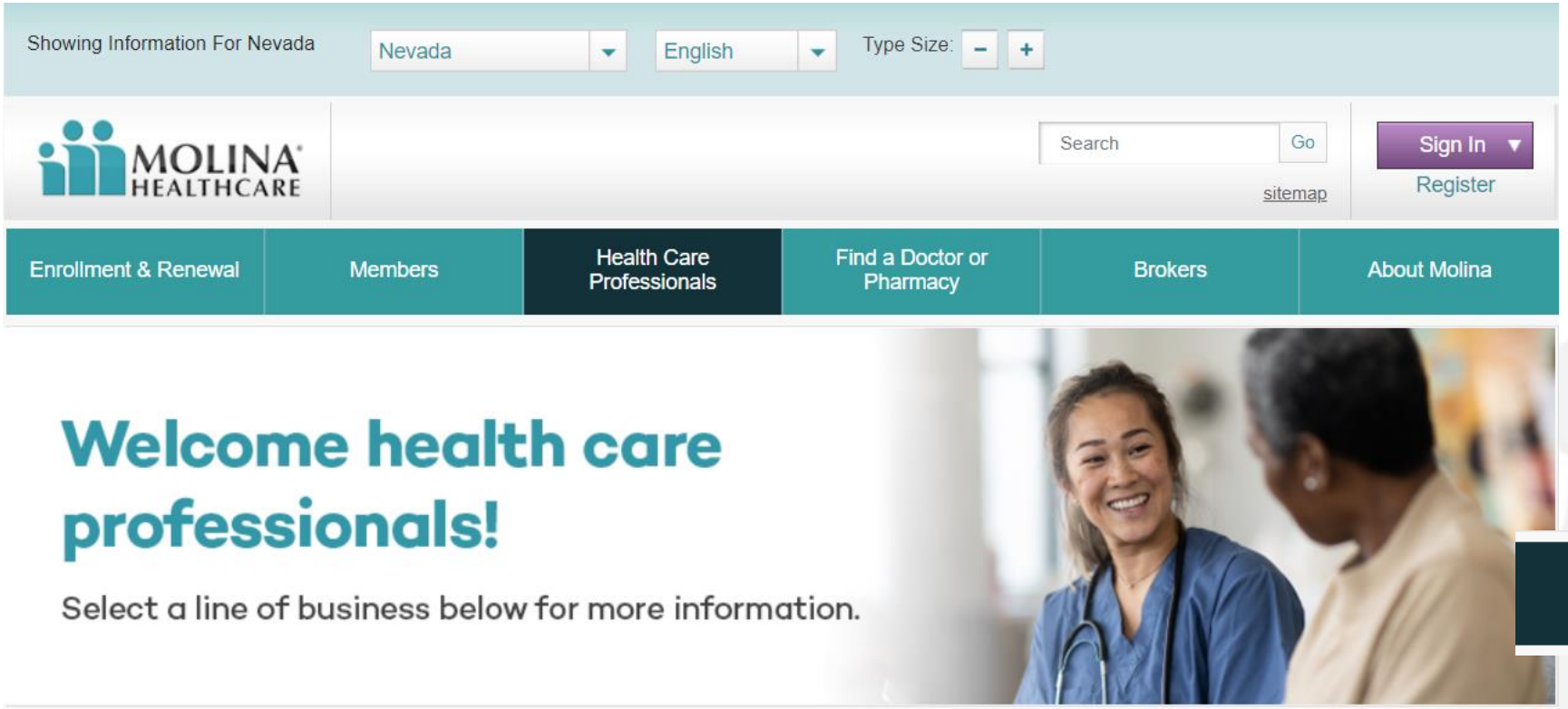
Communication

- Provider Bulletin and Provider Newsletters
- Online Provider Manuals
- Online Trainings, Health Resources, and Provider Resource Guides
- Secure Messaging on the Availity Essentials Provider Portal (Availity)

Technology

- 24-hour Provider Portal
- Online Prior Authorization and Claim Dispute Submission
- Prior Authorization (PA) Lookup Tool on Provider Portal and Provider Website
- MCG Auto-Authorization for Advanced Imaging & Cardiology PA Submission

Provider Website

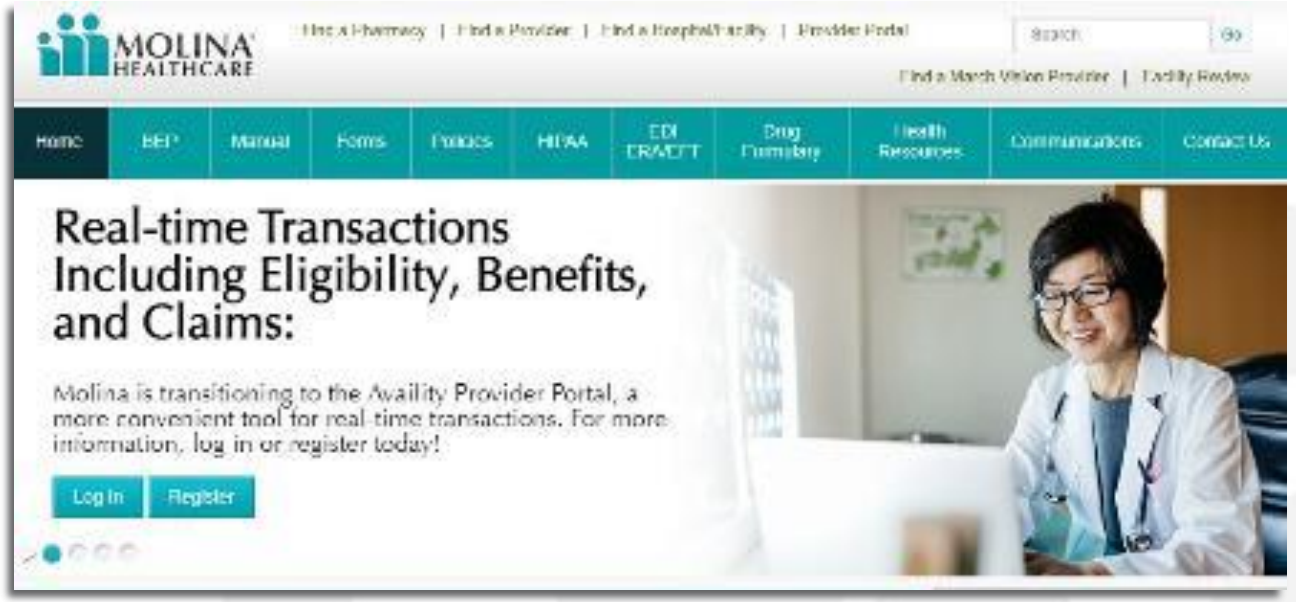


Molina has a Provider Website for each line of business, available under the Health Care Professionals drop-down menu.

Find the Provider Website at MolinaHealthcare.com.

Provider Online Resources

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



MolinaHealthcare.com

MOLINA HEALTHCARE

Molina Provider Portal

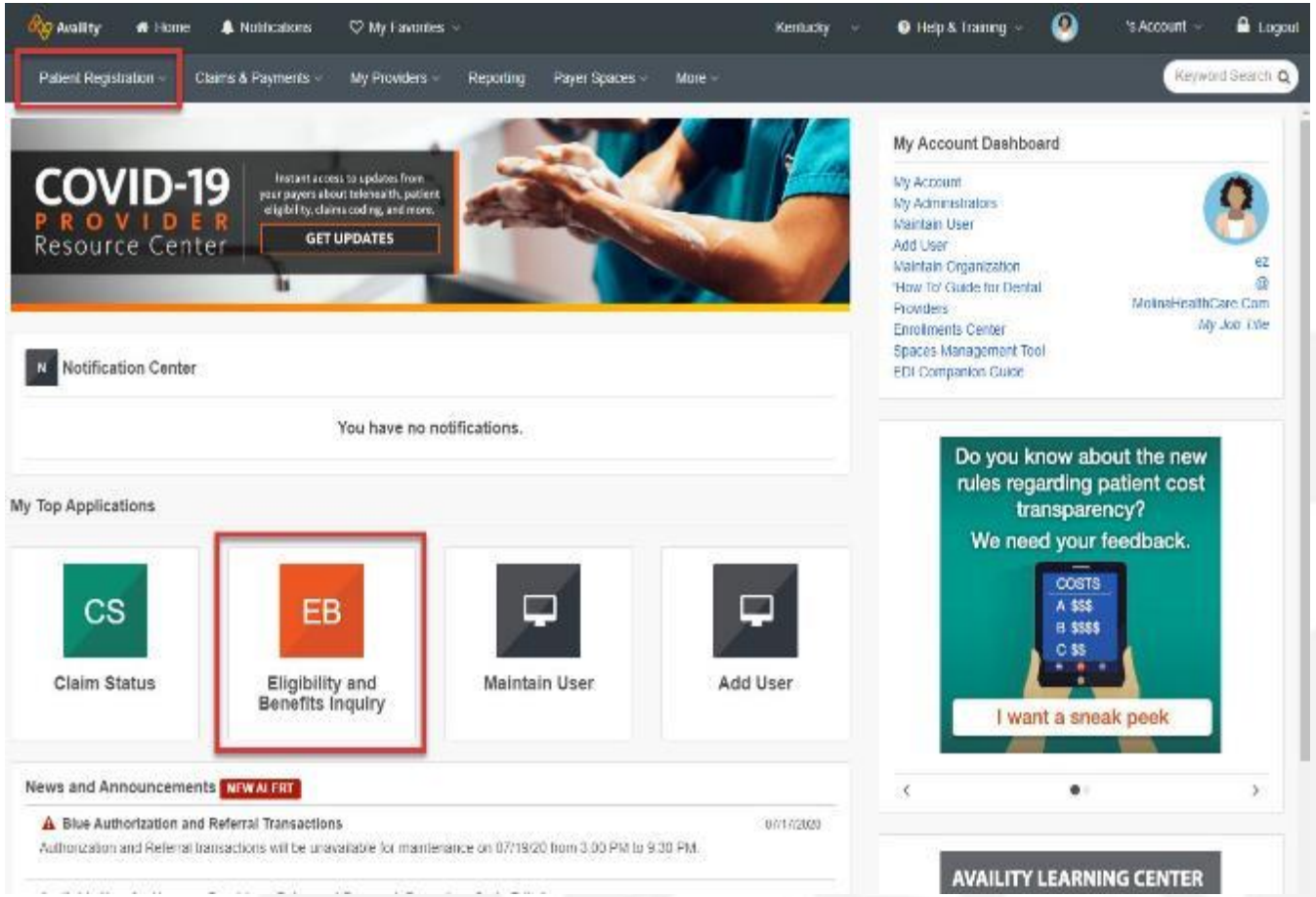
Molina utilizes Availity for our Provider Portal. Providers may register for access to our Provider Portal for services that include self service member eligibility, claim status, provider searches, to submit requests for authorizations and to submit claims.

Organization Registration Resource

http://www.availity.com/registration-tips

Availity Payor ID: A6106

Availity Payer Name: Molina Healthcare of Nevada



Availity Provider Portal

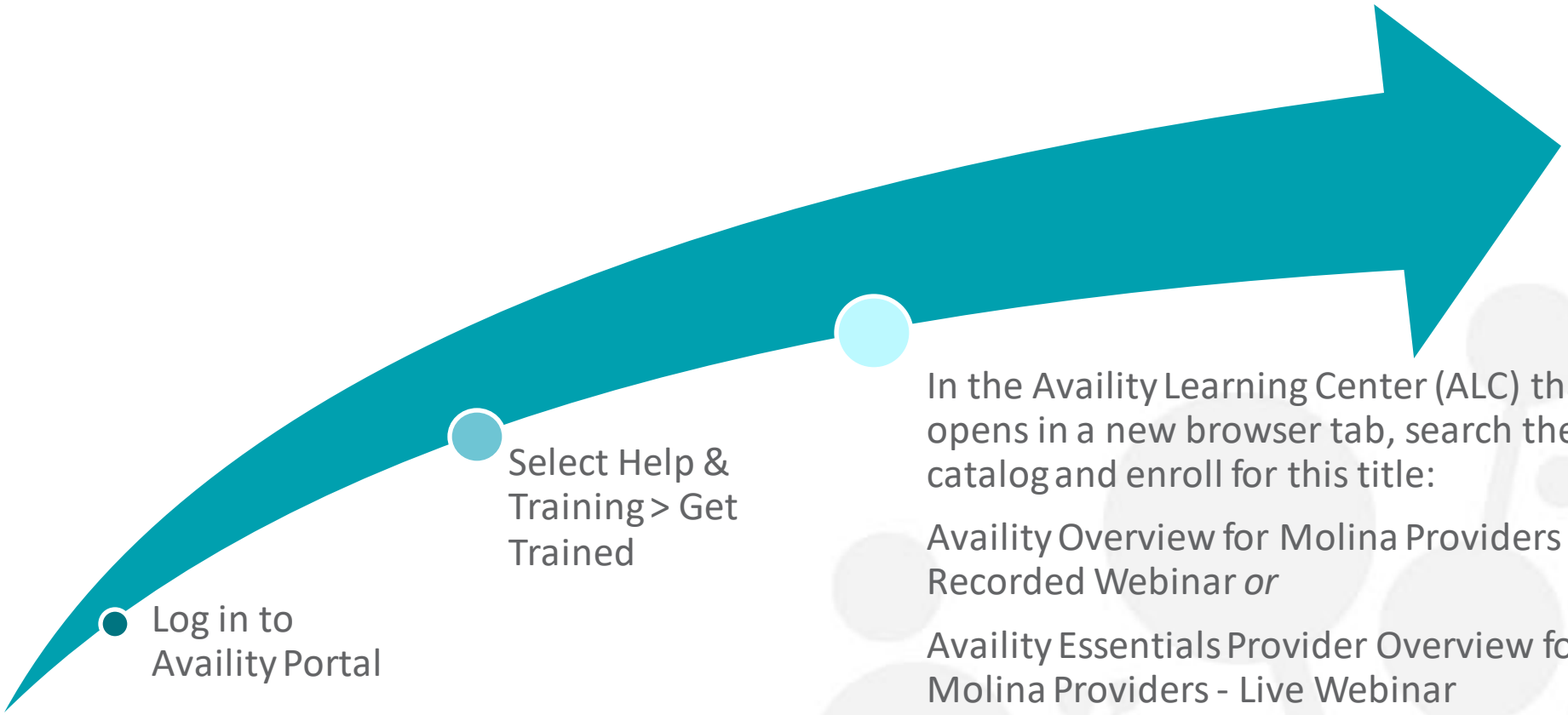
The Availity Provider Portal is secure and available 24 hours a day, seven days a week. Self-service Provider Portal options include:

- Online Claim Submission
- Claims Status Inquiry
- Corrected Claims
- Member Eligibility Verification and Benefits
- Secure Messaging
- Submit & Check Status of Claim Disputes
- Care Coordination Portal
- Submit and Check Status of PA Requests

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Manage Overpayment Request
- Remittance Viewer
- View PCP Member Roster

Availity Provider Portal Training

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



Provider Manual

Molina's Provider Manuals are written specifically for each Molina health plan to address the requirements of delivering healthcare services to our members, including the responsibilities of our participating providers.

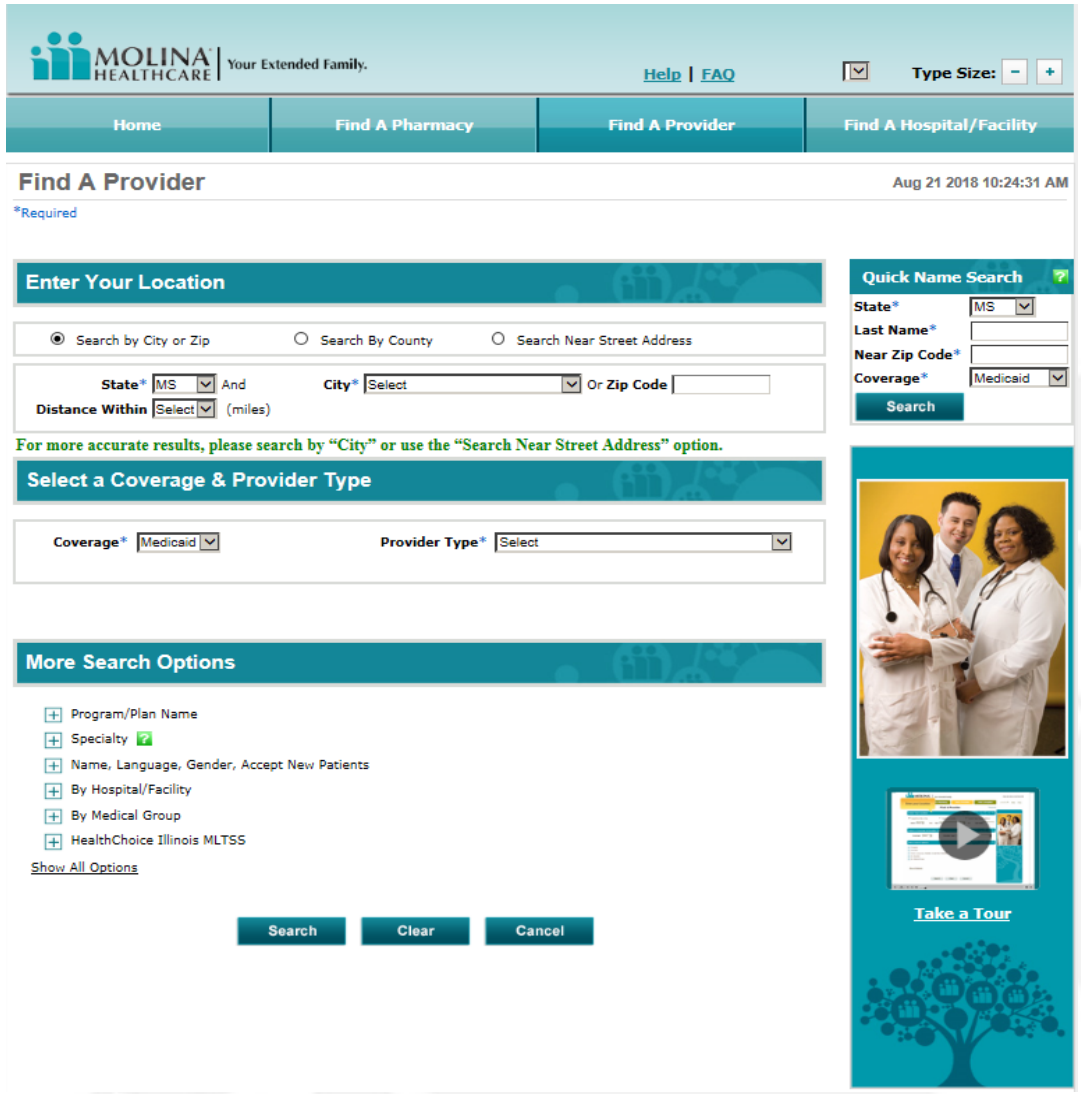
Providers may view the manual on our provider website, at: https://www.molinahealthcare.com

Provider Manual Highlights	
Benefits and Covered Services	Long Term Supports and Services
Claims, Encounter Data and Compensation	Member Grievance and Appeals
Compliance and Fraud, Waste, and Abuse Program	Member Rights and Responsibilities
Contacts	Model of Care
Credentialing and Re-credentialing	Pharmacy
Health Insurance Portability and Accountability Act (HIPAA)	Quality Improvement
Behavioral Health	Transportation Services
Healthcare Services	Provider Responsibilities
Interpreter Services	Utilization Management

Provider Online Directory

Providers may use Molina's Provider Online Directory (POD) located on our website www.MolinaHealthcare.com or request a copy of the Provider Directory from their Provider Relations Representative(s).

Providers are encouraged to validate their information as it appears within the POD at least quarterly and submit updates to: NVProviderRelations@MolinaHealthcare.com.



Provider Data Accuracy

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

- ✓ **Email Provider Information Update Form (PIF) and other information to:**
  - ✓ **Your Provider Relations Representative**
  - ✓ **NVProviderRelations@MolinaHealthcare.com**

Access the PIF here:
https://www.molinahealthcare.com/providers/nv/medicaid/resources/forms.aspx

Important Reminders:

- Providers must validate their information at least quarterly for correctness and completeness.
- Notice of changes must be made at least 30 days in advance of any of the following:
  - Change in office location, office hours, phone, fax, or email
  - Addition or closure of an office location
  - Addition or termination of a provider
  - Change in Practice Name, Tax ID and/or National Provider Identifier (NPI)
  - Open or close your practice to new patients (PCP only)

Verifying Member Eligibility

Molina offers various tools to verify member eligibility.

- Molina's self-service Provider Portal: Availity.com
- Customer Service/IVR Automated System: **(833) 685-2103**
- Eligibility rosters

Providers may also verify eligibility for Medicaid via the Nevada Department of Health and Human Services website at https://www.medicaid.nv.gov/home.aspx

Please Note – At no time should a member be denied services because his/her name does not appear on the PCP's eligibility roster. If a member does not appear on the eligibility roster the provider should contact the Plan for further verification.

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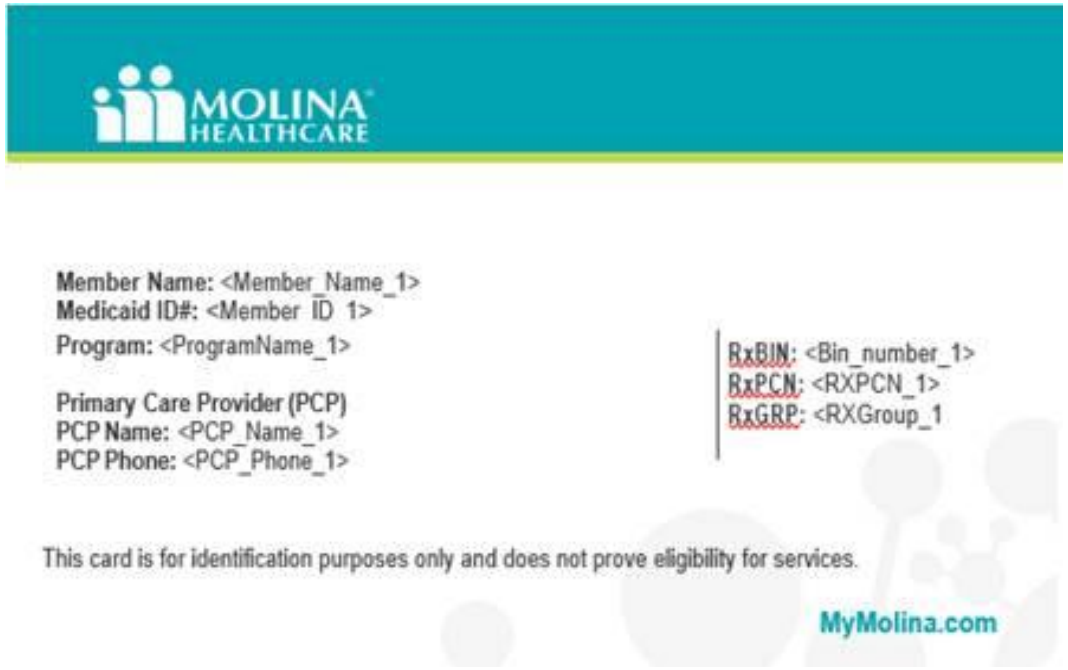
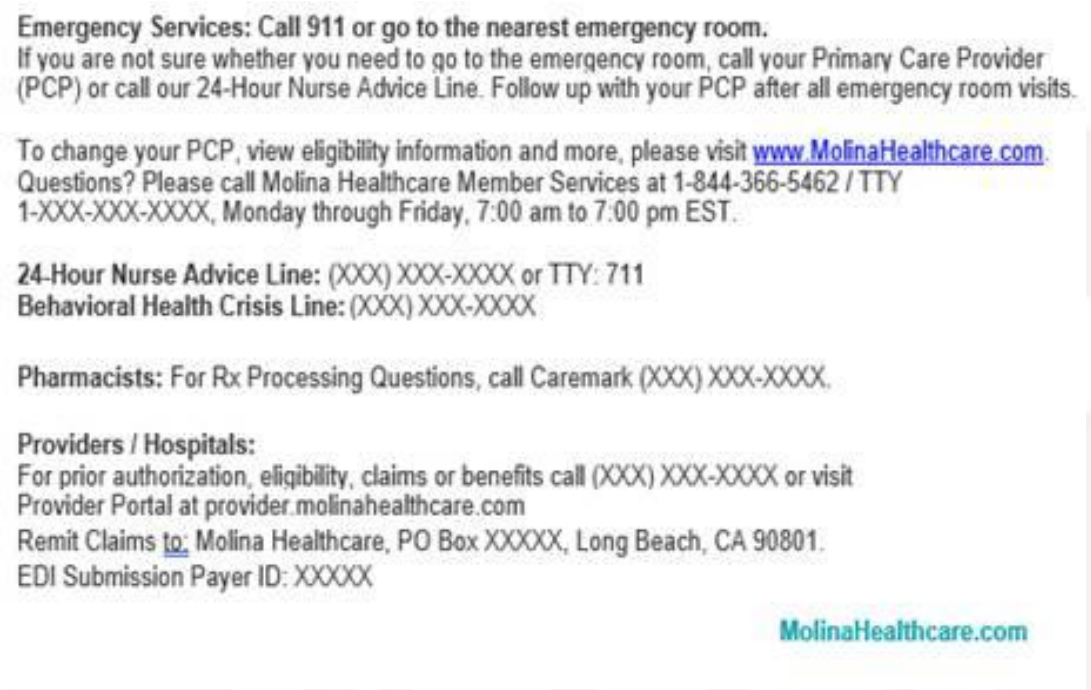
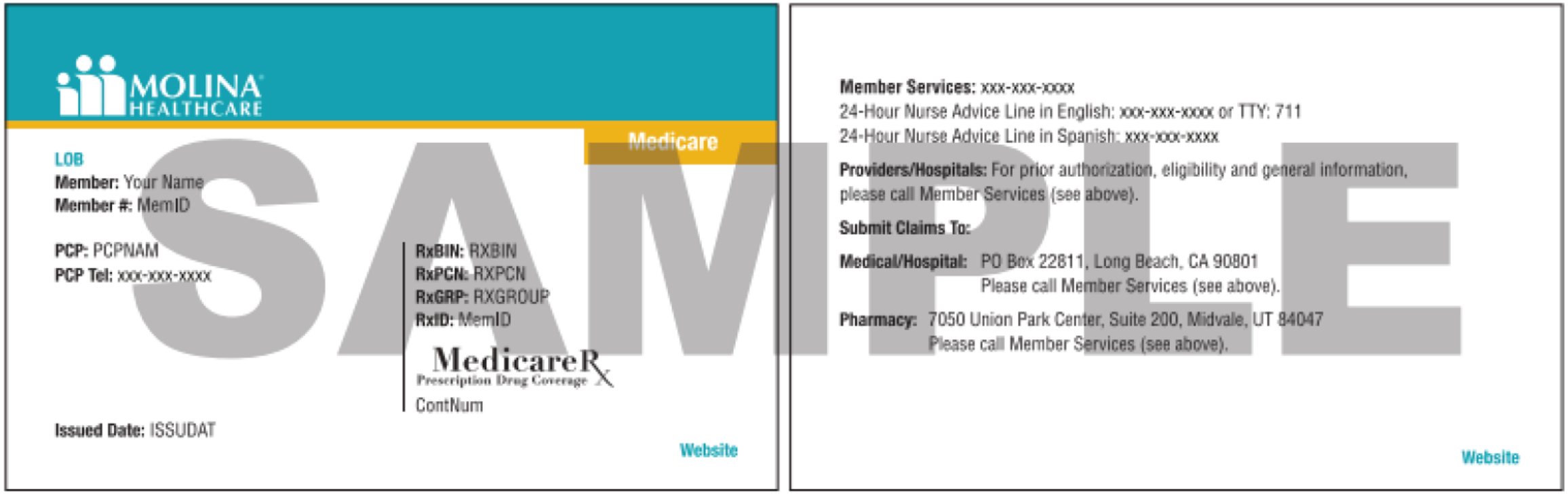
Molina Healthcare Medicaid Member Identification (ID) Card





Molina Medicare Advantage Member ID Card



2024 Molina Healthcare Medicare Advantage Plans

Molina Medicare Complete Care (HMO D-SNP)
Molina Medicare Choice Care (HMO)

Molina Marketplace Member ID Card

2024 Marketplace Plans

Gold 1

Gold 1 with Adult Vision Services

Silver 1

Silver 1 with Adult Vision Services

Silver 12 with First 4 Primary Care Visits Free

MolinaHealthcare.com

Model of Care – Medicare Special Needs Plan (SNP)

The **Centers for Medicare and Medicaid Services (CMS)** requires certain contracted Medicare medical providers to complete an annual basic training and attest to the Molina specific Dual Eligible Special Needs Plan (D-SNP) Model of Care.

Molina Nevada Medicare Model of Care is *Mandated* for all providers accepting Medicare:

- All Primary Care Providers
- All Cardiology Providers
- All Hematology and Oncology Providers
- All Behavioral Health Providers

Model of Care Training and Attestation Form are available at MolinaHealthcare.com

Model of Care Training Attestations by each qualifying provider should be submitted online on MolinaHealthcare.com or emailed to NVProviderRelations@MolinaHealthcare.com.

Partnering with Molina: Medicaid Renewals

We're asking for your support and partnership!

Together, we can provide the education and resources to retain our Medicaid members and offer solutions to those in our communities who have lost their coverage during the recertification process.

Look for your patients' Medicaid renewal dates in the Availity provider portal when you verify eligibility & benefits or the member roster section.

See specific steps on the Provider Website Renewals FAQ page.

Remind patients to update their contact information including address and phone number with Department of Welfare and Supportive Services DWSS.

accessnevada.dwss.nv.gov

Find additional information about Medicaid Renewals at Molina Healthcare Medicaid Renewals.

How Can Members Renew?

Online: Log in to **Access Nevada** Benefits Portal: accessnevada.dwss.nv.gov.

By Phone:

Southern Nevada: (702) 486-1646

Northern Nevada: (775) 684-7200

By Mail: Complete the Medicaid Renewal Form received in the mail. Return completed, signed form to the address shown on the letter.

In Person: Visit their local DWSS office. Bring the documents needed to report income and fill out a form in person. Find the address at dwss.nv.gov.

Provider Responsibilities

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

For additional information view the "Provider Responsibilities" section of the **Provider Manual**, located at MolinaHealthcare.com. Topics include:

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

You Matter to Molina

Provider Bulletins
- Posted on the webpage
- Discuss Fax vs Email Preferences
- Include Updates or changes made due to individual provider feedback

Trainings
- New Provider Orientation
- New Product Lines
- Billing Guidelines
- Quality – Gap Closure

In Person Meetings
- Town Halls
- Focus Groups
- Interviews
- JOCs

Surveys
- JOC Follow Up
- Individual Provider Services Rep – Issue Resolution (Drawing for Gift Cards)
- Updating Demographic data
- MOC Attestations
- Suggestion Box

Provider Concierge Program
- Review calls to the Provider Call Center
- Resolve Issues

Provider Resources
- Availity Tutorials
- HEDIS Tip Sheet
- Billing Reference Guides
- Value Added Benefits
- Psych Hub
- RubiconMD

Presentations
- Provider Advisory Council decks
- All decks with external presentations that Network Providers can reference

We Heard You
- Feedback from Suggestions
- Changes and Updates that have been made
- Success Stories of the Program

Quality

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Quality Improvement

Health Education/Disease Management

Molina Healthcare offers programs to help our Members and their families manage a diagnosed health condition. You as a Provider also help us identify Members who may benefit from these programs. Members can request to be enrolled or dis-enrolled in these programs. Our programs include:

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

For more info about our programs, please call: Provider Services Department at (833) 685-2103 (TTY/TDD at 711 Relay) or visit MolinaHealthcare.com

Access Standards

Molina Healthcare monitors compliance and conducts ongoing evaluations regarding the availability and accessibility of services to Members. Please ensure adherence to these regulatory standards:

Medical Appointment Types	Standard
Routine PCP (excludes visits to monitor chronic condition if less frequent visits are indicated)	Within 2 weeks
Medically Necessary PCP	Within 2 calendar days
PCP Urgent Care	Within 24 hours
After Hours Care	24 hours/day; 7 day/week availability
Specialty Care (Urgent)	Within 3 calendar days of referral
Specialty Care (Routine)	Within 30 calendar days
Specialist Care for Adolescents (12-17)	Urgent – within 3 calendar days or Routine – within 30 calendar days
Well-Child Preventative Care	Within 14 calendar days
Adult Preventative Care	Within 21 calendar days
Prenatal Care Initial Visit	1st and 2nd Trimester – within 7 calendar days of request 3rd Trimester – within 3 calendar days of request High Risk – within 3 calendar days of identification of high risk, or immediately if emergency exists

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a twenty-four (24) hour phone 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.

Access Standards

Molina Healthcare monitors compliance and conducts ongoing evaluations regarding the availability and accessibility of services to Members. Please ensure adherence to these regulatory standards:

Behavioral Health Appointment Types	Standard
Life Threatening Emergency	Immediately
Non-Life Threatening Emergency	Within 6 hours
Urgent Care	Within 72 Hours
Behavioral Health/Substance Use Disorder Providers Routine Visit	Not to exceed 30 calendar days
Follow-up Routine Care	Within 2 weeks

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a twenty-four (24) hour phone 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.

Cultural and Linguistically Appropriate Services (CLAS) Standards

Highlights: Communication and Language Assistance (5-8 of 15):

The National Culturally and Linguistically Appropriate Services Standards, (CLAS) are a set of standards and guidelines developed by the Office of Minority Health, with the aim of ensuring that healthcare services are respectful, responsive, and inclusive of individuals from diverse cultural and linguistic backgrounds. CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a framework to implement culturally and linguistically appropriate services. For providers, adherence to CLAS standards promotes equitable healthcare by recognizing and addressing the unique needs of diverse patient populations. By implementing CLAS standards, providers enhance the quality of care, strengthen patient-provider communication, and ultimately contribute to improved health outcomes for all individuals they serve, regardless of their cultural or linguistic background.

When implementing CLAS standards in your practice you will:

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

Cultural and Linguistic Humility and Competency

Cultural Humility:

Is the recognition and respect of the cultural and linguistic differences of others while also acknowledging your own limitations and biases. It involves a willingness to learn by asking questions and engage in self reflection and critique.

Cultural Competency:

involves developing an understanding of different cultural practices and beliefs, as well as the ability to adapt your own behavioral and communication style to work respectfully and effectively with people from diverse cultures and backgrounds.

Molina's Continued Commitment to Serve a Culturally Diverse Population:

National census data shows that the United States' population is becoming increasingly diverse. Molina has a thirty-year history of developing targeted healthcare programs for our culturally diverse membership and is well-positioned to continue to successfully serve these growing populations by:

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

To request interpreter, contact the Molina Call Center: (833) 685-2103

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Provider Commitment & Cultural Linguistic Resources

In alignment with Molina's commitment to ensuring health equity for the members we serve; providers are required to participate in and cooperate with Molina's provider cultural competency education and training efforts as well as member education and efforts. Providers are also to comply with all health education, cultural and linguistic standards, disability standards, policies and procedures.

Molina's Cultural and Linguistic Resources for Providers:

Low-literacy Materials:
Providers have access to tailored materials designed for ease of comprehension, catering to individuals with varying literacy levels.

Translated Documents:
Molina offers a range of documents translated into multiple languages to bridge linguistic barriers and promote comprehensive understanding.

Accessible Formats:
Molina provides materials in accessible formats such as Braille, audio, or large font, accommodating diverse needs.

Cultural Sensitivity Training and Consultation:
Providers can benefit from cultural sensitivity training and consultation services, to assist in fostering an environment where cultural nuances are acknowledged and integrated into care practices.

Healthcare Literacy

Healthcare literacy is the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Without this, individuals may experience hardships such as difficulty understanding medical instructions, managing chronic conditions, and the risk of medication errors.

Ways to Help Increase Healthcare Literacy:

Communication Strategies:

- Use plain language and avoid medical jargon.
- Encourage questions and provide clear explanations.
- Utilize visual aids and written materials.
- Teach back method: Explaining a single concept/diagnosis/treatment plan to an individual and asking them to explain what they heard back to you.
- Repeat until they demonstrate a satisfactory understanding of the information.

Active Listening:

- Assess patient understanding by actively listening to concerns.
- Confirm comprehension and address any misconceptions.

Use of Digital Tools:

- Leverage technology for interactive patient education.
- Provide online resources and apps for health information.

For more information, guidance, and tools to help address health literacy, please go to: https://www.cdc.gov/healthliteracy/basics.html

Healthcare Services

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Healthcare Services Teams

Organizational design aims to work towards facilitating a deeper collaboration and growth between the following teams:

- HCS Support & Operations
  - ✓ Encompasses Utilization Management and Care Management activities
  - ✓ Partners with IT to support HCS technology applications and platform enhancements.
- Behavioral Health
  - ✓ Infusing new energy and collaboration around physical health and behavioral health integration
- New Initiatives
  - ✓ Models of Care – developing and transitioning new programs and enhancements to our HCS offerings

Utilization Management

Care Management

Behavioral Health

Clinical Practice Guidelines

- Clinical practice guidelines are documents which seek to guide decisions about the diagnosis and treatment of certain health conditions.
- Clinical practice guidelines are based on:
  - scientific evidence,
  - review of the medical literature, or appropriately established authority.
  - Recommendations are based on published agreed on guidelines and do not favor any particular treatment based solely on cost considerations.
- The recommendations for care are suggested as guides for making clinical decisions. Clinicians and their patients must work together to develop individual treatment plans that are tailored to the specific needs and circumstances of each patient.
- Molina Healthcare reviews and revises guidelines as clinical evidence is updated. Once the guidelines have been reviewed and modified as needed by a dedicated Quality Improvement Committee, Molina Healthcare providers will be notified of any changes and updates by fax and/or mail.
- To request a copy of any guideline, please contact Molina Healthcare Provider Services.

www.molinahealthcare.com

Preventative Health Guidelines

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

- These guidelines are meant to recommend a standard level of care and do not preclude the delivery of additional preventive services depending on the individual needs of the patient.

- Molina Healthcare reviews and revises guidelines as clinical evidence is updated. Once the guidelines have been reviewed and modified as needed by a dedicated Quality Improvement Committee, Molina Healthcare providers will be notified of any changes and updates by fax and/or mail.

- To request a copy of any guideline, please visit www.molinahealthcare.com or contact Molina Healthcare Provider Services.

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How to Contact Healthcare Services

Utilization Management: (833) 685-2103

Prior Authorization and Concurrent review for physical and behavioral health.

Care Management: (833) 685-2102, Email: **NV_CM@MolinaHealthCare.com**

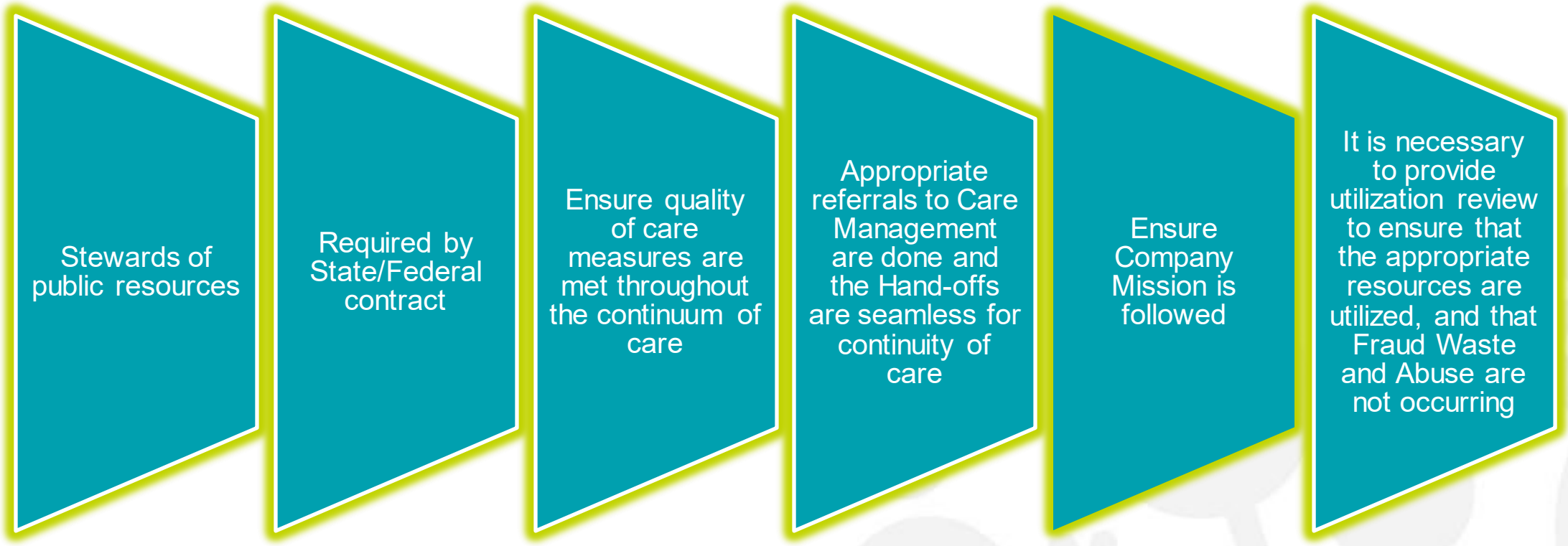
Physical/Behavior Health Case Managers, Care Coordinators and Social & Health Equity Navigators can assess member's needs, collaborate with members to create individualized care plans, assist with navigating through the continuum of care and address any identified needs or concerns.

Utilization Management

Our Utilization Management (UM) functions include:

- Assuring that services are Nevada Medicaid and Check Up (CHIP) covered benefits
- Ensuring that Molina staff does not approve requested services that are deemed to be experimental and investigational
- Applying nationally accepted evidence-based criteria that support decision making to determine the medical necessity or appropriateness of services
- Monitoring of our members benefits to ensure a safe discharge plan with appropriate follow up services

Why is it Important to do a Utilization Review?



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.

Information is to 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 Case Management and Disease Management opportunities
  - ✓ Improve coordination of care

Requests for services listed on the Molina Healthcare Prior Authorization Guide are evaluated by licensed nurses and trained staff that have the authority to approve services.

Utilize our Prior Authorization Code LookUp tool at MolinaHealthcare.com

Need a Prior Authorization?

Code LookUp Tool

Prior Authorization Request Submissions

Submit Prior Authorizations via the **Availity Provider Portal** : Availity.com

Requests may be faxed to the HCS using the Molina Healthcare Service Request Form which is available on our website: **MolinaHealthcare.com**

Prior Authorizations:
Phone: (833) 685-2103
Fax: 1 (775) 460-4900

Behavioral Health Authorizations:
Phone: (833) 685-2103
Fax: (775) 460-4900

Please indicate on the fax if the request is non-urgent or expedited/urgent.

For telephonically submitted requests, it may be necessary to submit additional documentation before the authorization can be processed.

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Required Behavioral Health Screening Tools

- As part of the Utilization Management Program, Providers are required to utilize the following Behavioral Health Screening Tools. These completed tools and/or corresponding scores should be submitted with Prior Authorization requests for services.
  - ✓ The American Society for Addiction Medicine (ASAM) for substance abuse services for Medical Necessity review for all populations ages seven (7) and older;
  - ✓ ESPDT criteria when evaluating service requests for children;
  - ✓ Level of Care Utilization System (LOCUS) scores for Mental Health Services for Medical Necessity reviews for Members age eighteen (18) and older;
  - ✓ Child and Adolescent Level of Care Utilization System (CALOCUS) scores for Mental Health services for Medical Necessity reviews for children and adolescents age six (6) through seventeen (17); and
  - ✓ Either the Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for infants, toddlers and preschoolers to determine Medical Necessity for children ages zero (0) through five (5) or another validated assessment tool with prior approval by the State.
- ✓ For more information, please refer to the Provider Manual located on our website: www.MolinaHealthcare.com

Request for Prior Authorization

Our goal is to ensure our members are receiving the *right services at the right time AND in the right place.* Providers can help meet these goals by sending all appropriate information that supports the member's need for Services when they send us the authorization request.

The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina prior authorization documents are updated annually, or more frequently as appropriate, and the current documents are posted on the Molina website at www.molinahealthcare.com.

Authorization for elective services should be requested with supporting clinical documentation for medical necessity review. Information generally required to support decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services
- 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
- Any other information or data specific to the request

Prior Authorization - Responses

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation.

Standard requests:

Molina makes the determination and provides response within fourteen (14) calendar days.

Expedited requests:

Molina makes the determination as promptly as the member's health requires and no later than seventy-two (72) hours after Molina receives the initial request for service.

In the event a provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a member's life or health, Molina will process such requests as expedited as well.

New Century Health – Cardiology Prior Authorizations

Molina will continue its collaboration with New Century Health (NCH) to administer prior authorizations for **cardiology** services for members 18 years and older.

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

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

Senior Provider Network Manager:
Precious McClendon-McCray
Phone: (888) 999-7713 X1973 office
Phone: (562) 237.8962 mobile
Fax: (209) 441-5918
Email: pmcclendon@newcenturyhealth.com

New Century Health

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

Online:
NCH Provider Web Portal
https://my.newcenturyhealth.com

Phone:
1 (888) 999-7713
Cardiology – Option 3

Fax:
1 (877) 624-8807

MOLINA HEALTHCARE

New Century Health – Oncology Prior Authorizations

Molina Healthcare of Nevada cares about our members' health and continually enhances programs to improve the quality of care. We are pleased to announce our collaboration with **New Century Health (NCH)** as the Molina Healthcare Oncology Quality Management program administrator.

Oncology-related infused and injectable chemotherapeutic agents, supportive/symptom management medications, and radiation treatments administered in a physician's office, outpatient hospital, or ambulatory setting must be submitted to **NCH** for prior authorization. Treatment plans will be reviewed using nationally recognized evidence-based guidelines. We realized an error with Molina's previous authorization matrix where authorization requirements were applied for members aged 18 years and older.

New Century Health

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

Online:
NCH Provider Web Portal
https://my.newcenturyhealth.com

Phone:
1 (888) 999-7713
Oncology – Option 6

Fax:
1 (877) 624-8807

MOLINA HEALTHCARE

Notification of Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays.

- For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department.
- Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate inpatient review and discharge planning.

Phone: (833) 685-2103

Fax: (775) 460-4900

We require that the notification include:

- ✓ Member demographic information, Facility information, Date of admission and Clinical information sufficient to document the Medical Necessity of the admission.
- ✓ Emergent inpatient admission services performed without meeting notification and Medical Necessity requirements or failure to include all of the needed documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient admission.
- ✓ Molina performs concurrent inpatient review in order to ensure patient safety, Medical Necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Molina will request updated original clinical records from inpatient facilities at regular intervals during a Member's inpatient admission.
  - ✓ *This information is due from the inpatient facility within twenty-four (24) hours of the request.*

MOLINA HEALTHCARE

Care Management

Social and Health Equity Navigators (SHENs):

- Coordinates services through community partnerships & programs

Care Coordination

- Connects members with community resources
- Collaborate with the case managers

Case Management

- Works to develop an individualized care plan (ICP) with continued follow-up on a regular schedule.
- Collaborates with the Interdisciplinary Care Team (ICT) to identify and address member needs and concerns

Justice Liaison

- Works collaboratively with Justice System agencies ensuring members receive care coordination and appropriate access to eligible and necessary services.

Care Manager

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

Members may receive Health Risk Assessments (HRA) that help identify physical health, behavioral health, medication management problems, and social determinants of health to target high-needs members who would benefit from assistance and education from a Care Manager.

Care Management

Molina Healthcare's Care Management Program involves collaborative processes aimed at meeting an individual's health needs, promoting quality of life, and obtaining cost-effective outcomes.

Care Management employs a multi-disciplinary team approach in developing interventions to meet member needs. Members of this team are determined by the member and may include but not limited to:

- Member and their caregiver/representative
- Member's PCP
- Molina Medical Director
- Case Manager
- CAM Inpatient Review Nurse
- Molina Pharmacist
- Molina BH Specialist
- Molina or External SW
- Any provider who can provide input on the members care

Care Management: Case Managers

- Case Managers (CM) are nurses and social workers who conduct health risk assessments either by phone or face-to-face to identify member needs and develop specific interventions to help meet those needs.
- Molina Case Managers use information from the assessment process to develop and implement individual care plans with the member based on member's own identification of primary health concern and an analysis of available data on the member's medical condition and history.
- All Nevada Medicaid and Check Up (CHIP) Members are eligible for Case Management services; different levels of interventions are based on the individual needs and conditions of each individual:
  - **Health Management** - Health Management is focused on disease prevention and health promotion. It is provided for members whose lower acuity chronic conditions put them at risk for future health problems.
  - **Case Management** - Case Management is provided for members who are at high risk for re-hospitalization post ToC intervention with case management needs that warrant triage. These services are designed to improve the member's health status and reduce the burden of disease through education and assistance with the coordination of care including LTSS.
  - **Complex Case Management** - Complex Case Management is provided for members who have experienced a critical event or diagnosis requiring the extensive use of resources and need additional support navigating the health care system. The primary goal of Complex Case Management is to help members improve functional capacity and regain optimum health in an efficient and cost-effective manner.
  - **Intensive Needs Case Management** - Level 4 focuses on members having an end-stage diagnosis that would otherwise meet criteria for palliative care or hospice services. This level includes members at high risk for re-hospitalization post ToC intervention with continued need for stabilization, comfort care or other high intensity, highly specialized services.

Molina Partners - Lab

Molina Healthcare of Nevada has partnered with national lab companies to provide services for our Nevada members – *Quest Laboratories*.

Quest Laboratories is the preferred provider of laboratory services for Molina Healthcare. Quest Laboratories offers:

- An extensive testing menu with access to more than 3,400 diagnostic tests so you have the right tool for even your most complicated clinical cases.
- Approximately 900 PhDs and MDs are available for consultation at any time.
- Results within 24 hours for more than 97% of the most commonly ordered tests.
- 24/7 access to electronic lab orders, results, ePrescribing and Electronic Health Records.
- Email reminders either in English or Spanish about upcoming tests or exams.

If you have questions about Quest Diagnostics services, test menus, and patient locations, please call **866-MY-QUEST** to request a consultation with a Quest Diagnostics Sales Representative.

Molina Partners - Pharmacy

CVS/Caremark is the Pharmacy Benefit Manager (PBM) for Molina Healthcare.

The “Formulary”, also known as the “Preferred Drug List” (PDL), is available on the Molina Healthcare website: MolinaHealthcare.com.

The formulary was created to help manage the quality of our Members’ pharmacy benefit; it is the cornerstone for a progressive program of managed care pharmacotherapy. Prescription drug therapy is an integral component of a patient's comprehensive treatment program, and the formulary was created to ensure that our members receive high quality, cost-effective, rational drug therapy.

Prescriptions for medications requiring prior approval, for most injectable medications or for medications not included on the formulary may be approved when medically necessary and when formulary alternatives have demonstrated ineffectiveness. When these exceptional needs arise, providers may fax a completed Prior Authorization/Medication Exception Request.

Phone: (833) 685-2103

Prior Authorization Fax: (844) 259-1689

The Prior Authorization Request Form is included in the Orientation Kit and is also available on our website: MolinaHealthcare.com

Lock-In Program – Non-Emergent Care Settings

- Members may be locked into a certain set of providers or emergent / urgent care settings based on the members misuse or overuse of pharmacy or emergency department care.
- Members potentially eligible for lock-in have their utilization reviewed to determine clinical composition, risk and possible misuse or overuse of healthcare services.
- Members may be referred to care management prior to lock-in to educate and support behavioral changes and positive health outcomes.
- If member's behaviors do not change, regardless of care management engagement, the Case Manager will initiate member enrollment into the lock-in program.
- The member's Case Manager will contact their assigned PCP to make the PCP aware of the member's potential to be locked-in to certain providers and settings of care as a part of the Lock-In program.
- *Refer the Pharmacy section for pharmacy lock-in criteria in our Provider Manual.*

Claims

MOLINA HEALTHCARE

Electronic Payment Requirement – EFT/ERA

- Participating Providers are required to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)
- EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and receive payment and ERA access faster than the paper check and remittance advice (RA) processes.
- Molina contracts with our payment vendor, Change Healthcare, who has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing. On this platform you may receive your payment via EFT/ACH, a physical check, or a virtual card.

If you would like to opt-out of receiving a Virtual Card,
you may contact ECHO Customer Service at
(888) 834-3511 or edi@echohealthinc.com.
Request that your Tax ID for payer Molina Healthcare of Nevada, Inc.
be opted out of Virtual Cards.

Claims

Claims Processing Standards – On a monthly basis, over 90% of claims received by Molina from our health plan network providers are processed within 30 calendar days;100% of claims are processed within 90 working days

These standards have to be met in order for Molina to remain compliant with regulatory requirements and to ensure that our providers are paid in a timely manner

Claims Submission Options

- Molina requests that contracted providers submit all claims electronically.
- Electronic claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Molina Provider Web Portal. Additional information on EDI
- The Provider Portal (Availity.com) is available free of charge and allows for attachments to be included.
- Via a Clearinghouse.
- Providers may use the Clearinghouse of their choosing. (Note that fees may apply).
- Change Healthcare is Molina Healthcare's chosen clearinghouse. When submitting EDI Claims (via a clearinghouse) to Molina Healthcare, providers must use the applicable ***payer ID # MLNNV***

NEW! Home Health: Payer ID: NVMOL

Claims Submission- Availity Portal

Molina's Provider Portal- *Preferred*

- The Availity Provider Portal is the recommended and most efficient method to submit claims with attachments.

- It's Free!
  - To register:
  - Contact the Molina Provider Services call center to obtain the Molina Provider ID # required to register : **(833) 685-2103**

- Allows for submission of UB and CMS 1500 claims, including attachments and corrected claims

- Appeal denied claims

The portal can be accessed at: Availity.com

Claims Submission: EDI

Clearinghouse:

- Molina Healthcare of Nevada uses Echo Health (part of Change Healthcare) as its gateway clearinghouse. Echo Health has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

- Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. In order to ensure that all data being submitted to our gateway is received properly your submitter must utilize the latest version of the 837 standard. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

- Payer ID# ***MLNNV***
- **New Payer ID for Home Health Services*: NVMOL***

EDI Claim Submission Issues

Please call the Echo Health Customer Services Team at **(888) 834-3511**; and/or
Submit an email to: edi@echohealthinc.com; and/or
Contact your Provider Relations Representative @
NVProviderRelations@MolinaHealthcare.com

Claims Submission: Paper

When submission of an Electronic claim is not possible, paper claims may be submitted to the following address:

Molina Healthcare of Nevada, Inc.
PO Box 22666
Long Beach, CA 90801

Claims Submission – Timely Filing

Providers are encouraged to submit claims for Covered Services rendered to members as soon as possible following the date of service.

- Claims must be submitted by provider to Molina Healthcare ***within one hundred eighty (180) calendar days*** after the following have occurred: discharge for inpatient services or the date of service for outpatient services; and provider has been furnished with the correct name and address of the member's health maintenance organization.
- All claims shall be submitted in a form acceptable to and approved by Molina Healthcare and shall include any and all medical records pertaining to the claim if requested by Molina Healthcare or otherwise required by Molina Healthcare's policies and procedures.
- If Molina Healthcare is not the primary payer under coordination of benefits or third-party liability, provider must submit claims to Molina Healthcare ***within one hundred-eighty (180) calendar days*** after the final determination is made by the primary payer.
- Except as otherwise provided by law, any claims that are not submitted to Molina Healthcare within these timelines shall not be eligible for payment, and provider hereby waives any right to payment therefore.
- NOTE: Clean claim timely filing is 180 days (In State Providers) and 365 days (Out Of State Providers)

Corrected Claims and Disputes

Corrected Claims

Corrected claims are considered to be new claims.

- Corrected claims may be submitted electronically via the Provider Portal, through an EDI clearinghouse or on paper
- Corrected claims must include the correct coding to denote if a claims is a Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P. (See the Provider Manual for additional details on how to correctly include this coding.)

Claims Reconsideration

Providers seeking a redetermination of a claim previously adjudicated must request such action within ninety (90) days of Molina Healthcare's original remittance advice date. Additionally, any claim(s) dispute requests (including denials) should be submitted to Molina Healthcare using the standard claims reconsideration review form (CRRF). This form can be found on the provider website.

In addition to the CRRF, providers should submit the following documentation:

- The previous claim and remittance advice, any other documentation to support the adjustment and a copy of the Service Authorization form (if applicable) must accompany the adjustment request.
- The claim number clearly marked on all supporting documents.
- Forms may be submitted via fax or mail. See the Provider Manual for the mailing address and fax number.

Claims: Coordination of Benefits

- Medicaid is the payer of last resort; private and governmental carriers must be billed prior to billing Molina Healthcare
- Provider should inquire with Members to learn whether Member has health insurance, benefits or Covered Services other than from Molina Healthcare
- Provider must immediately notify Molina Healthcare of any other coverage
- Provider will be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to exceed Molina Healthcare's contracted allowable rate.
- Provider must include a copy of the other insurance's EOB with the Claim.

Providers can submit claims free of charge with attachments, including EOBs and other required documents, by utilizing Molina's Provider Portal.

Claims: Third Party Liability

- Molina Healthcare as payer of last resort will make every effort to determine the appropriate Third-Party payer for services rendered.
- Molina may deny claims when a Third Party has been established and will pay claims for covered services when probable Third-Party Liability (TPL) has not been established or third-party benefits are not available to pay a claim.
- Molina Healthcare will attempt to recover any third-party resources available to members and shall maintain records pertaining to TPL collections on behalf of members for audit and review.

***Note**: Molina complies with Federal law(s) which require Medicaid Payers to reimburse for certain covered services even when a third-party source exist. In these instances, Molina will reimburse the provider for specific covered services, and then pursue recovery of the Medicaid payment from the third-party source.*

Claim Appeals

A Provider may file an Appeal orally or in writing. An Appeal is a request for Molina to review an Adverse Benefit Determination related to a provider; which may include, but is not limited to, for cause termination by the Molina, or delay or non-payment for covered services.

- Appeals must be filed within thirty (30) calendar days from the Adverse Benefit Determination or denial. A written acknowledgement letter must be sent within ten (10) calendar days of receipt of the Appeal.
- Appeals must be resolved as expeditiously as possible: no later than thirty (30) calendar days from receipt.
- The timeframe for Appeals resolution may be extended up to fourteen (14) calendar days in compliance with state regulation.
- For decisions not resolved wholly in the provider's favor, Providers have the right to request a state Administrative Hearing from the Division of Medicaid.

Balance Billing and Claims Payment

Providers *may not* balance bill Molina Members for any reason for *covered* services. Detailed information regarding the billing requirements for non-covered services are available in the Nevada Provider Manual.

Your Provider Agreement with Molina requires that your office verify eligibility prior to rendering any service and obtain approval for those services that require prior authorization.

In the event of a denial of payment, providers shall look solely to ***Molina*** for compensation for services rendered, with the exception of any applicable cost sharing/co-payments.

- ✓ The date of claim receipt is the date as indicated by its data stamp on the claim.
- ✓ The date of claim payment is the date of the check or other form of payment.

Appeals and Grievances

MOLINA HEALTHCARE

Appeals & Grievances

Providers have the right to file a complaint, grievance or appeal through a formal process. The Division of Medicaid shall have the right to intercede on a provider's behalf at any time during the contractor's Complaint, Grievance, and/or Appeal process whenever there is an indication from the Provider, or, where applicable, authorized person, that a serious quality of care issue is not being addressed timely or appropriately.

Written acknowledgement letters will be sent within five (5) calendar days of receipt of the Grievance by Molina. All Grievances will be resolved as expeditiously as possible; all will be resolved no later than thirty (30) calendar days from receipt.

Providers may file a complaint or formal grievance by contacting Molina
toll-free at **(844) 826-4335** Mon. - Fri. 7:30 a.m. to 6:00 p.m. excluding State holidays

Grievances may also be submitted in writing to our Regional Appeals & Grievances Team:

Molina Healthcare of Nevada
Attention: Grievance & Appeals Department
P. O. Box 401825
Las Vegas, NV 89140
Fax (833) 412-3146
NV_Provider_AG@MolinaHealthCare.Com

Compliance

MOLINA HEALTHCARE

Fraud, Waste & Abuse

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

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

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

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

False Claims Act, 31 USC Section 3279

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

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

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

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

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

Deficit Reduction Act

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

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

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

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

Deficit Reduction Act cont'd

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

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

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

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

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

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.

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

Detecting Fraud, Waste and Abuse

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

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

Reporting Suspected Fraud, Waste & Abuse

To report an issue by telephone, call Molina Healthcare's Compliance AlertLine (Hotline) toll free: 1-866-606-3889.

To report an issue online:
Visit: molinahealthcare.alertline.com

You may also report an issue in writing. Please contact your local Compliance team for further instructions.

Issues may also be reported directly to the State at:

ATTN: Office of the Attorney General
Medicaid Fraud Control Unit
100 North Carson St.
Carson City, NV 89701

Compliant form available at: https://ag.nv.gov/Complaints/File_Complaint/

Value Based Payments (P4Q/P4P)

MOLINA HEALTHCARE

Value-based purchasing: the evolving story of health care payment methodologies

Traditional fee-for-service (FFS) care

- Traditional payment model
- Providers must increase service volume to maximize revenue
- Ignores quality of care provided
- Ignores acuity of patients served
- Disease-first
- Siloed services

Health care industry shift to VBP

Value-based purchasing (VBP)

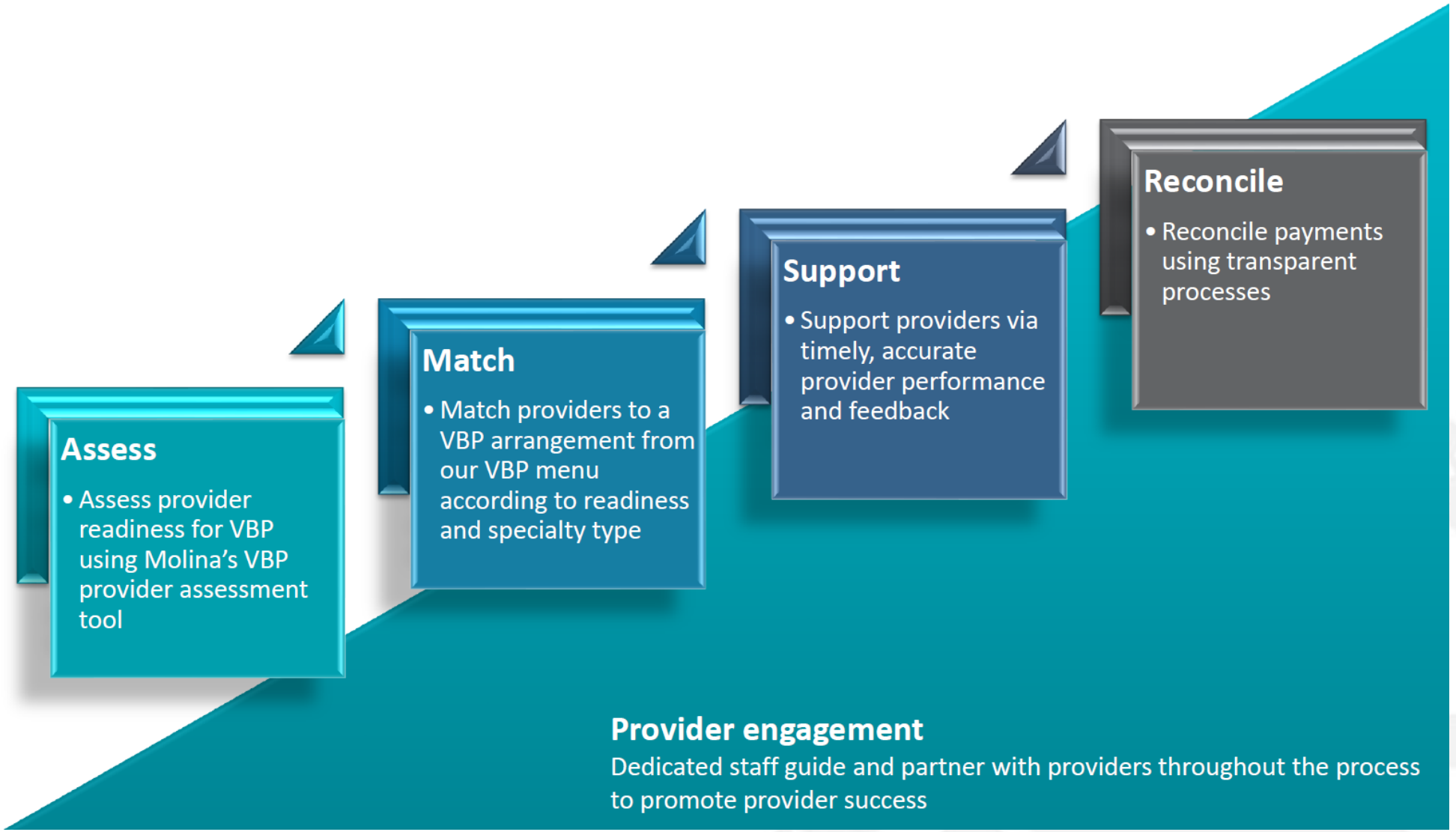
- Alternative payment models (APMs)
- Providers can increase revenue by investing in care coordination and prevention
- Incentivizes high quality outcomes
- Considers patient acuity
- Patient-first
- Whole-person care

- In 2020, about 41% of health care payments occurred as part of shared savings, shared risk, or population-based APMs
- The Centers for Medicare and Medicaid Services (CMS) set new goals to ramp up the adoption of risk-sharing models by 2025
- State bid requirements for health plans are likely to mirror CMS goals
- 87% of health care payers expect further VBP growth

The Health Care Payment Learning & Action Network (HCP-LAN)

MOLINA HEALTHCARE

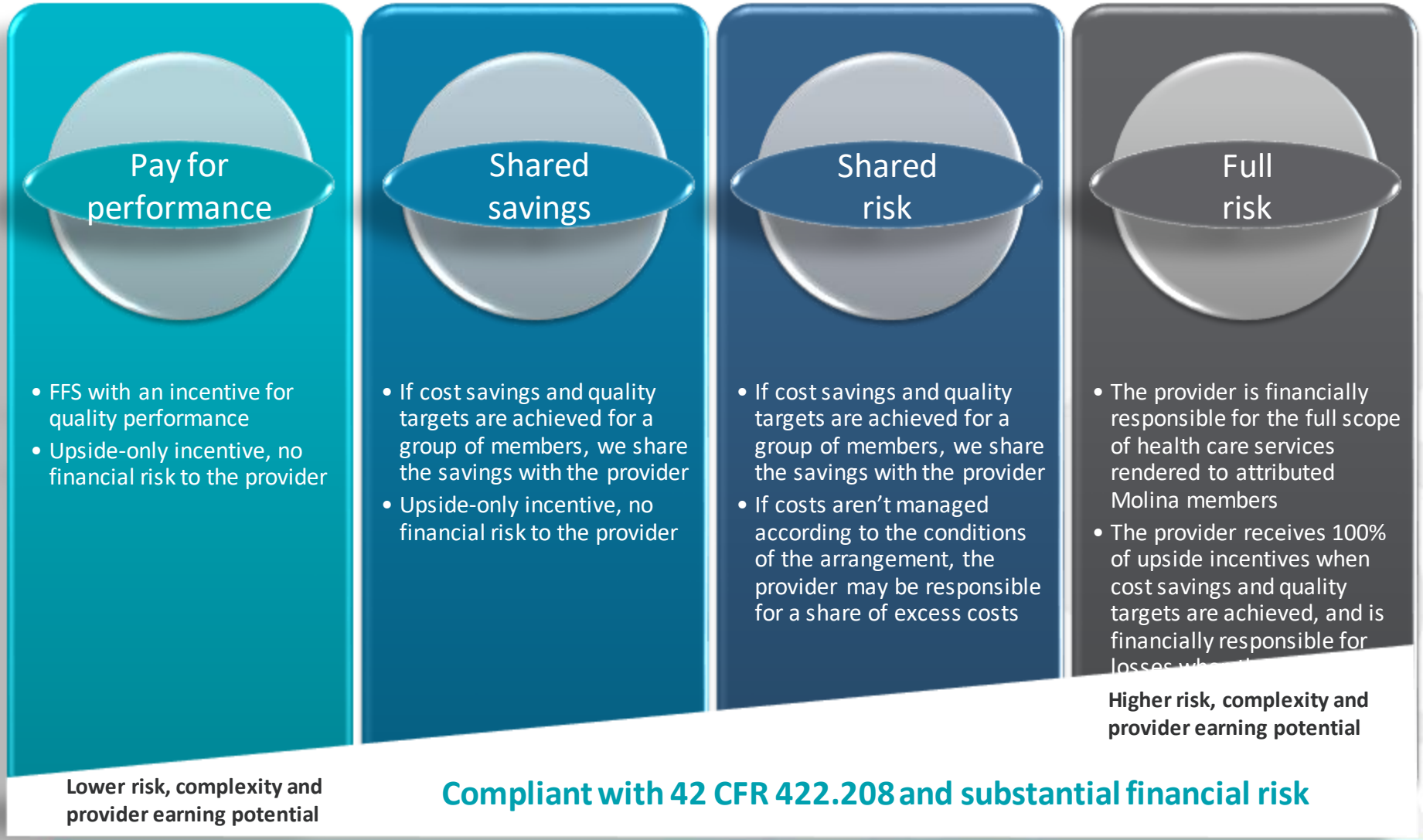
Molina's path to value-based purchasing success



MOLINA HEALTHCARE

Molina's VBP continuum

We partner with providers to move toward higher complexity arrangements



MOLINA HEALTHCARE

Our VBP goals

Improve quality performance

- Engage providers on HEDIS® & STAR performance measures via timely, accurate feedback
- Reward providers for delivery of patient-centered, high-quality care

Increase clinical documentation accuracy

- Encourage providers to consistently engage members in annual comprehensive physical exams thoroughly evaluating and documenting all member conditions during their visit
- Encourage providers to submit claims with diagnoses coded to the highest level of specificity appropriate for the member's condition(s)

Manage appropriateness of care

- Ensure members receive the right care, at the right time, in the right place
- Decrease the use of inappropriate and unnecessary services
- Engage members with high health risks to optimize their care plans

MOLINA HEALTHCARE

Value Based Payment Continuum

Molina recognizes the need to "*meet providers where they are*" in order to increase value-based payment opportunities and improvements in access, quality, efficiency and outcomes.

Our Value Based Payment (VBP) methodologies support that objective with an accountable care continuum of value-based models, including pay-for-performance, quality payment bundles, gain share, partial shared-risk models, and full-risk capitation all of which reward quality improvements, and some that also incentivize improved cost of care.

Value Based Payment (VBP) Methodologies

Pay-for-Performance (P4P)	• Offers enhanced reimbursements tied to measures such as appropriate ED use, preventable readmission rates, and discharge planning.
Pay-for-Quality (P4Q)	• Includes enhanced reimbursements tied to relevant HEDIS measures and focuses on Providers investing in processes to drive better outcomes and lower cost.
Shared Risk & Accountable Care Organizations (ACOs)	• Provides additional compensation from a shared savings or risk resulting from improved care quality and outcomes with potential to move to an accountable care arrangement that includes upside/downside risk

Signature P4Ps and P4Qs

Eligible providers have the opportunity to participate in a number of signature Molina VBP programs beginning in the first year of the program, and additional information will be sent out throughout the year on performance, bonus payments and further opportunities to earn more incentives.

PCP P4Q Bonus Program

PCP Pay-for-Outcomes (Performance) Bonus

Maternal and Infant Health P4Q Bonus Program Doulas P4Q Bonus Program

HealthHIE EHR P4Q Bonus Program

Community for Me P4Q Bonus Program

Shared Risk and ACO Arrangements

Molina also offers comprehensive shared savings, shared risk and ACO arrangements for interested provider groups and health systems:

Additional compensation from share in savings or risk resulting from improved care quality and outcomes with potential to move to accountable care contract including upside/downside risk based on benchmark data and quality measures.

Progress into partial/full risk arrangements with more experienced providers demonstrating a track record or positive administrative experience and capability in successfully managing government sponsored health care populations.

For more information on VBP, please email: NVProviderRelations@MolinaHealthcare.com

Provider Relations Department Contacts

Southern Nevada

LaDonna Washington, Sr. Prov. Relations Rep.	LaDonna.Washington@MolinaHealthcare.com	(702) 232-7555
Melvin Goree, Sr. Provider Relations Rep.	Melvin.Goree@MolinaHealthcare.com	(702) 218-0498
Nicole Spaight, Sr. Provider Relations Rep.	Nicole.Spaight@MolinaHealthcare.com	(702) 239-6982
Paris Graham, Provider Relations Rep.	Paris.Graham@MolinaHealthcare.com	(725) 270-0703
Alicia Simmons Lewis, Sr. Business Analyst	Alicia.Simmonslewis@MolinaHealthcare.com	(725)258-4585
Leslie Brown, Director	Leslie.Brown2@MolinaHealthcare.com	(725) 258-4584

Northern Nevada

Brittany Lloyd, Sr. Provider Relations Rep.	Brittany.Lloyd@MolinaHealthcare.com	(775) 530-9457
Tyler Ranville, Provider Relations Rep.	Tyler.Ranville@MolinaHealthcare.com	(775) 484-0393

General Inquiries: NVProviderRelations@MolinaHealthcare.com

Provider Take-Aways

- Register for the Availity Provider Portal: Availity.com
- Attend Availity Provider Portal Training (On Demand or Live Webinars)
- Complete the Molina Healthcare Model of Care (MOC) Training and return signed Attestation to NVProviderRelations@MolinaHealthcare.com
- Provide Complete Provider Roster to Molina
  - Include Provider names, NPIs, Service Locations
  - Accepting New Patients Y/N
  - Telehealth Y/N
  - Ages of Patients Served
  - Or used the preferred **Molina Roster Template**
- Provide Molina Provider Relations Representative with contacts for practice manager, billing manager, credentialing specialist and other key personnel.

Thank You for Your Attendance!!

MOLINA® HEALTHCARE | You Matter to Molina

Contact Us!

Molina Healthcare of Nevada Provider Relations

NVProviderRelations@MolinaHealthcare.com

MolinaHealthcare.com