Provider Orientation 2023

PRESENTED BY:

MOLINA HEALTHCARE OF IOWA PROVIDER SERVICES

MOLINA HEALTHCARE

Iowa Health Link
Iowa HHS

Hawki
Iowa HHS

Agenda

- Introduction to Molina Healthcare
- Member Rights and Responsibilities
- Provider Responsibilities
- Provider Tools & Resources
- Pharmacy
- MLTSS/HCBS Services
- Critical Incident
- VBP
- Healthcare Services
- Quality
- Compliance
- Claims
- BH/IHH
- Q&A Session

Introduction to Molina Healthcare

What Matters To Molina

Our Mission

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

Our Vision

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

MOLINA HEALTHCARE | Iowa Health Link Iowa HHS | Hawki Iowa HHS

Our Values

Integrity Always
Quality of being honest, whole, and undivided

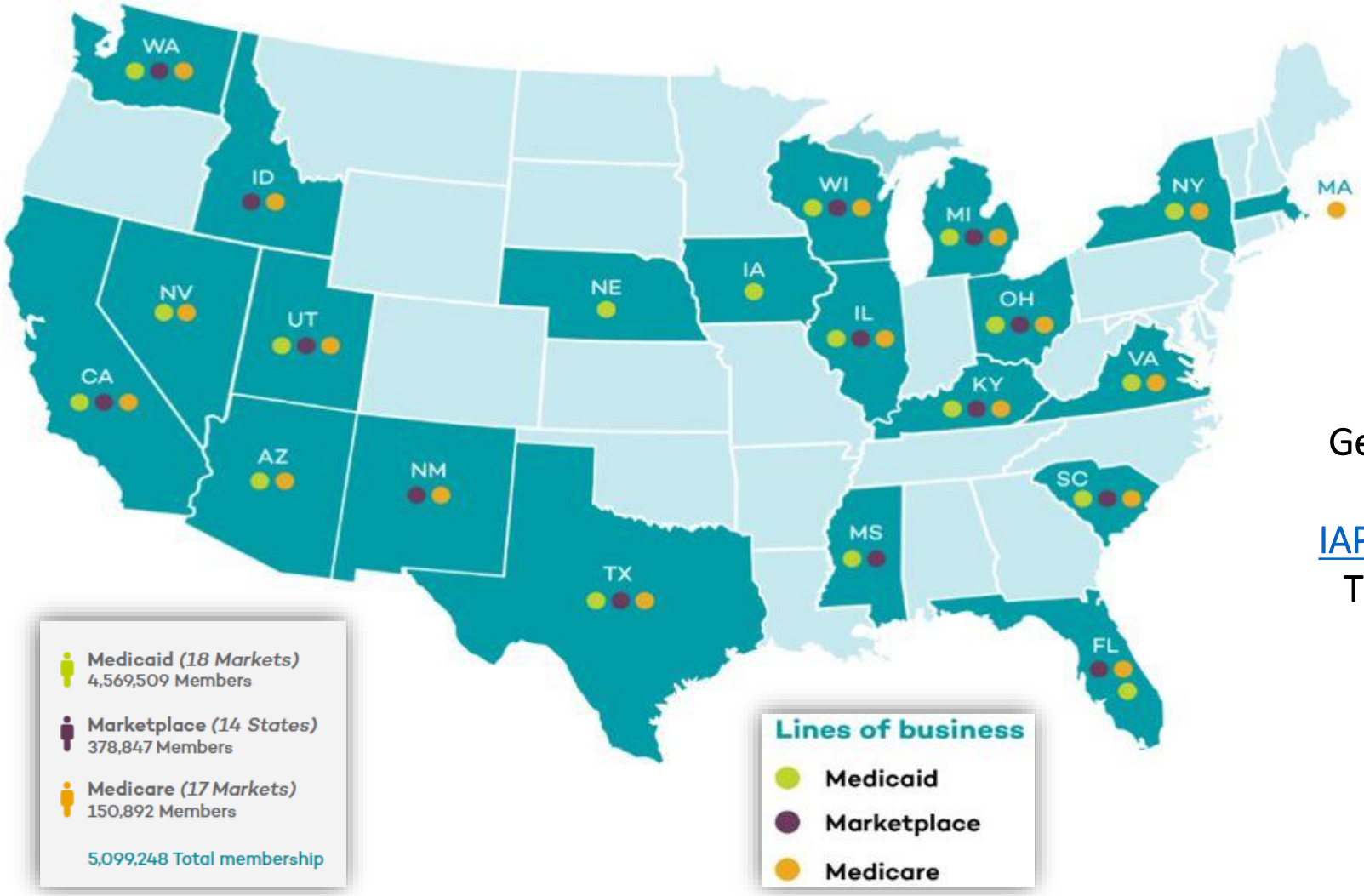
Absolute Accountability
Complete the tasks we are assigned, to perform the duties required by our jobs, and to always be present

Supportive Teamwork
Having commitment and trust with one another and adaptable to changing conditions

Honest & Open Communication
The way relationships are built and a vital ingredient to any successful organization

Member & Community Focused
We honor and bring together people whose leadership, volunteerism, and public advocacy embody the spirit of service and community to our members

Welcome to the family!



Get to know your regional provider services representative! Email: IAProviderRelations@molinahealthcare.com. They will provide guidance for any, and *all* questions.

Recognized for Quality, Innovation, and Success

Molina Healthcare plans have been ranked among America's top Medicaid plans by U.S. News & World Report

FORTUNE 500 Company by Fortune Magazine

Business Ethics magazine 100 Best Corporate Citizens

Alfred P. Sloan Award for Business Excellence in Workplace Flexibility in 2011

11 of our 13 plans have earned the Multicultural Health Care Distinction from NCQA

Molina Healthcare is a leader in quality with the majority of its health plans accredited and rated by the National Committee for Quality Assurance (NCQA).

FORTUNE 500

MOLINA HEALTHCARE | Iowa Health Link Iowa HHS | Hawki Iowa HHS

Strategic Priorities

In all that we do, we will stay true to our mission, vision and values by delivering on four strategic priorities:

- Maximizing value
- Facilitating effective care management
- Improving administrative efficiency, eliminating obstacles
- Breaking down barriers to accessing care

Member Rights and Responsibilities

Member Rights

A. Treated with respect, dignity, privacy, confidentiality, accessibility and nondiscrimination;

B. To be provided with information about Molina Healthcare of Iowa, its services, the practitioners providing care, and members' rights and responsibilities in accordance with 42 CFR 438.10;

C. To be able to choose primary care practitioners, including specialists as their PCP if the member has a chronic condition, within the limits of the network, including the right to refuse care from specific practitioners;

D. Ask questions and receive complete information relating to the member's medical condition and treatment options, including Specialty Care;

E. Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and request a State Fair Hearing from the Contractor and/or the Department;

F. Timely access to care that does not have any communication or physical access barriers;

G. Prepare Advance Medical Directives pursuant to Pursuant to Section 1902(w)(1) of the Act, the Patients' Self-Determination Act,

H. To have access to his/her medical records in accordance with applicable federal and state laws and to request that they be amended or corrected as specified in 45 CFR Part 164;

I. Timely referral and access to medically indicated Specialty Care;

J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

K. Receive information in accordance with 42 C.F.R. 438.10; and

L. Be furnished health care services in accordance with 42 C.F.R. Part 438

NOTE – Additional details are in the Molina Healthcare of Iowa Provider Manual and Member Handbook

Member Responsibilities

A. Become informed about Enrollee Rights;

B. Tell Iowa Medicaid Member Services about any changes to other health insurance coverage, including Third-Party Liability (TPL). Tell them if coverage ends, you lose or get new coverage, or change insurance companies. Call Member Iowa Medicaid Member Services toll-free at (800) 338-8366;

C. Become informed about services and treatment options;

D. Actively participate in personal and care decisions, practice healthy lifestyle;

E. Actively work with your provider to develop treatment goals. Follow the care plan that you and your provider have developed;

F. Report suspected Fraud and Abuse; and

G. Keep appointments or call to cancel.

NOTE – Additional details are in the Molina Healthcare of Iowa Provider Manual and Member Handbook

Provider Responsibilities

PCP Responsibilities

The PCP or physician in a Primary Care Site serves as the member's initial point of contact. The PCP must be given responsibility for the following tasks, as well as Molina to retain responsibility for monitoring PCP and Primary Care site activities to ensure compliance with the State's requirements. The PCP or the physician at the Primary Care Site is responsible for the following:	i. Delivery of covered Medically Necessary primary care services and preventive services, including Early & Periodic Screening, Diagnosis & Treatment (EPSDT) screening services and Well Baby/Child Services; ii. Provider of twenty-four (24) hour, seven (7) days per week coverage; iii. Referrals for specialty care and other covered Medically Necessary services in the managed care benefit package; iv. Members must be allowed to self-refer for family planning (in or Out-of-Network), and obstetrical, gynecological, mental health and substance abuse services within Molina's Network; v. Continuity and coordination of member's health care; vi. Maintenance of a current medical record for the member, including documentation of all services provided by the PCP, specialty or Referral services, or Out-of-Network services such as Family Planning and Emergency Services. vii. Medicaid enrollment ▪ Provider must be enrolled with the State as a Medicaid provider. Prior to becoming a network provider, a provider who is a non-Medicaid enrolled provider will be referred to the State's fiscal agent and must complete the Medicaid provider enrollment process. The provider is not required to see FFS recipients.

Provider Responsibilities

Nondiscrimination in Health Care Service Delivery

- Providers must comply with the nondiscrimination of health care service delivery requirements as outlined in the Cultural Competency and Linguistic Services section of the Provider Manual.
- Additionally, Molina requires providers to deliver services to Molina members without regard to source of payment. Specifically, providers may not refuse to serve Molina members because they receive assistance with cost sharing from a government-funded program.

Facilities, Equipment, and Personnel

- The provider's facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

Provider Data Accuracy and Validation

It is important for providers to ensure Molina has accurate practice and business information.

This allows us to better support and serve Molina members and provider network.

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA required element.

Invalid information can negatively impact member access to care, member/PCP assignments and referrals.

Providers must validate their provider information on file with Molina at least once every 90 days for correctness and completeness.

Provider Data Accuracy and Validation

Please visit our Provider Online Directory at

MolinaHealthcare.com/IA

to validate your information.

For corrections and updates, providers can make updates through the CAQH portal, or you may submit a full roster that includes the required information above for each health care provider and/or health care facility in your practice.

Providers unable to make updates through the CAQH portal or roster process should contact their Provider Services representative for assistance.

Continuity & Coordination of Care b/w Medical & Behavioral Health (BH) Care

BH providers may refer a member to an in-network PCP, or a member may self-refer. PCPs are able to screen and assess members for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

Members may be referred to primary care and specialty providers to manage their health care needs. Members may be referred to an in-network Behavioral Health (BH) provider via referral from a PCP or by member self-referral.

Emergency psychiatric services do not require Prior Authorization. All requests for Behavioral Health services should include the most current version of DSM classification.

BH providers may identify other health concerns, including physical health concerns, that should be addressed by referring the member to a PCP.

Primary Care & BH - After Hours Care

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed one hour. All PCPs are required to monitor waiting times and 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 requires providers to maintain a 24-hour telephone service, seven 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 911/988 or go immediately to the nearest emergency room. Voicemail alone after hours is not acceptable.

Advanced Directives

§ 489.100 Definition.

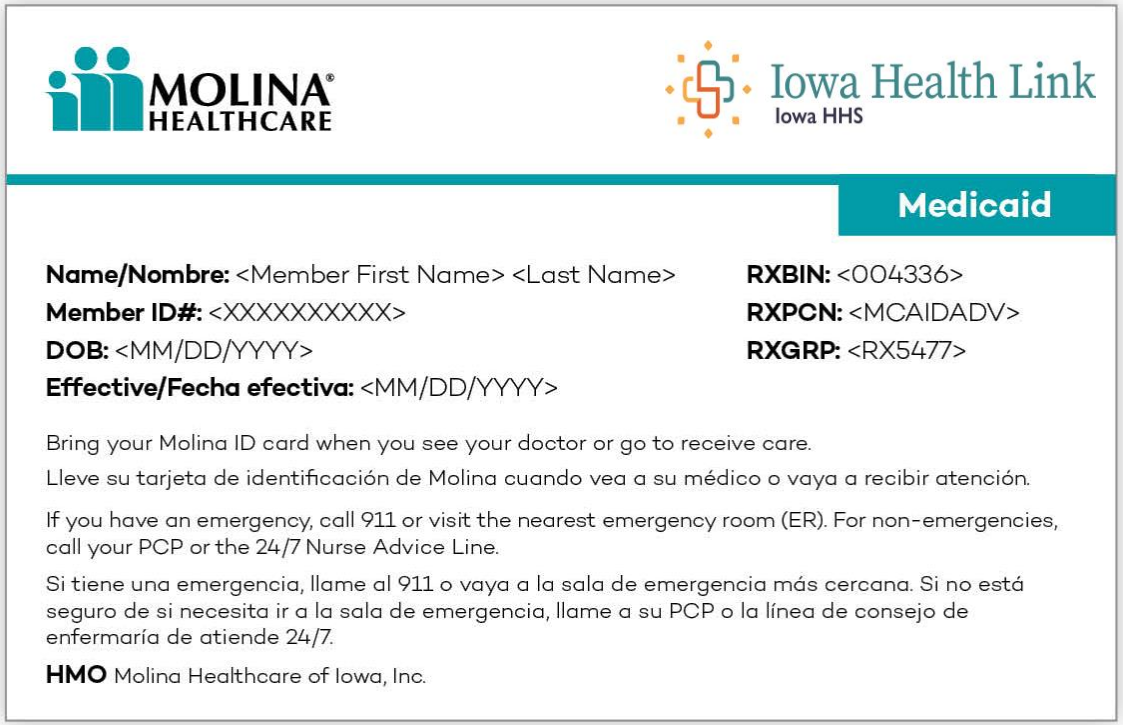
"For purposes of this part, advance directive means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated."

42 CFR § 489.102 - Requirements for providers

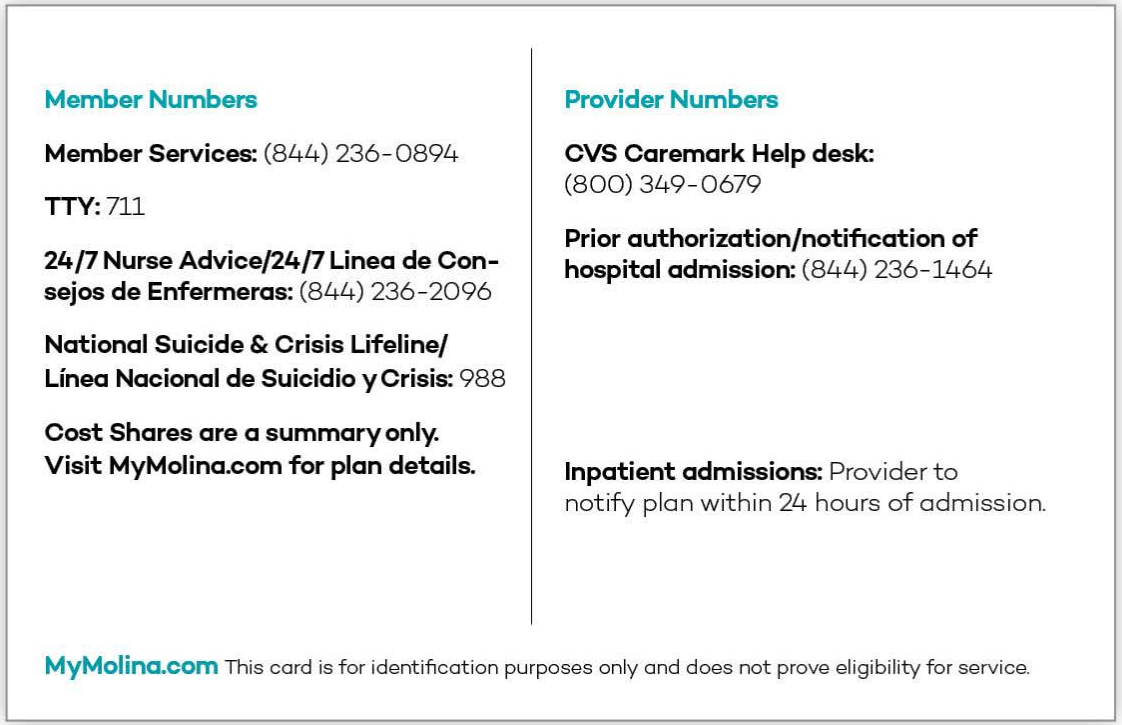
(a) Hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), hospices, and religious nonmedical health care institutions must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care, or patient care in the case of a patient in a religious nonmedical health care institution, by or through the provider and are required to following in accordance with https://www.law.cornell.edu/cfr/text/42/489.102

Provider Tools & Resources

Molina Healthcare Member Identification (ID) Card



Card Front



Card Back

Provider Manual

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

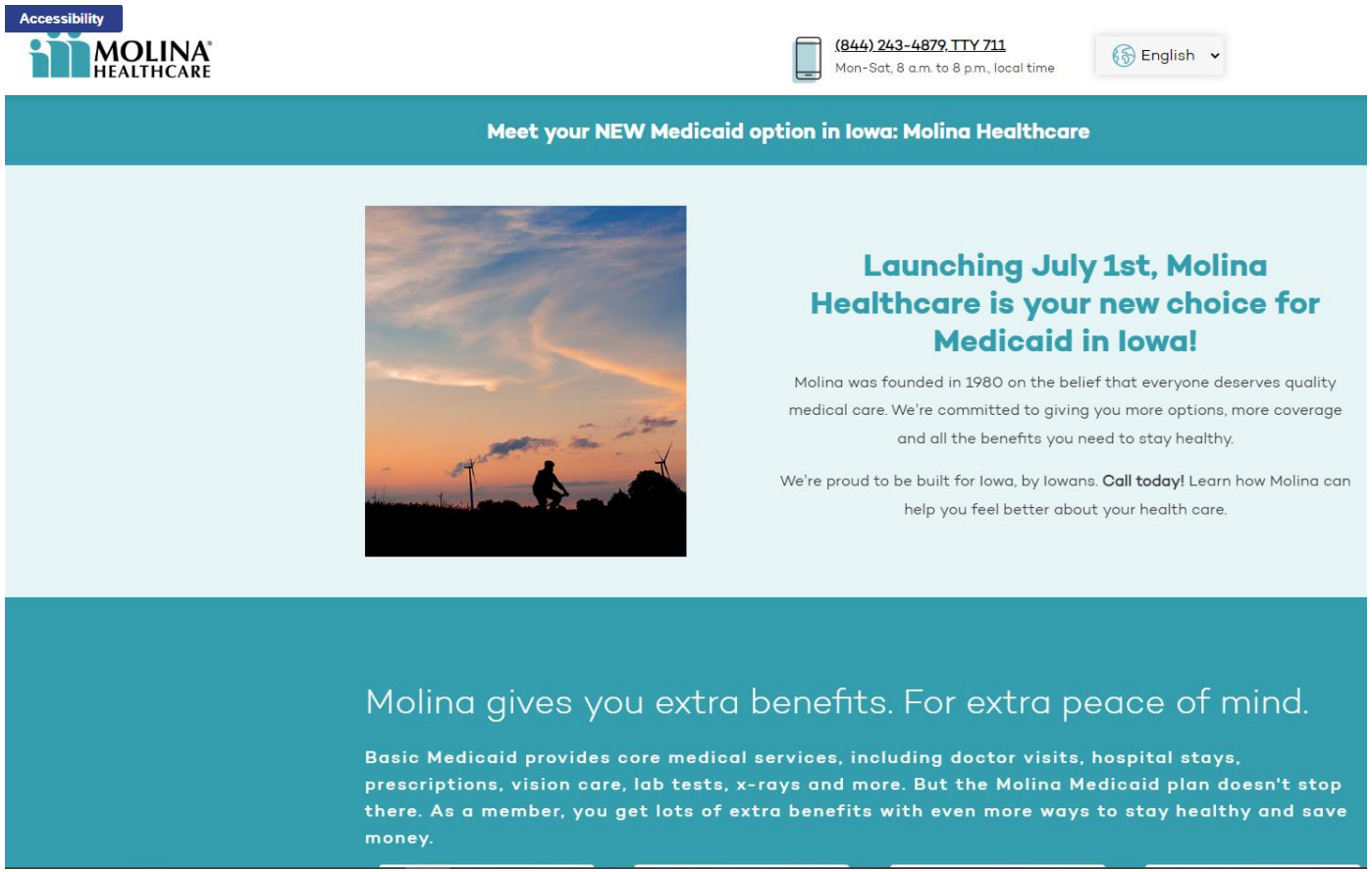
Provider Manual Highlights	
Benefits and Covered Services Overview	Long Term Supports and Services
Claims, Encounter Data and Compensation (including the no balance billing requirements)	Member Grievances and Appeals
Compliance and Fraud, Waste, and Abuse Program	Member Rights and Responsibilities
Contacts	Model of Care
Credentialing and Re-credentialing	Pharmacy
Utilization Management, Referral and Authorization (Healthcare Services)	Preventative Health Guidelines
Eligibility, Enrollment, and Disenrollment	Provider Responsibilities
Health Management (Health Education & Disease Management)	Quality Improvement
Health Insurance Portability and Accountability Act (HIPAA)	Transportation Services
Interpreter Services	

View the manual on our provider website: MolinaHealthcare.com/IA

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 & Abuse Information
- ✓ Frequently Used Forms
- ✓ Communications & Newsletters
- ✓ Member Rights & Responsibilities
- ✓ Contact Information

MolinaHealthcare.com/IA



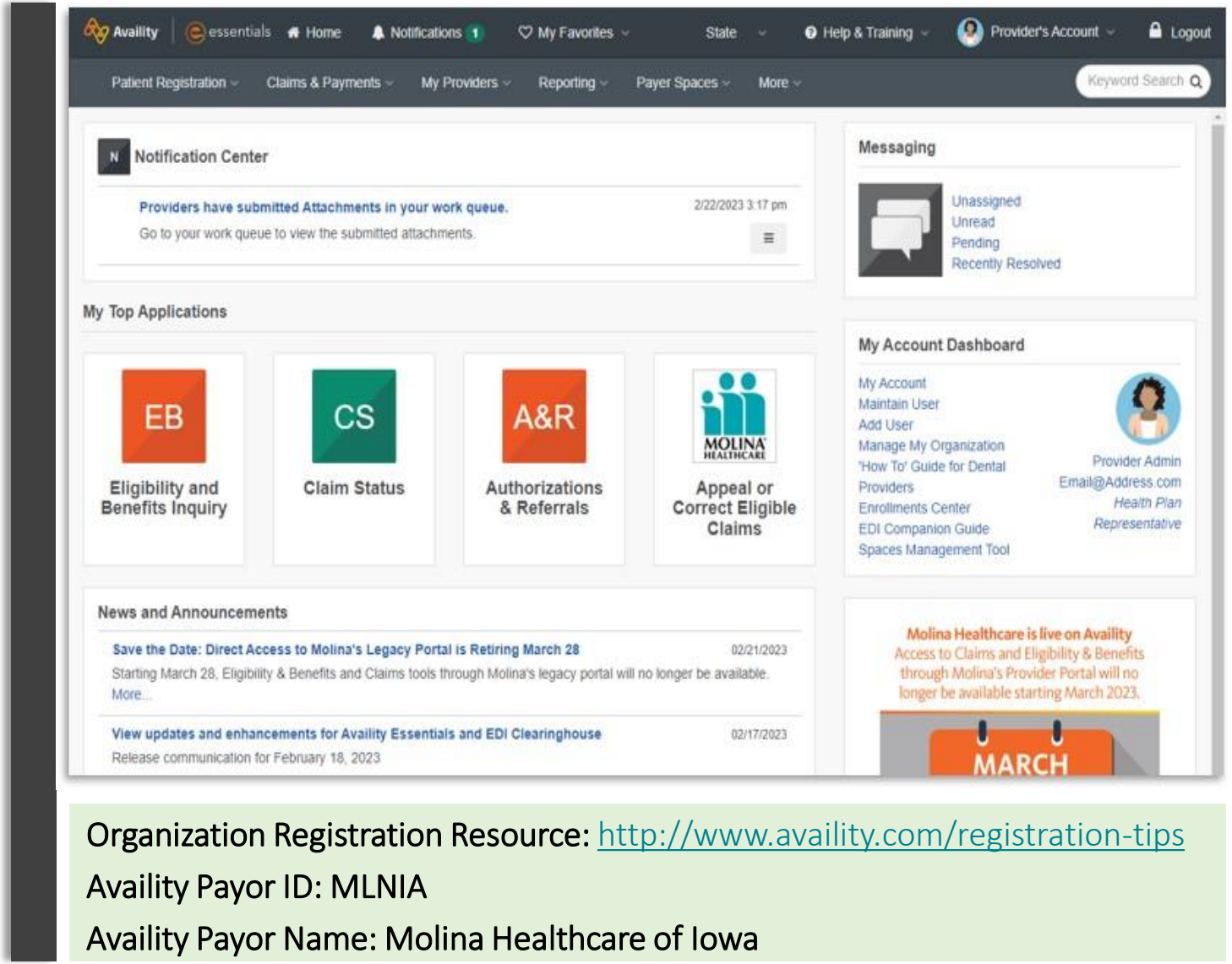
Molina Provider Portal

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.

Services Offered by Availity and Molina:

- Claim Submission/resubmission
- Claim Status
- Remittance Viewer
- Obtaining Member Eligibility & Benefits
- Submitting Authorization Requests
- HEDIS Information



Organization Registration Resource: http://www.availity.com/registration-tips

Availity Payor ID: MLNIA

Availity Payor Name: Molina Healthcare of Iowa

Verifying Member Eligibility

Providers who contract with Molina may verify a member's eligibility and/or confirm PCP assignment by checking the following:

Availity Essentials portal at https://provider.molinahealthcare.com/

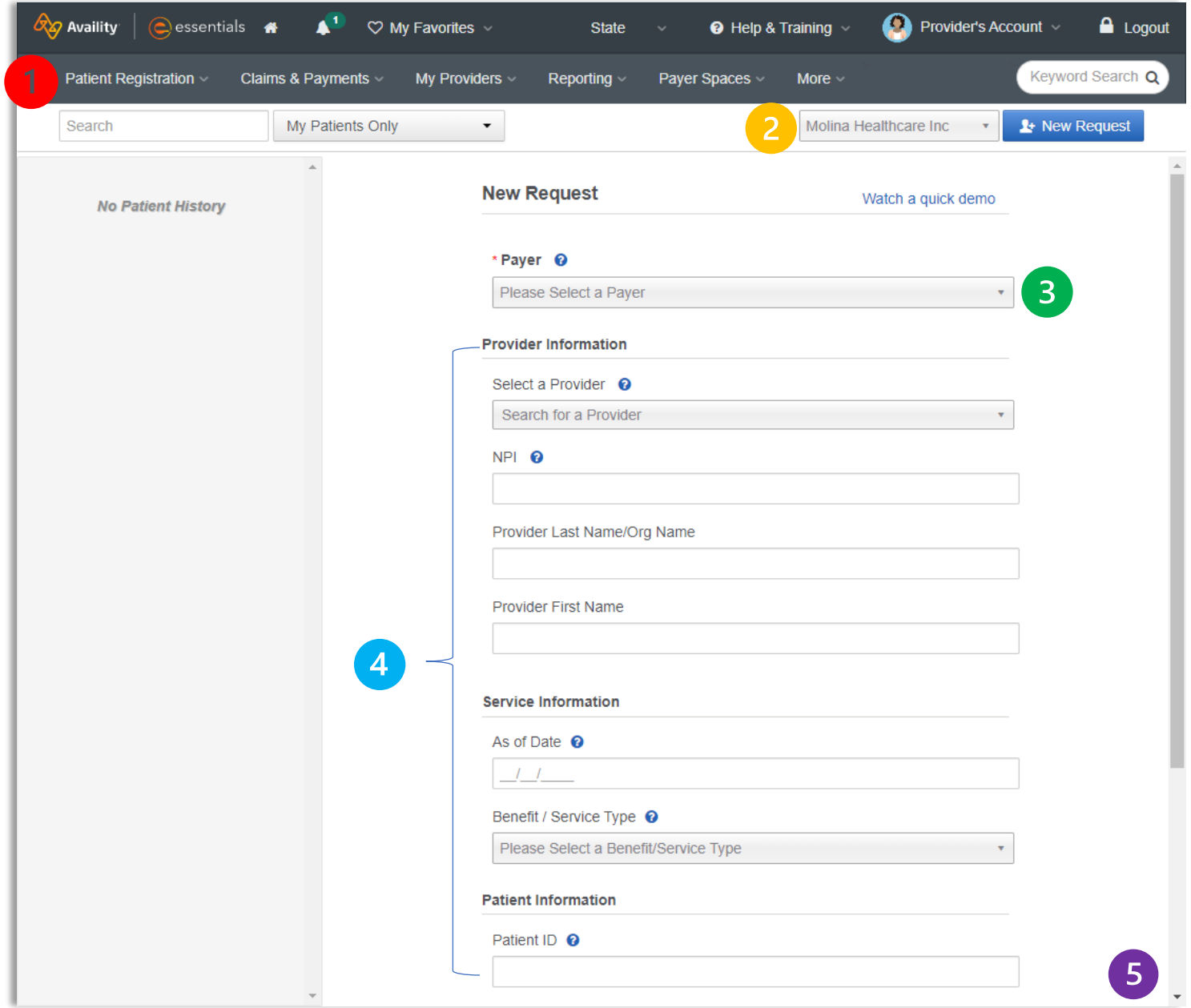
Visit ELVS portal: https://dhs.iowa.gov/ime/providers/tools-trainings-and-services/provider-tools/ELVS or Call (800) 338-7752

Medicaid Eligibility can also be verified through HHS by accessing the Eligibility and Verification Information System (ELVS)

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.

Member Eligibility Search

Select Patient Registration → Eligibility and Benefits;



Select the organization;

In the Payer field, select the payer from the pre-populated list;

Complete the fields (in order from top to bottom);

Select Submit button and explore the response results!

New Provider Online Directory

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

Molina is committed to improving your online experience. The new Provider Online Directory enhances search functionality so information is available quickly and easily.

Key benefits include:

- User-friendly and intuitive navigation
- Provider profile cards for quick access to information
- Browsing by category, search bar and common searches
- Expanded search options and filtering for narrowing results
- Provider information you can save to use later

Pharmacy

Pharmacy

Molina will align its pharmacy benefit coverage with the Iowa Medicaid Preferred Drug list (PDL), including prior authorization status, quantity limits, and days supply limits. Prior authorization criteria will also align with Iowa Medicaid.

	Pharmacy Benefit	Medical Benefit
Definition	Prescribed Drugs	Physician Administered Drugs
Billing	Point of Sale in a Pharmacy	Reimbursed by clinic billing *Must have NDC, units of service and HCPCS code*
Preferred Drug List	States required PDL Preferred Drug Lists | Iowa Medicaid PDL OR www.molinahealthcare.com	Must be on Rebate eligible list Rebatable Drug List for J-Code Billing | Iowa Department of Health & Human Services
Prior Authorization	States required criteria and forms PA Forms | Iowa Medicaid PDL OR www.molinahealthcare.com	Universal Form (must use) Prior Authorization | Iowa Department of Health & Human Services OR www.molinahealthcare.com
PA Forms Fax	877-733-3195	1-319-774-1295
Approval Process	Pharmacy UM team	Medical UM Team

Email:
IowaProviderInquiry@MolinaHealthcare.com

For Appeals & Grievances:
Molina Healthcare, Inc.
Attn: Appeals & Grievances
PO Box 93010
Des Moines, IA 50393

Provider Fax:
(855) 275-3082

Pharmacy – Prior Authorization

- Prior Authorization is required as noted on the PDL or for FDA approved drugs not found on the PDL (excluding non-covered drug categories).

- Completed prior authorization forms and supporting documentation should be faxed to Molina at 877-733-3195.

MLTSS/HCBS Services

Managed Long-Term Services and Supports (MLTSS)

What is MLTSS?

MLTSS include nursing facility care, adult daycare programs, home health aide services, personal care services, transportation, and supported employment as well as assistance provided by a family caregiver.

Who receives MLTSS?

Molina coverage provides services and supports to meet the behavioral, social, environmental and functional needs of our members who are:

- Part of an HCBS program, like a waiver or Habilitation (State Plan Amendment)
- Nursing facility residents
- Skilled nursing facility (SNF) residents
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) residents
- Residents in a nursing facility for the mentally ill (NF/MI)

MLTSS / HCBS Services and Molina

MLTSS includes both Long-Term Care (LTC) and Home and Community Based Services (HCBS).

Long-Term Care programs are when an individual is living in a facility-based care setting (such as a nursing home or intermediate care facility).

Home and community-based services programs provide alternatives to living in facility-based care settings.

These programs empower members to take an active role in their health care and to remain in the community.

The programs serve children and adults, including Older Adult population, people with intellectual and/or developmental disabilities, or people with disabilities.

Molina's MLTSS provider network is a critical component to ensuring Molina members receive the right care, in the right place, at the right time.

MLTSS / HCBS Services

Managed Long-Term Services and Supports (MLTSS) and Home and Community Based Services (HCBS) are benefits that help members stay safe and independent in their home or community.

Members can receive MLTSS services if they need help with daily healthcare and living needs and meet the level of care eligibility standards.

Iowa MLTSS/HCBS programs:

- Children's Mental Health Waiver
- Brain Injury Waiver
- Health and Disability Waiver
- Intellectual Disability Waiver
- Physical Disability Waiver
- Elderly Waiver
- AIDS/HIV Waiver

*HCBS Habilitation Services (State Plan Amendment)

MOLINA HEALTHCARE | Iowa Health Link Iowa HHS | Hawki Iowa HHS

MLTSS / HCBS Services

All MLTSS members will receive care management and be assigned a care manager from Molina.

The care management team for MLTSS will include at a minimum the member and/or their authorized representative, care manager, and PCP.

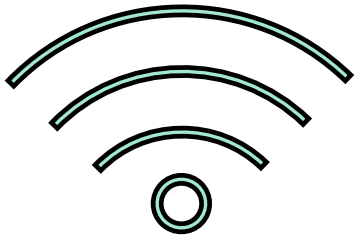
The person-centered Interdisciplinary Care Team (ICT) will include at minimum the member and/or their authorized representative, care manager, and anyone a member requests to participate.

ICT members may also include MLTSS providers, PCP, specialist(s), behavioral health clinician, Targeted Case Management service providers, and pharmacist.

The ICT can also include family/caregivers, peer supports, or other informal supports and is not limited to the list of required members.

Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) is technology used to verify and document that authorized HCBS visits occur. EVV ensures that services are delivered to the members needing services, and that billing is correct.
Molina partners with CareBridge for EVV requirements. Please visit https://hhs.iowa.gov/ime/providers/EVV for more information.



Services that are required to use EVV include, but may not be limited to:

- Attendant Care S5125
- Homemaker S5130
- Homemaker NOS S5131
- Personal Care Services T1019

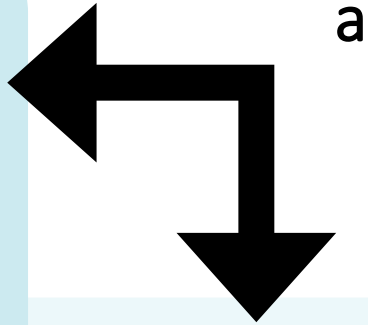
Critical Incident

Critical Incident - Defined

A critical incident is any serious or traumatic event that causes, or can cause, physical or mental harm or harm to the well-being of a person. Critical incidents are classified as abuse, neglect or exploitation.

Major (critical) incident is an occurrence involving a member that:

- Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital;
- Results in the death of any person;
- Requires emergency mental health treatment for the member;
- Requires the intervention of law enforcement;
- Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
- Constitutes a prescription medication error or a pattern of medication errors
- Involves a member's location being unknown by provider staff who are assigned protective oversight.



What constitutes as a critical incident?

Minor incident is an occurrence involving a member that is not a major incident which:

- Results in the application of basic first aid
- Results in bruising
- Results in seizure activity
- Results in injury to self, to others, or to property
- Constitutes a prescription medication error

Provider Reporting Procedure

When a major incident occurs, or a staff member becomes aware of a major incident:

The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor

- First point of contact when an incident occurs

2. The member or the member's legal guardian

- *EXCEPTION*: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The member's case manager

- Once CM becomes aware of incident, CM will follow up.
- If member is not in care management, they will be assigned to a CM for follow-up.

Provider Reporting Procedure (cont.)

By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to Molina Healthcare via email at: **IA_CM@molinahealthcare.com**.

All providers must report Major Incidents to Molina using the data elements in HHS Form 470-4698 : https://dhs.iowa.gov/sites/default/files/470-4698.pdf?010920231435

Data is collected through CHAMP, IMPA (Iowa Medicaid Portal Access) database. Analysis is performed to assess whether any individual or global trend(s) exist in various ways.

Critical Incident Workflow

Receipt

Critical Incident is entered into Molina CHAMP system

RN determines severity

Report

Incident is reported to APS, CPS, and/or other applicable state agencies

Check

Case Manager performs a safety and welfare check on the member

Update

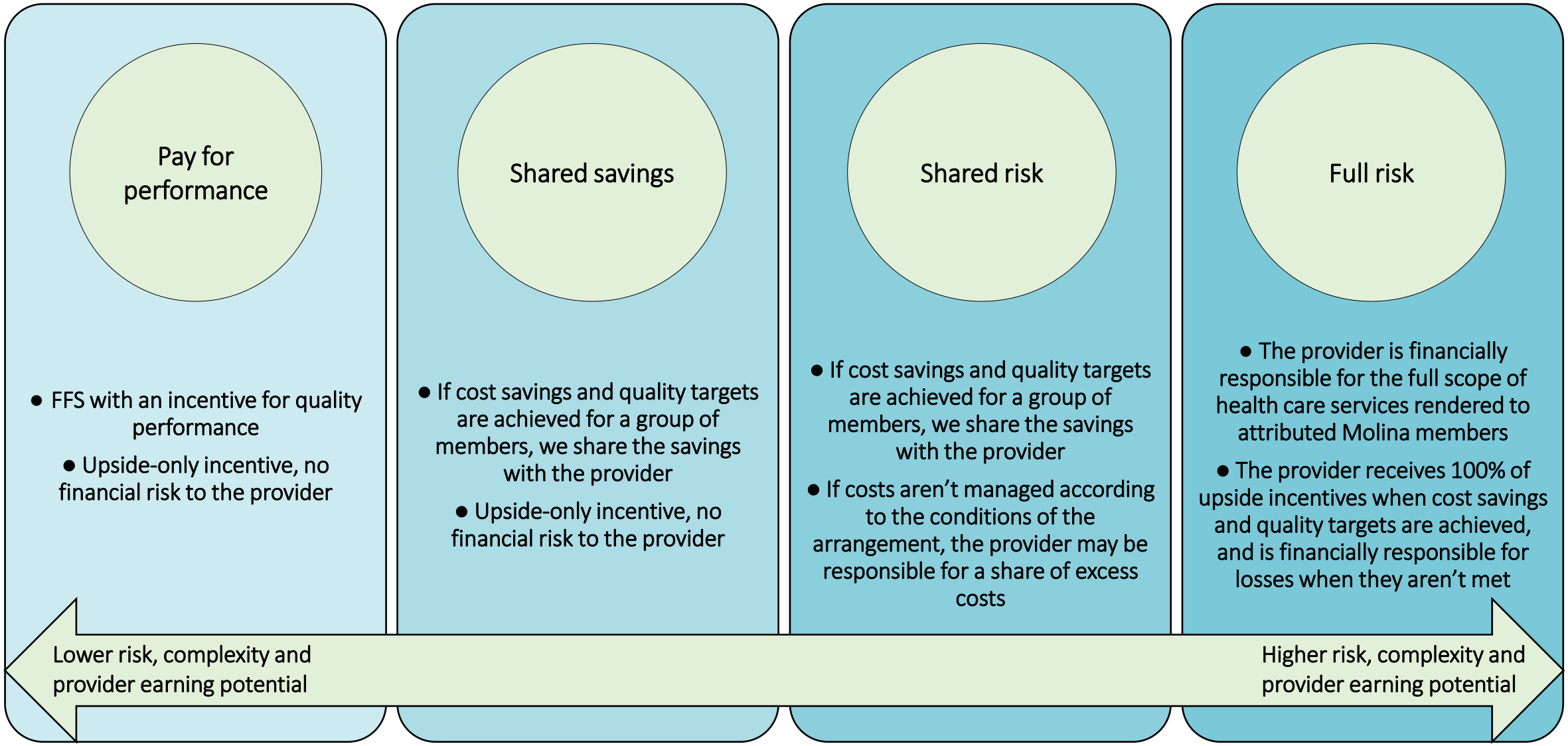
CHAMP is updated as incident details become known

Close

Incident is closed in CHAMP upon notification of resolution (as applicable)

VBP – Value Based Purchasing

Molina's VBP Continuum



Molina's Path to Value-based Purchasing Success

ASSESS

Assess provider readiness for VBP using Molina's VBP provider assessment tool

MATCH

Match providers to a VBP arrangement from our VBP menu according to readiness and specialty type

SUPPORT

Support providers via timely, accurate provider performance and feedback

RECONCILE

Reconcile payments using transparent processes

Healthcare Services

Care Management

Molina's team of Care Managers are ready to serve!

What is Care Management?

Care Management helps you make choices and decisions about your care in partnership with your family, care givers and providers

- Scheduling provider appointments
- Creating and updating patient care plans
- Getting medications

How can Care Managers help?

We put you in the center of all your healthcare decisions through an integrated approach.

- Finding community resources
- Understanding discharge plans

Finding solutions that align with your choices to meet your healthcare needs!

Care Management

High-Touch, Team-Oriented Approach

RIGHT CARE TO KNOW WHEN TO USE THE E.R.

HELPING MEMBERS EASE THE CHANGE BETWEEN CARE SETTINGS

HIGH-QUALITY OB CARE ACCESSIBILITY

VISITING MEMBERS FACE-TO-FACE IN THEIR HOMES

Care Management Roles

CASE MANAGEMENT: MEMBER-CENTERED PROBLEM-SOLVERS

INTERDISCIPLINARY CARE TEAM: COLLABORATIVE EFFORTS FOR BEST OUTCOMES

TRANSITIONS OF CARE: HIGH-TOUCH CARE FOLLOWING DISCHARGE

Care Management

Who should request Care Managers?

Members who live with chronic conditions. For example:

- Asthma
- Behavioral Health Disorders
- Chronic Obstructive Pulmonary Disease (COPD)
- Substance Use Disorder
- High Blood Pressure
- High Risk Pregnancy
- Other High-Risk Conditions

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 member's care

Transition of Care (ToC)

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

Examples:

Hospital ⟹ Rehab/Skilled Nursing Facility

Hospital/Rehab/Skilled Nursing Facility ⟹ Home

Note - Sometimes a member can use both of the above during a single episode of care

During an episode of illness in a facility, members may receive care in multiple discharge settings, which can result in fragmented and poorly executed transitions.

The Molina Healthcare ToC Program is designed to proactively identify those members at a higher risk for readmission and implement interventions to provide a safe discharge, with the goal preventing readmissions or ED visits within the first 30 days post discharge.

Transition of Care (ToC)

The ToC program provides members with a ToC Coach who follows the member closely during the first 30 days post discharge and makes a minimum of four contacts over the 30-day period.

Contacts usually occur as follows:

- 1st Contact - while in the hospital; and
- 2nd Contact - within 48 hours of discharge; and
- 3rd Contact - 7 days after the second contact; and
- 4th Contact - 14 days after the 3rd contact.

Additional contacts are made based on member needs.

Utilization Management

Our Utilization Management (UM) program functions by:

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

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.

A list of services and procedures that require prior authorization is included in our Provider Manual, and is also posted on our website: MolinaHealthcare.com/IA

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 https://www.MolinaHealthcare.com

Provider UM Req / PA Fax: 3197741295

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

Availity Essentials

Availity Essentials portal:

Participating providers are encouraged to use the Availity Essentials portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the Availity Essentials portal: https://availity.com/molinahealthcare

The benefits of submitting your prior authorization request through the Availity Essentials portal are:

- Create and submit Prior Authorization Requests
- Check status of Authorization Requests
- Access dashboard where you can easily see your authorizations and the status update.
- Attach medical documentation required for timely medical review and decision making

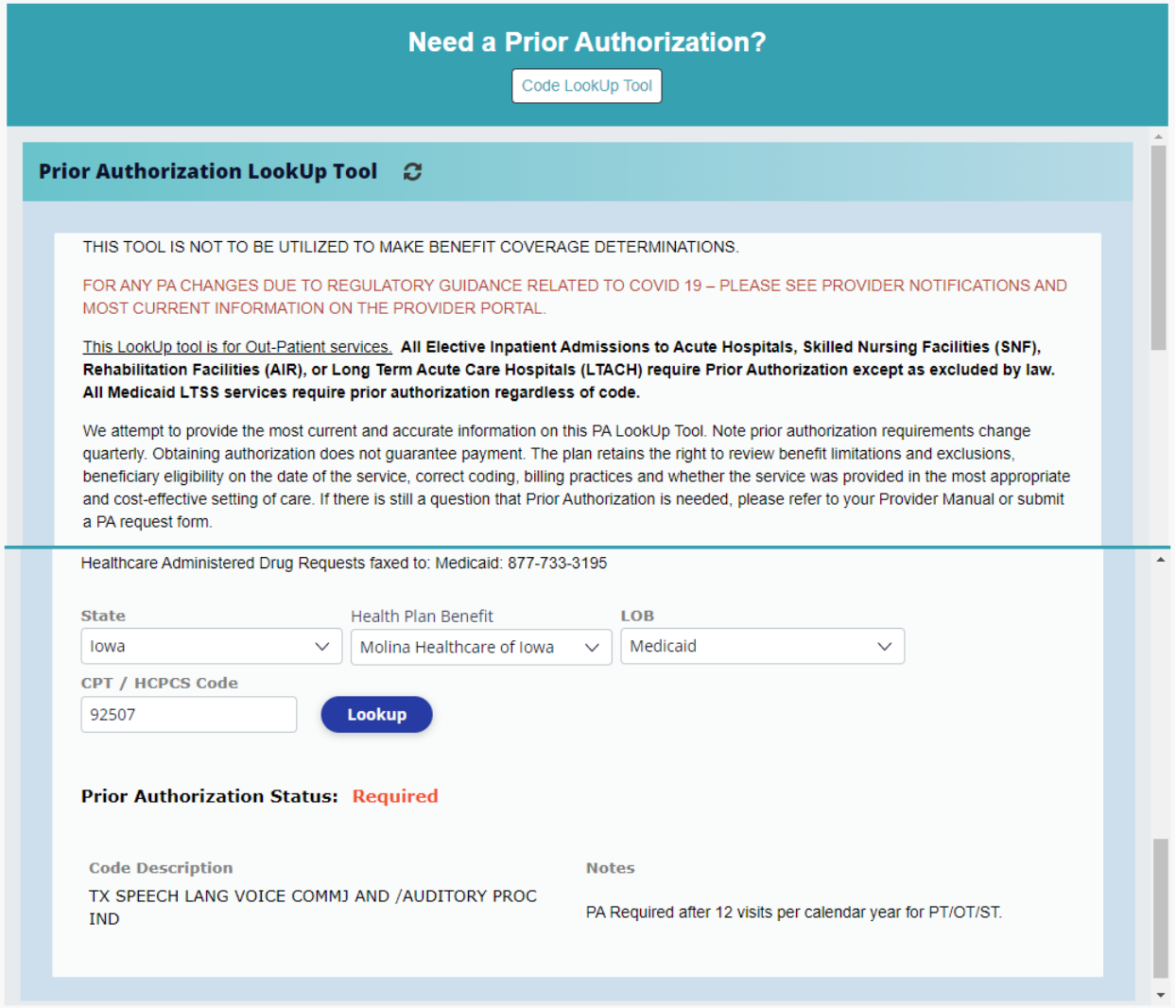
Request Responses

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

For a standard authorization request, Molina makes the determination and provides response within fourteen (14) calendar days.

For an expedited request for authorization, Molina makes a 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.

Prior Authorization Look Up Tool



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

To access the Prior Authorization Look-up Tool instructions, go to: Provider Look Up Tool Walk Through

This will also direct you to the most current Prior Authorization Guidelines and the Prior Authorization Request Form.

Prior Authorization Review Guide (cont'd)

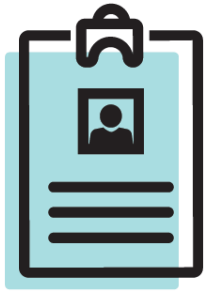
For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate inpatient review and discharge planning.

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.

We require that the notification includes:

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



*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*

Molina Healthcare Partners

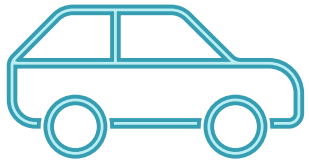
Molina Healthcare of Iowa is partnering with the following providers for our Medicaid, LTSS, and CHIP members:

Vision Services – *March Vision*	• Toll Free # : (844) 496-2724 • March Vision
Teledoc	• Virtual Care Page w/ Teledoc services FAQs • Teledoc Services
Non-Emergency Transportation – *Access 2 Care (A2C)*	• Toll Free #: (844) 544-1389 • A2C

Access2Care

Molina provides FREE non-emergency transportation so our members can get to their scheduled visits.

Unlimited round-trip or one-way trips for covered, medically necessary services each calendar year.



Call Access2Care at (844) 544-1389 to schedule a ride

*Members should call **2 business days** in advance of an appointment to schedule a free ride.*

Molina Partners – *Quest Lab*

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.
- Email reminders either in English or Spanish about upcoming tests or exams.
- 24/7 access to electronic lab orders, results, ePrescribing and Electronic Health Records.

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.

Quality

Performance Improvement

Performance Measures

Molina Healthcare captures, reviews, and analyzes various performance measures and outcomes to sustain continuous improvement in the quality of care provided to our members.

Clinical Practice Guidelines

Molina adopts Clinical Practice Guidelines and Preventive Health Guidelines to provide up-to-date treatment and diagnostic information about important clinical and preventive health topics.

We monitor performance in coordination with NCQA and state-identified focus areas.

Some focus areas include:
Adults' Access to Preventive/Ambulatory Health Services (AAP)
Follow-up After Hospitalization for Mental Illness (FUM)
Child and Adolescent Well-Care Visits (WCV)
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC)
Prenatal and Postpartum Care: Postpartum Care (PPC)
Hemoglobin A1c Control for Patients with Diabetes (HBD)
Blood Pressure Control for Patients with Diabetes (BPD)
Potentially Preventable Emergency Department Visits (3M PPV)

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

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
PCP Routine, asymptomatic	Within 4-6 weeks
PCP, persistent symptoms	Within 48 hours
PCP, Urgent Care	Within 24 hours
After Hours Care	24 hours/day; 7 day/week availability
Specialty Care (Routine)	Within 30 calendar days
Optometry Care Non-urgent	Within 3 weeks
Optometry Care Urgent	Within 48 hours
Lab and X-Ray Non-urgent	Within 3 weeks
Lab and X-Ray Urgent	Within 48 hours
Urgent Specialty Care	Within 24 hours
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:

Behavior Health Appointment Types	Standard
Life Threatening Emergency	Immediately
Mobile Crisis	Within 1 hour
Urgent Care	Within 1 hour of presentation at service delivery site or within 24 hours of telephone contact request
Persistent symptoms	Seen or referred to appropriate provider within 48 hours of reporting symptoms
Routine Care Visit	Within 3 weeks of request for appointment
Substance Use Disorder & Pregnancy (Pregnant and in need of SUD services)	Admitted within 48 hours of seeking treatment
Intravenous drug-use	Admitted not later than 14 days after request for admission, or 120 days after request if no program has capacity and interim services are made available within 48 hours
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

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

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

Cultural and Linguistic Expertise

National census data shows that the United States' population is becoming increasingly diverse. Molina has over 40 years of history of developing targeted healthcare programs for a culturally diverse membership and is well-positioned to successfully serve these growing populations by:

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

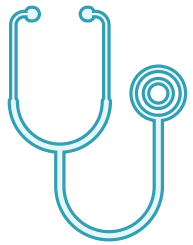
Providers are required to participate in and cooperate with Molina's provider education and training efforts as well as member education and efforts. Providers are also to comply with all health education, cultural and linguistic, and disability standards, policies, and procedures.

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

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

Nurse Advice Line

This telephone-based nurse advice line is available to all Molina members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available **(24) hours a day, seven (7) days a week** to assess symptoms and help make good health care decisions.



Nurse Advice Line (NAL)
24 hours per day, 365 days per year

(866)236-2096- TTY/TDD: 711 Relay

Note: The Nurse Advice Line telephone number is also printed on member ID cards.

Includes Behavioral Health: BH Crisis Line only

Compliance

Fraud, Waste & Abuse

Molina seeks to uphold the highest ethical standards for the provision of health care services to its members. Molina 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

This 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

This 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.

Abuse

This 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

Examples of Fraud, Waste & Abuse

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;	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; and	Concealing patients misuse of their ID Card; and
Falsifying claims.	Failure to report a patient's forgery/alteration of a prescription.

Detecting Fraud, Waste and Abuse

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: www.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:
Iowa Medicaid,
Program Integrity Unit
1-877-446-3787 or at
515-256-4615 (local)

Iowa Health and Human Services available at: https://hhs.iowa.gov/report-abuse-and-fraud

Claims

Electronic Payment Requirement

Participating providers are required to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. 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. There is no cost to the provider for EFT enrollment, and providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery processes.

Molina contracts with our payment vendor, Change Healthcare, who has partnered with ECHO Health, Inc.

You may contact ECHO Customer Service at (888)834-3511 or edi@echohealthinc.com

Electronic Payment Requirement

1. Once you have enrolled for electronic payments you will receive the associated ERAs from ECHO with the Molina Payer ID. Please ensure that your Practice Management System is updated to accept the Payer ID referenced below. All generated ERAs will be accessible to download from the ECHO provider portal: www.providerpayments.com

2. If you have any difficulty with the website or have additional questions, ECHO has a Customer Services team available to assist with this transition. Additionally, changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO Health Customer Services team at (888)834-3511.

3. Molina's Payer ID: **MLNIA**

4. Once your account is activated, you will begin receiving all payments through EFT, and you will no longer receive a paper explanation of payment (EOP) (i.e., Remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and can view, print, download and save historical and new ERAs with a two-year lookback.

5. Additional instructions on how to register are here: ECHO Enrollment

Claims

Claims Submission Options

- Molina requests that contracted providers submit all claims **electronically.**
- These are submitted via a clearinghouse using the EDI process.
- The Availity Provider Portal https://provider.molinahealthcare.com/ is available *free of charge* and allows for attachments to be included.

- Via your regular Clearinghouse - Providers may use the Clearinghouse of their choosing. (Note that fees may apply).
- ***SSI*** is Molina Healthcare's chosen clearinghouse.
- When submitting EDI Claims (via a clearinghouse) to Molina Healthcare, providers must use the applicable payer ID: ***#MLNIA***

Claims Processing Standards

These standards must be met on a **monthly basis** to ensure our providers are paid in a timely manner:

- Over 90% of *clean claims* received by Molina from our health plan network providers are processed within ***30 calendar days.***
- 100% of *clean claims* are processed within ***90 working days***.

EDI Claim Submission Issues:

- Providers can submit an email to **EDI.Claims@molinahealthcare.com.**

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

All claims shall be submitted electronically, and include medical records pertaining to the claim if requested by Molina Healthcare

Out-of-network providers = 365 calendar days after discharge from Date of Service

Corrected Claims = 365 calendar days from the last adjudication date for up to 2 years from Date of Service

Claims Submission and Disputes

Corrected Claims

- Corrected claims are considered new claims, and may be submitted electronically via the Availity Provider Portal https://availity.com/molinahealthcare, or through an EDI clearinghouse.
- Correct and Void claims must be submitted with a valid Molina Claim ID. If the ICN is blank, or does not contain a Molina Claim ID, the claim will be rejected. **277 Remark Code:**

Category Code	Status Code	Status Code Description	Entity Code	Entity code description	Error description
A3	748	Missing incomplete/invalid payer claim control number. Corrected	n/a	n/a	Invalid/Missing Original ClaimID

Claims Disputes/Adjustments

- Providers seeking a redetermination of a claim previously adjudicated must request such action within **one hundred-eighty (180) 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.

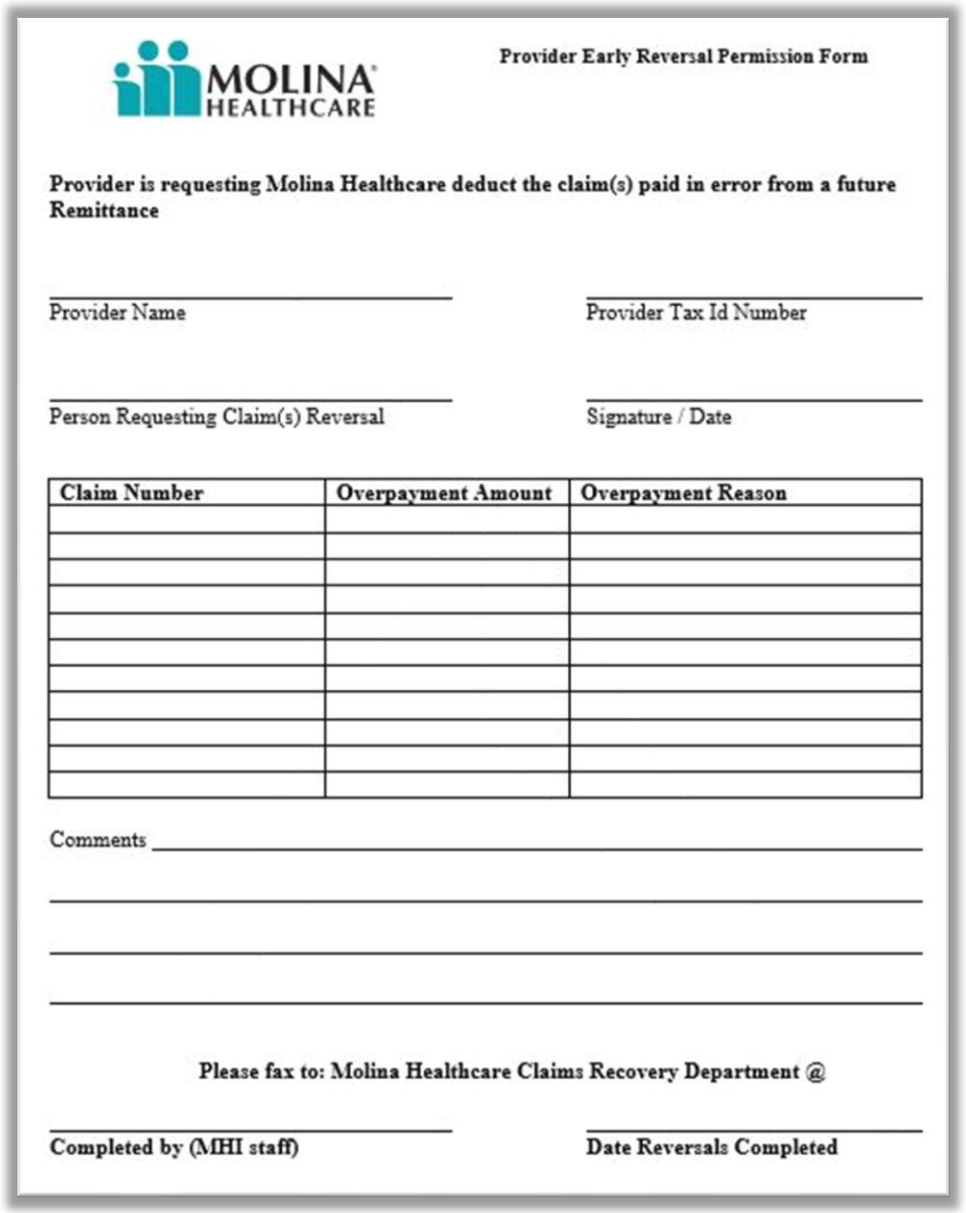
Claim Disputes & Reconsiderations

Providers are encouraged to submit claim disputes electronically, using the Availity Essentials portal.	The item(s) being resubmitted should be clearly marked as reconsideration and must include the following documentation: ▪ Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request. ▪ The Claim number clearly marked on all supporting documents.
Claim reconsiderations shall be submitted at:	Availity Essentials portal: https://provider.molinahealthcare.com/ Fax: (855) 275-3082

Overpayment Disputes

The provider will be notified of Molina's decision in writing within 60 calendar days of receipt of the Claims Dispute/Adjustment request. Overpayment Disputes should be received within 90 days of overpayment notification letter date and should be mailed to:

Molina Healthcare of Iowa
PO Box 2470
Spokane, WA, 99210-2470



MOLINA HEALTHCARE

Provider Early Reversal Permission Form

Provider is requesting Molina Healthcare deduct the claim(s) paid in error from a future Remittance

Provider Name _____ Provider Tax Id Number _____

Person Requesting Claim(s) Reversal _____ Signature / Date _____

Claim Number	Overpayment Amount	Overpayment Reason

Comments _____

_____

_____

_____

Please fax to: Molina Healthcare Claims Recovery Department @

_____ _____

Completed by (MHI staff) **Date Reversals Completed**

Claims: Coordination of Benefits and Third-Party Liability

Coordination of Benefits (COB)

Medicaid is the payer of last resort (private and governmental carriers must be billed prior to billing Molina Healthcare or medical groups/IPAs)	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

Provider can submit claims with attachments, including EOBs and other required documents, by utilizing Molina's Provider Portal

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

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 Iowa Provider Manual.

Your Provider Agreement with Molina requires that your office verifies 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.

Behavioral Health / IHH

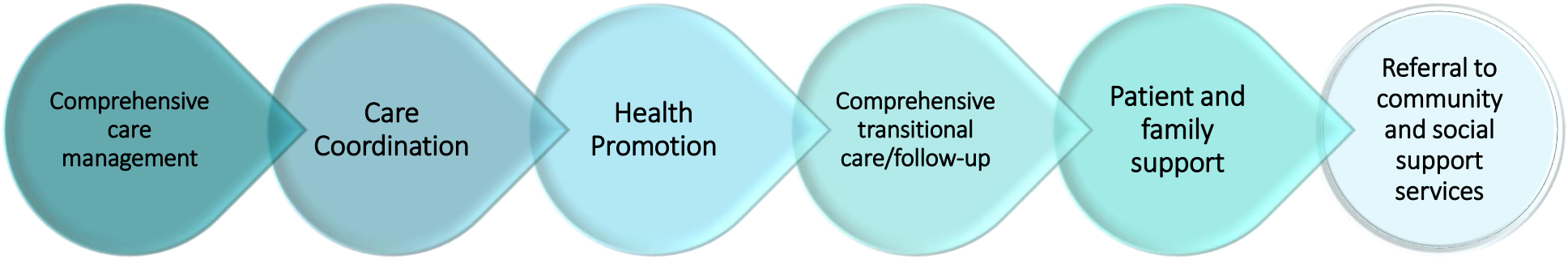
Required Behavioral Health Screening Tools

As part of the *Utilization Management Program*, providers 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 aged seven (7) years and older;
- EPSDT criteria when evaluating service requests for children;
- Level of Care Utilization System (LOCUS) scores for Mental Health Services for Medical Necessity reviews for members aged eighteen (18) years and older;
- Child and Adolescent Level of Care Utilization System (CALOCUS) scores for Mental Health services for Medical Necessity reviews for children and adolescents aged six (6) through seventeen (17) years; 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) years, or another validated assessment tool with prior approval by the State.

IHH - Defined

Six Core Services Include:



An **Integrated Health Home** (IHH) is a team of professionals, including family and peer support services, working together to provide whole-person, patient-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED).

Providers are enrolled as IHHs with Iowa Medicaid and then contracted as such with MCOs.

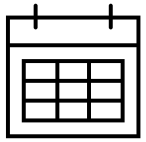
Member participation in the IHH model is voluntary.

As these services are similar to MCO Care Management, care needs to be taken to avoid duplication of services.

For more information see State On-Boarding Training Session, here: *MCO Orientation Iowa Health Home Program Final.pptx*

IHH Specialist

Dedicated Resource to support the following:



Monthly Learning Collaborative for IHH providers

Tracking Pay-for-Performance Measures

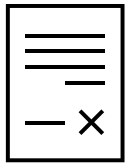
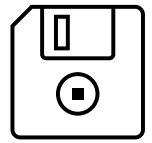
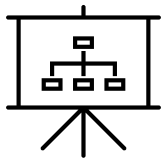


Chart Reviews of IHH Person-Centered Service Plans (PSCPs)

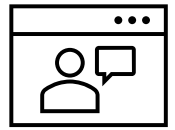
Supporting Data Sharing





Weekly MCO Logistics meetings with the State regarding the IHH Program

General training/technical assistance (TA) to IHH providers



Serve as SME to HCS staff regarding interplay of IHH with Molina care management for members on Hab or CMH Waiver

Thank you!

MOLINA HEALTHCARE

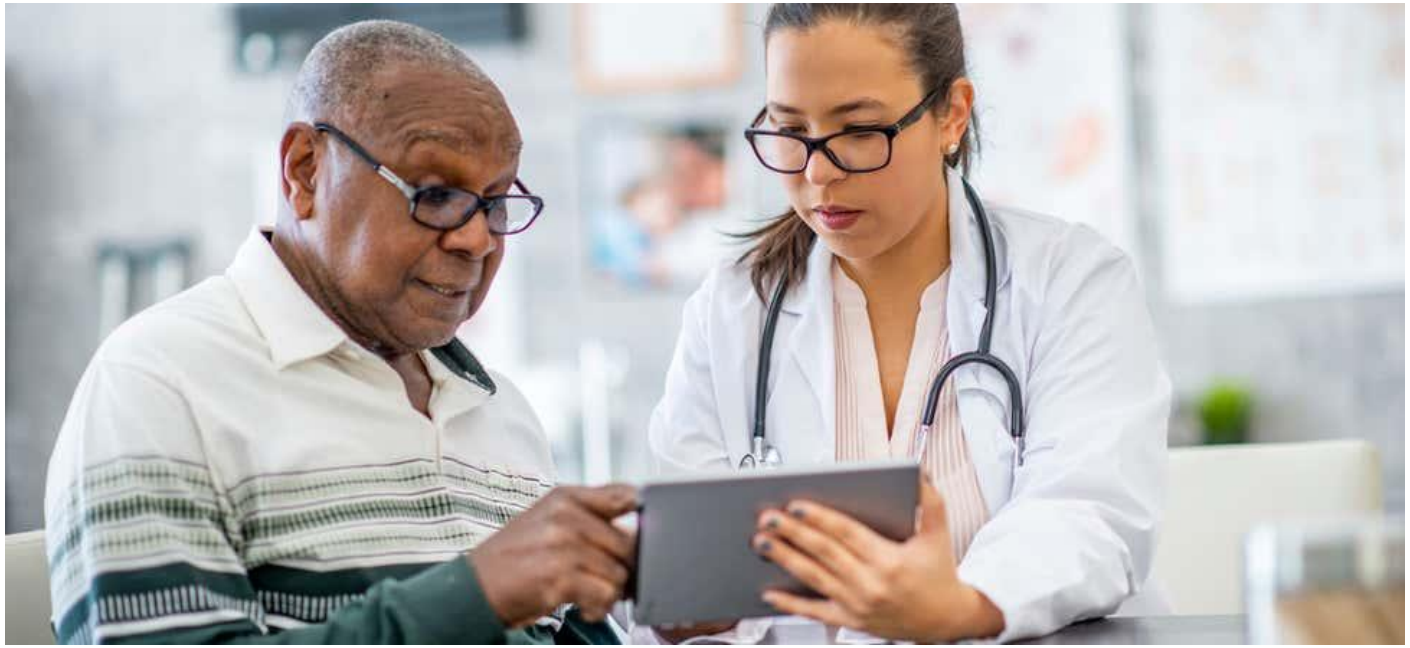
Iowa Health Link
Iowa HHS

Hawki
Iowa HHS

Questions?

Please continue further for MLTSS and Behavioral Health specific content

MLTSS Provider Specific Orientation



MOLINA HEALTHCARE Iowa Health Link Iowa HHS Hawki Iowa HHS

Intro & Overview of MLTSS

MLTSS / HCBS

Managed Long-Term Services and Supports (MLTSS) includes Long-Term Care (LTC) and Home and Community-Based Services (HCBS).

LTC: The member is living in a facility-based care setting (such as a nursing home or intermediate care facility).

HCBS: Programs that provide alternatives to living in facility-based care settings.

Molina offers MLTSS services to members of the following waiver programs:

- Persons who are elderly
- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury
- Persons in a supportive-living facility

Molina recognizes how critically important our provider network and Community-Based Organizations are to ensure our members receive MLTSS services that maintain their independence and ability to remain in the community.

Atypical Providers

Atypical providers are service providers that do not meet the definition of health care provider.

Examples include Adult Day Care, Respite Care, and Homemaker Services.

Billing Molina Members:

Providers may not bill members.

Balance billing is not allowed.

When billing Molina for MLTSS Services as an atypical provider, refer to the Provider Manual online for more detailed information: https://www.molinahealthcare.com/IA

Managed Long Term Supports and Services

Program Title	Description/eligibility
AIDS/HIV waiver	Provides services to members who have been diagnosed with AIDS/HIV
Brain Injury waiver	Provides services to members, one month old and up, who have been diagnosed with or acquired a brain injury
Children's Mental Health waiver	Provides services for children diagnosed with serious emotional disturbance
Elderly waiver	Provides services to members over the age of 65
Health and Disability waiver	Provides services to members who have been diagnosed as blind or disabled
Intellectual Disability waiver	Provides services to members diagnosed by a psychologist or psychiatrist with an intellectual disability or an equivalent mental disability
Physical Disability waiver	Provides services for members aged 18-65 that have been diagnosed with a physical disability
*Habilitation (State Plan Amendment)	Provides services that assist in self-help, socialization and adaptive skills for members diagnosed with a chronic mental illness

Managed Long Term Supports and Services

Habilitation Services	Service Description
Home Based Habilitation	Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan.
Day Habilitation	Day habilitation activities and environments are designed to foster the acquisition of skills, positive social behavior, greater independence, and personal choice. Services focus on supporting the member to participate in the community, develop social roles and relationships, and increase independence and the potential for employment. Services are designed to assist the member to attain or maintain the member to attain or maintain the member's individual goals as identified in the member's comprehensive service plan.
Pre-vocational Services	Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment.
Supported Employment	Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement. Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces.

Managed Long Term Supports and Services

Facility	Programming
Intermediate Care Facility for Individuals with Intellectual Disabilities	Provides 24-hour active treatment, cares, services, and supports for members diagnosed with an intellectual disability
Residential Care Facilities	Provides 24-hour care and services for members needing supports, excluding nursing care
Nursing/skilled nursing facilities	Provides 24-hour nursing or skilled nursing care for members

Integrated Care Management

Molina's Integrated Care Management Program (ICM)

Molina uses an integrated care management approach based on empirically validated best practices that promote high quality care to members.

The Integrated Care Management program ICM) interventions at all levels are designed to ensure that the member/member representative, family, caregivers, and providers understand key self-management concepts and ensure that member has the resources for implementation, as appropriate.

Molina strives for full integration of physical health, behavioral health, social support, and long-term services and supports (MLTSS) to eliminate fragmentation of care and provide a single, highly individualized integrated plan of care for members focusing on the abilities and preferences of each member.

Care Management:
Approach and Responsibilities

Care Management

Molina care manager will engage with members and routinely assess for barriers and opportunities to coordinate medical, behavioral health, and MLTSS services.

At a minimum, the care manager's name and their contact information and hours of availability are included in the care plan, which is shared with all Interdisciplinary Care Team (ICT) participants based on a member's recorded preferences.

All care managers are required to keep email and voicemail current with availability or backup as necessary for members and their providers.

Molina will work closely with the various Community-Based Providers and Partners for home and community-based services (HCBS) to ensure that the member is getting the care that they need. Once you have been identified as the provider of service, it will be your responsibility for billing of these services. The Person-Centered Service Plan (PCSP) will document services, duration, and any other applicable information.

Care Management

Molina will ensure the provision of the following service coordination services for the members:

- MLTSS Service Coordination
- Care and Service Plan Review
- Crisis Intervention
- Service Management
- Assessment of MLTSS Need
- Member Education

Care Manager Responsibilities

The care manager collaborates with the member and any additional participants as directed by the member to develop a Person-Centered support plan (PCSP) that includes recommended interventions from member's ICT as applicable.

Jointly, the care manager and the member/authorized representative(s) are responsible for implementing the plan of care. Additionally, the care manager:

- Monitors progress toward the member's achievement of PCSP goals in order to determine an appropriate time for the member's graduation from the ICM program.
- Assesses the member to determine if the member's needs warrant care management.
- Serves as a coordinator and resource to the members, their representative and ICT participants throughout the implementation of the PCSP, and revises the plan as suggested and needed.
- Monitors and communicates the progress of the implemented PCSP to the member's ICT as member needs warrant.
- Coordinates appropriate education and encourages the member's role in self-management.

Interdisciplinary Team & Person-Centered Service Plan:

Provider Engagement, Involvement and Guidance is Critical

Interdisciplinary Care Team (ICT)

All MLTSS members will receive care management and be assigned a care manager from Molina. The care management team for MLTSS will include at a minimum the member and/or their authorized representative, care manager, and PCP.

The Interdisciplinary Care Team (ICT) will include at minimum the member and/or their authorized representative, care manager, and anyone a member requests to participate. ICT members may also include MLTSS providers, PCP, specialist(s), behavioral health clinician, Targeted Case Management service providers, and pharmacist. The ICT can also include family/caregivers, peer supports, or other informal supports and is not limited to the list of required members.

Person-Centered Service Plan Coordination

As a provider you may be asked to be a part of the ICT. Services can be requested through the member's care manager at anytime, including during the assessment process and through the PCSP process. Service requests must be at the members direction and can be brought forward by the member, the care manger, and/or the ICT team. The Interdisciplinary Care Team (ICT) under member's direction, is responsible for developing the PCSP, and is driven by and customizable according to the needs and preferences of the member.

Continuity of Care & Claims

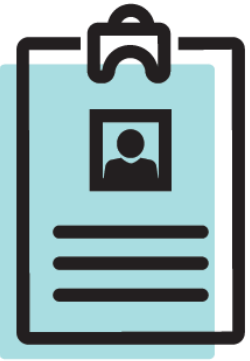
Continuity of Care (COC) Policy and Requirements

Molina will allow for the safe transition of members while adhering to minimal service disruption. Molina will honor the member's existing service plans, level of care, and providers (including out-of-network providers) until an updated service plan is completed, and either agreed upon by the member or resolved through the Appeals or fair hearing process and implemented.

During the first year of Molina's operations in Iowa Health Link, Molina will allow members using an MLTSS residential provider to continue to receive care from the residential provider being utilized at the time of enrollment for up to one year, even on an out-of-network basis.

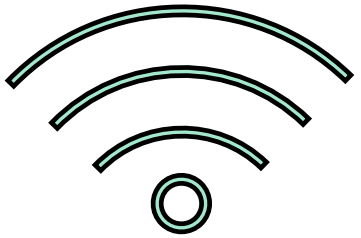
At all other times, a member's existing provider may be changed only in the following circumstances:

1. the member or member's representative requests a change;
2. the member or their representative provides written consent to transition based on quality or other concerns;
3. the residential provider has chosen not to contract with Molina; or
4. the residential provider chooses not to serve the enrolled member at the reimbursement rate offered.



Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) is technology used to verify and document that authorized HCBS visits occur. EVV ensures that services are delivered to the members needing services, and that billing is correct.
Molina partners with CareBridge for EVV requirements. Please visit https://hhs.iowa.gov/ime/providers/EVV for more information.



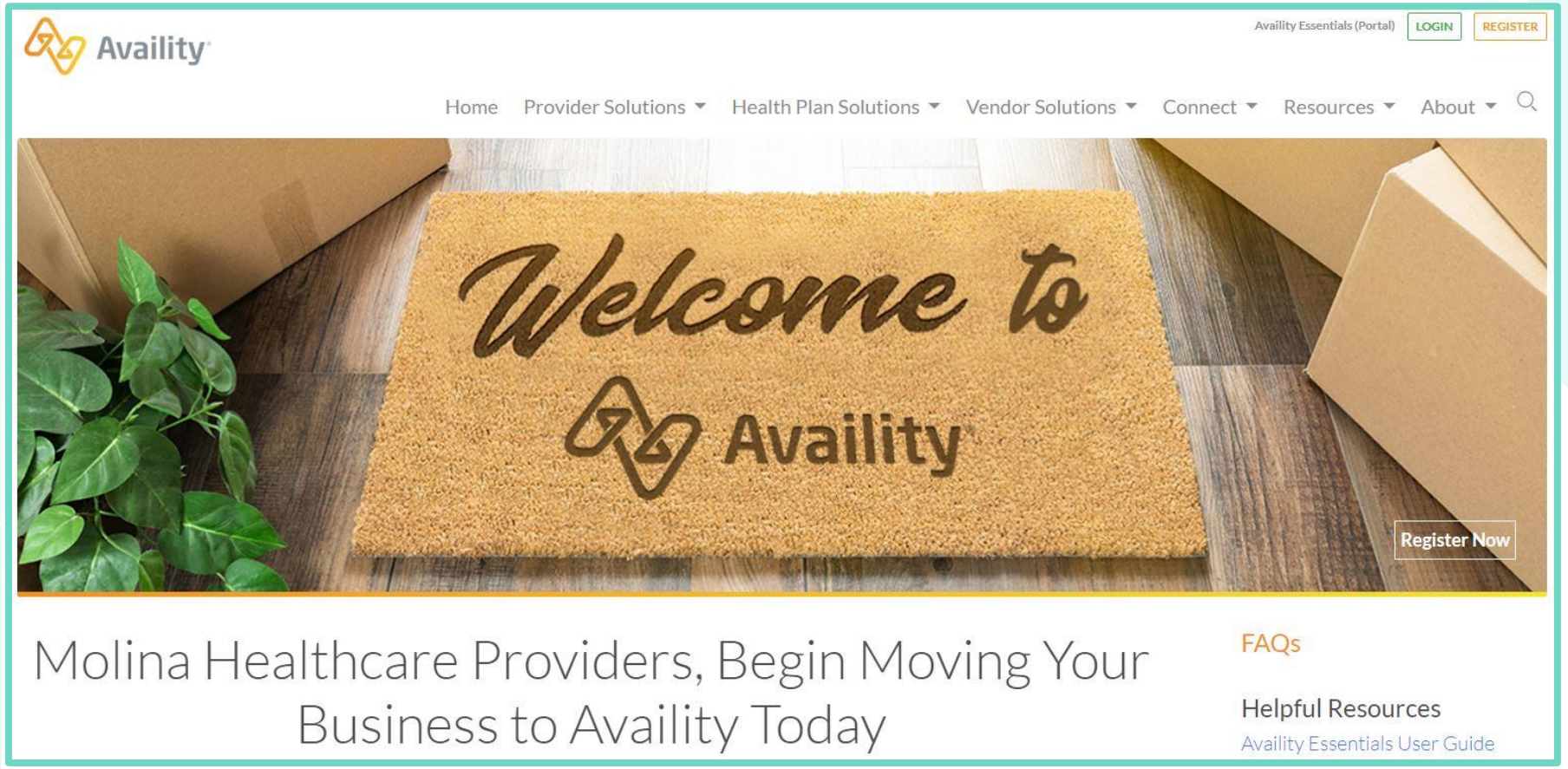
Services that are required to use EVV include, but may not be limited to:

- Attendant Care S5125
- Homemaker S5130
- Homemaker NOS S5131
- Personal Care Services T1019

Claims for MLTSS Services

Services providers are encouraged to bill Molina for all MLTSS waiver services electronically, using EDI submission, the Availity Essentials portal, or by paper Claim submitted to the correct PO Box.

The Availity Essentials portal, available at no-cost, offers additional features and benefits. After registering, a provider will be able to check eligibility, Claim status and create/submit Claims to Molina.



To register please visit: https://availity.com/MolinaHealthcare

Behavioral Health

Whole Person Care

Whole person health involves looking at the whole person—not just separate organs or body systems—and considering multiple factors that promote either health or disease.

Helping and empowering individuals, families, communities, and populations to improve their health in multiple ***interconnected*** biological, behavioral, social, and environmental areas.

Instead of treating a specific disease, ***whole person health*** focuses on restoring health, promoting resilience, and preventing diseases across a lifespan.

Behavioral health gets ***equal attention*** along with medical, social determinants of health needs/concerns for everyone!

BH Conditions Defined

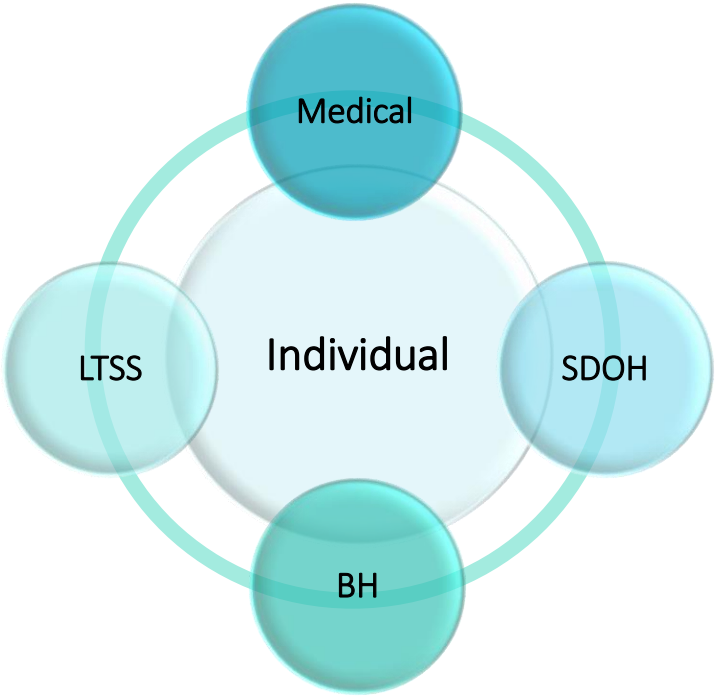
Behavioral Health = the umbrella term for mental health, substance use, and behavioral disorders like (gambling or eating disorders).

There is a very important difference between a symptom, a diagnosis and a disease – and they all matter. Depression can be:

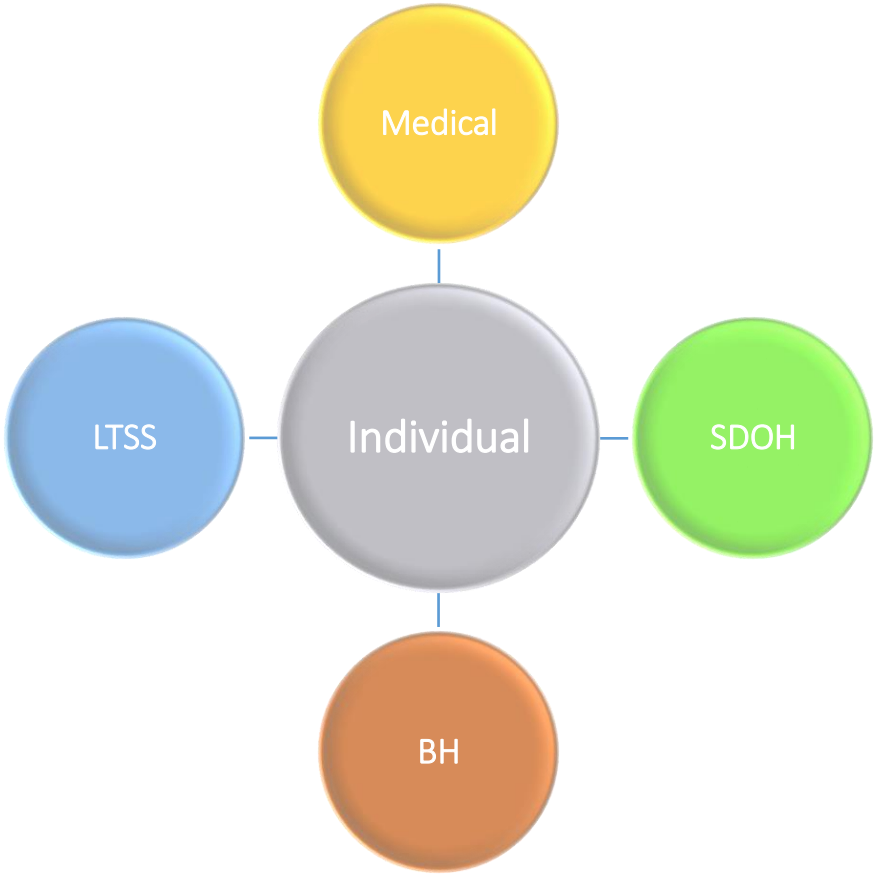
- both a symptom we temporarily experience as a mood or feeling which passes;
- can also be a diagnosis; and/or
- be a severe and persistent disease.

BH conditions tend to be rolling in terms of severity and all follow a cyclical pattern of stability/relapse/recovery.

BH Integration and Collaboration of SME



VS



Continuum Ladder of BH SME

A subject matter expert, or SME, is a person who possesses a deep understanding beyond common knowledge regarding a particular subject.

SME's may have collected their knowledge through intensive levels of schooling, or through years of professional experience with the subject.

Our goal is to employ individuals in HCS that cover the full breath of the ladder and a range of depth across the continuum within each step.

Iowa's Approach to BH in HCS

No dedicated *standalone* BH Care Management (CM) team, ***rather*** BH SME imbedded throughout teams.

Every CM will be responsible for paying attention to BH needs of their members, and enrolling members in various enterprise care models, like SMI or SUD.

Integrated *and* different!

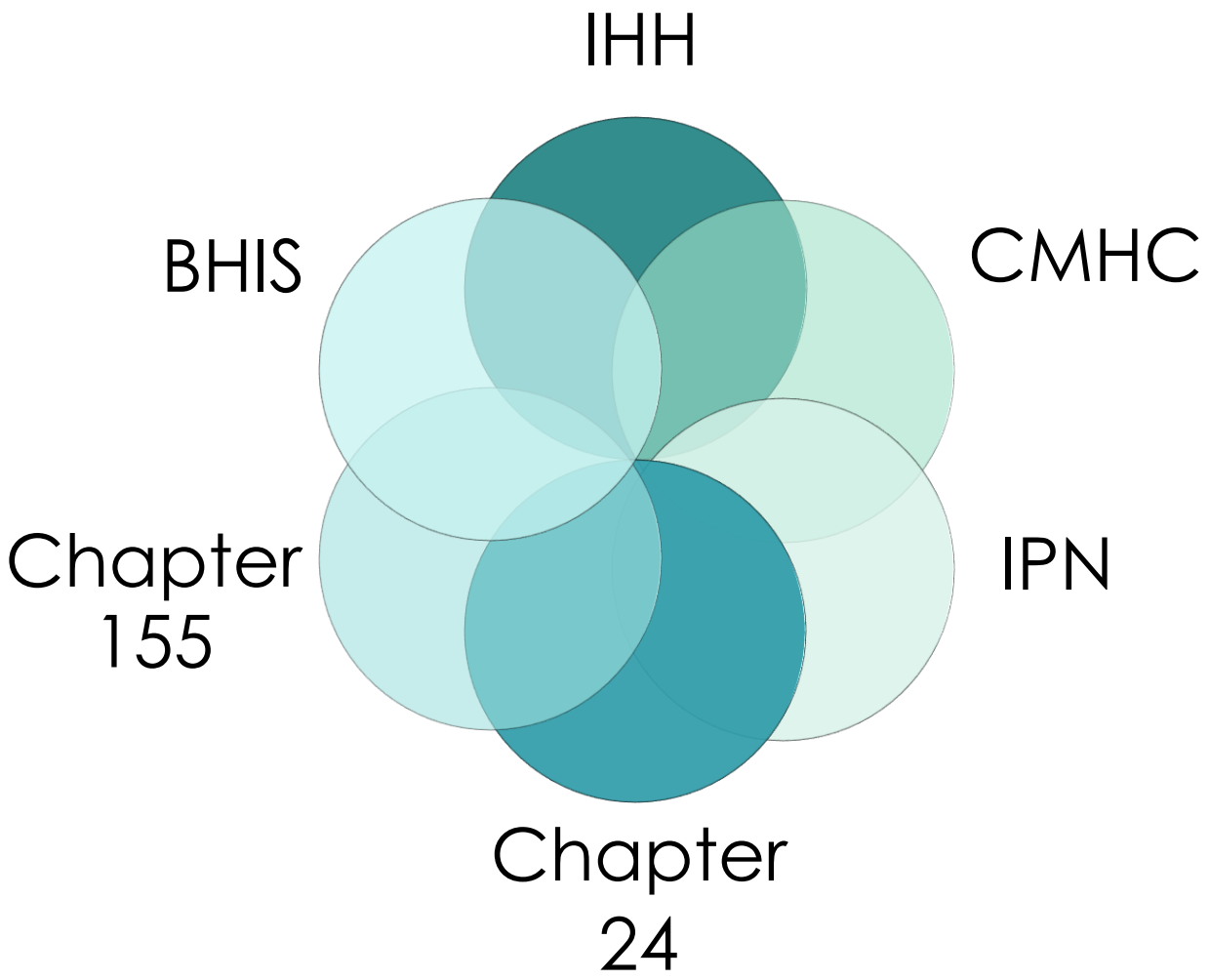
Doubles Down on Whole Person Care

Empowers CM Teams with More Tools

Fosters Collaboration

Emphasizes Relationships

Example of BH Overlapping Provider Types



IHH = Integrated Health Home

CMHC = Community Mental Health Clinic

IPN = Integrated Provider Network

Chapter 24 = MH accreditation

Chapter 155 = SUD

BHIS = Behavioral Health Intervention Services

Medicaid BH Fee Schedules & Provider Types

"B3" (no FS)

- ASAM 3.1 (H2034)
- ASAM 3.3 & 3.5 Community (H0018 TF)
- ASAM 3.3 & 3.5 Hospital (H0017 TF)
- ASAM 3.7 (H0018 TG)
- IPR (H2017)
- Community Support (H0037)
- Peer Support (H0038)
- Integrated Services (H2022)
- Respite (H0045)

CMH Waiver (HCBS FS)

- Case Management (T1017)
- Env modifications & Adapt Devices (S5165, S5199, T2028)
- Family & Community Support (H2021)
- In home family therapy (H0046)
- Respite Indv (S5150)
- Respite Group (T1005)
- Respite Camp (T2036/7)

Habilitation (HCBS FS)

- Case Management (T1017)
- Day Hab (T2020, T2021)
- Home-based Hab (H2016) Including IRSH (H2016 U7)
- Prevoc Services (T2015)
- Supported Employment (T2018, H2025)

State Plan (FS 21, 29, 48, 62)

- ABA (97151-97158)
- Day Tx (H2012)
- ECT (90870, 90871)
- PHP (H0035)
- SUD IOP (H0015)
- Misc OP BH Tx (100+ codes)

BHIS (FS 63)

- BH Res (H0019)
- Crisis (H2011)
- Skills Dev & Trng Adult (H2014)
- Skills Dev & Trng Child/Fam (H2019)

ACT (FS 48)

- ACT (H0040)

Crisis (FS 80, 81)

- Mobile Crisis (H2011)
- 23 hr Crisis Obs (S0201)
- Crisis Residential (S9484, S9485)
- Crisis Eval (90791)
- Crisis Counseling (90839, 90840)
- Sub Acute Crisis (H2013)

PMIC (FS 41)

- PMIC Bed Day (Rev Code 124)
- Home Leave (Rev Code 183)
- MH Hospital Leave (Rev Code 180)
- Elopement Leave (Rev Code 189

NIP (OP Hosp APC)

- Eating Disorder Tx (H0017)
- MH IOP (S9480)
- Day Tx (H2012)
- PHP (H0035)
- SUD Day Tx >4 hrs (H0047)
- SUD Day Tx <4 hrs (H2001)
- Rx Trng & Support (H0034)

Acute IP

- Med Detox
- IP Psych
- Psych Intern – PIC (90899 and Rev code 204)

IHH (99490)

- CCM (G0506)
- Care Coord (G9008)
- Health Promotion (99439)
- Comp Transition Care (99426)
- Ind & Fam Support (H0038)
- Referral (S0281)

Thank You!