Molina Healthcare Provider Orientation

2023

MOLINA HEALTHCARE

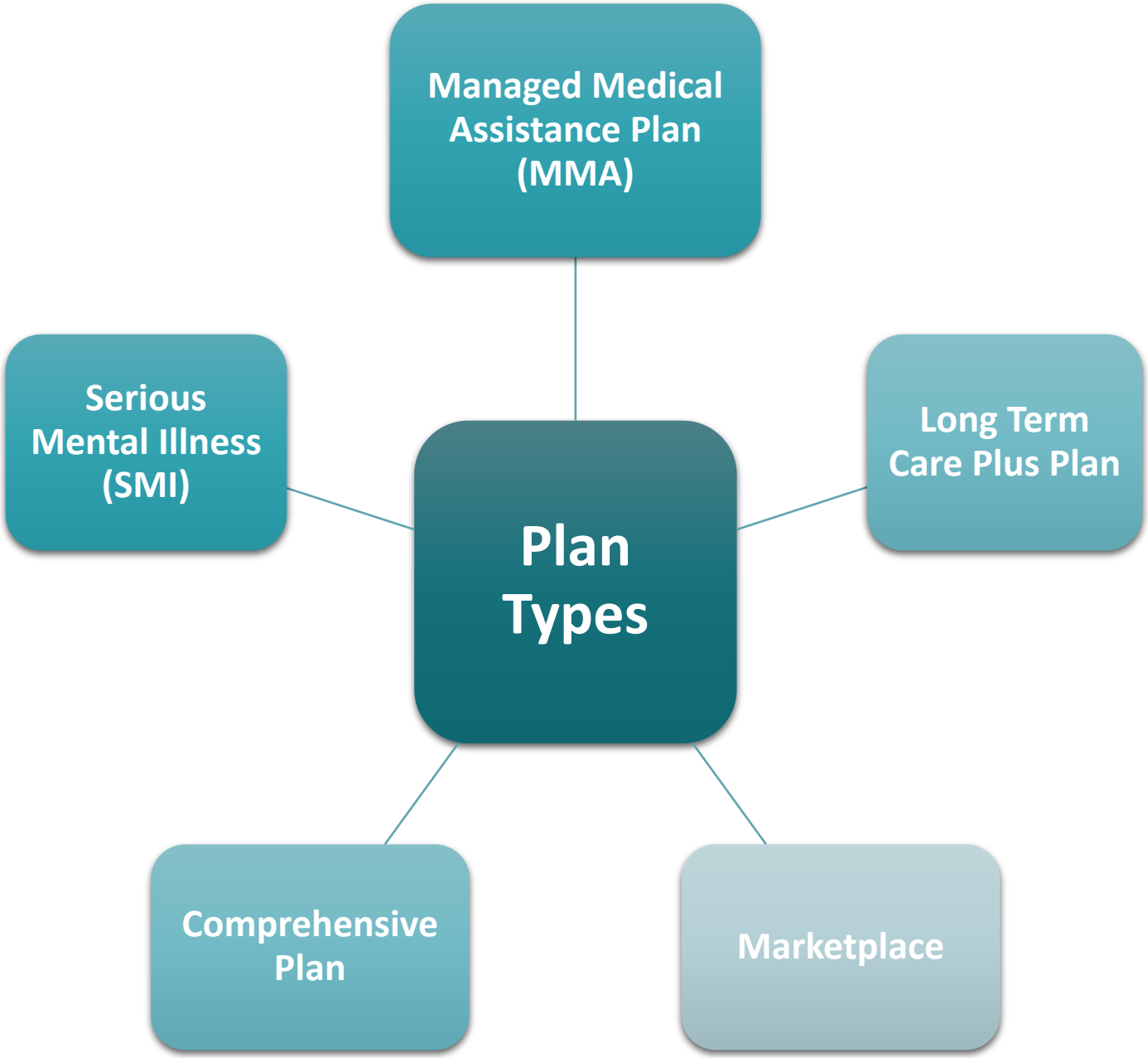
You Matter to Molina

Overview

Medicaid is the medical assistance program authorized by Title XIX of the Social Security Act, 42U.S.C. § 1396 et seq., and regulations thereunder, as administered in the State of Florida by the Agency for Healthcare Administration under s. 409.901 et seq., F.S. It is the state and federal system of health insurance that provides health coverage for eligible children, seniors, disabled adults and pregnant women.

The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as statewide Medicaid managed care (SMMC) and originally included two programs: one for medical assistance (MMA) and one for long-term care (LTC).

Molina Healthcare Plan Types



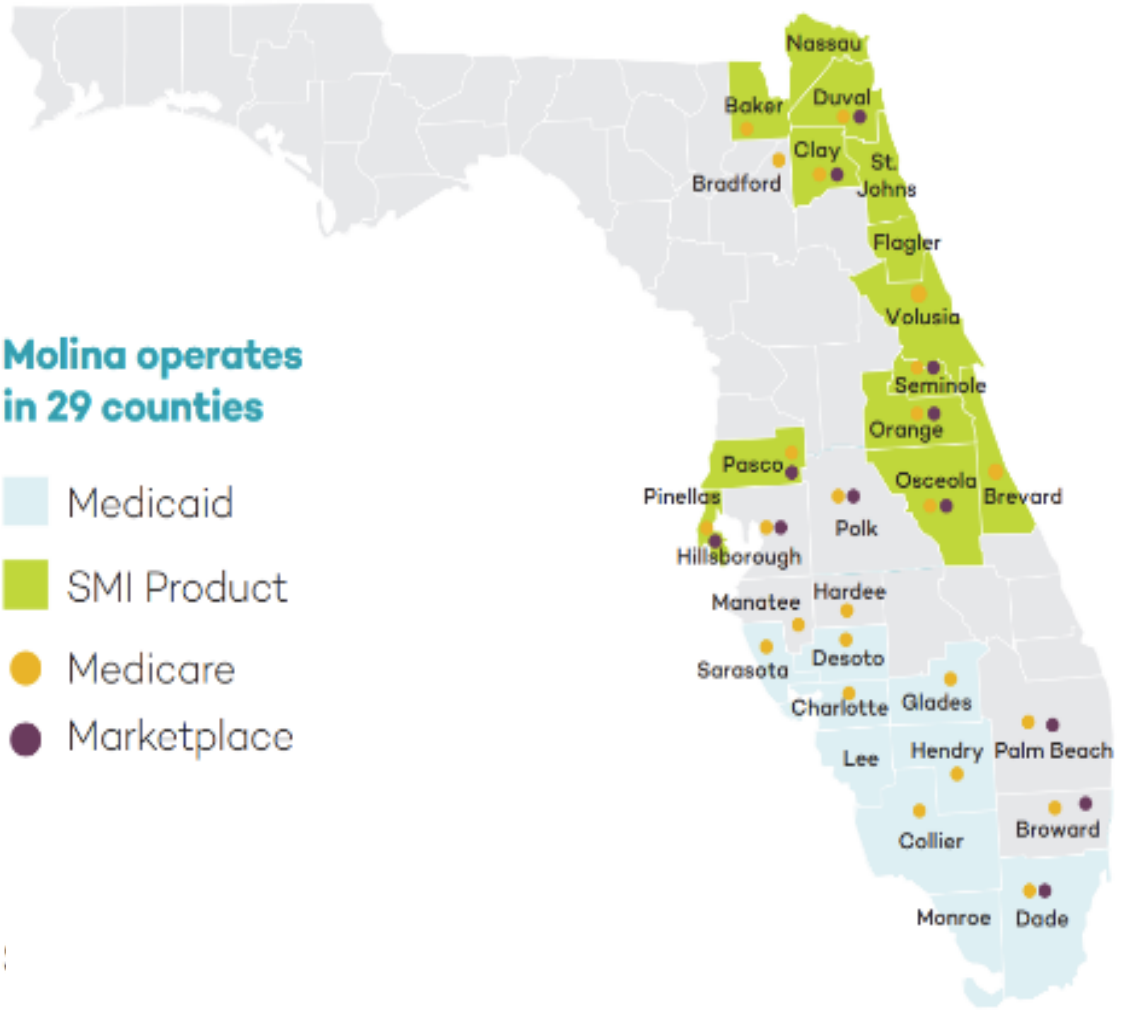
Product Service Areas

MMA/LTC:
- Charlotte
- Collier
- DeSoto
- Glades
- Hendry
- Lee
- Miami-Dade
- Monroe
- Sarasota

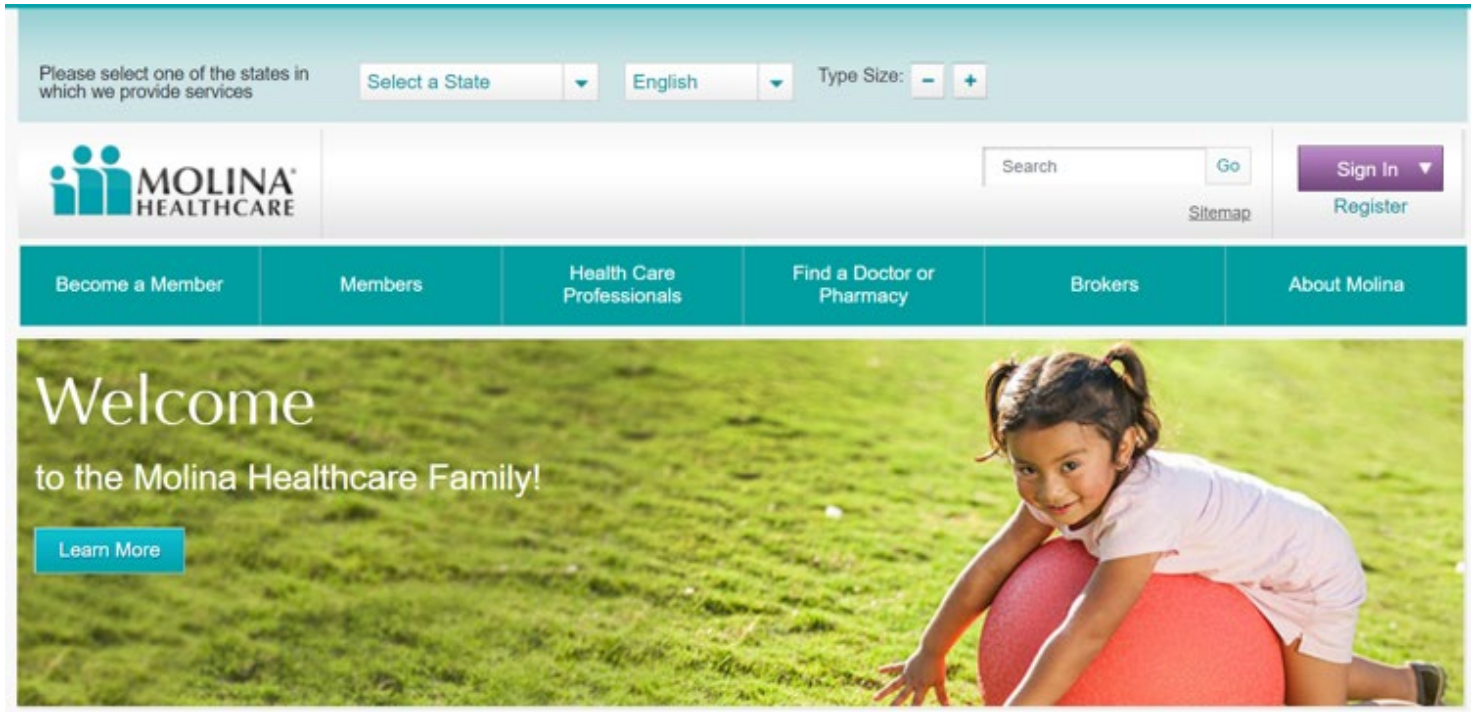
MP
- Broward
- Duval
- Clay
- Hillsborough
- Miami-Dade
- Orange
- Pasco
- Palm Beach
- Pinellas
- Polk
- Seminole

Specialty Plan
- Baker
- Brevard
- Clay
- Duval
- Flagler
- Nassau
- Orange
- Osceola
- Pasco
- Pinellas
- Seminole
- St. Johns
- Volusia

Medicare
- Broward
- Hillsborough
- Miami-Dade
- Palm Beach
- Pasco
- Pinellas
- Polk
- Baker
- Clay
- DeSoto
- Duval
- Glades
- Hendry
- Orange
- Osceola
- Sarasota
- Seminole
- Bradford
- Brevard
- Charlotte
- Collier
- Hardee
- Manatee
- Volusia



Molina FL Provider Services



The Provider Services Call Center is available Monday through Friday 8am – 5pm EST

1-855-322-4076

The Molina Provider Portal can be accessed via Availity at:
https://Availity.com/Molinahealthcare.com

Web Portal Tools

Member Eligibility	• Verify effective dates • Verify patient demographics • Download member roster (PCPs only)
Claims	• Check claim status • Submit claims
Authorizations	• Check status of an authorization • Request authorization
HEDIS	• View HEDIS rates by provider & measure
Claim Disputes	• Submit Claim Disputes
Referrals	• Submit Specialist Referrals (PCP's Only) • Review Referral Status

Availity Portal

Features

- Submit claims
- Send supporting medical documentation
- Check member eligibility and benefits, including COB
- Check HEDIS gaps or missed services with care reminders
- View claim status, electronic remittances and EOPs/EOBs
- Prior authorization submission and status reviews
- Automatic prior authorization requirement checks and real-time authorization approvals
- Claims corrections
- View PCP member rosters and patient health records
- Appeal/dispute or correct a claim
- Check your HEDIS profile for reporting on patient missed measures/gaps
- Run and retrieve/download health plan-specific reports

Not registered with Availity?

Registering your organization is easy and free. Your organization's administrator should register on https://www.availity.com/molinahealthcare

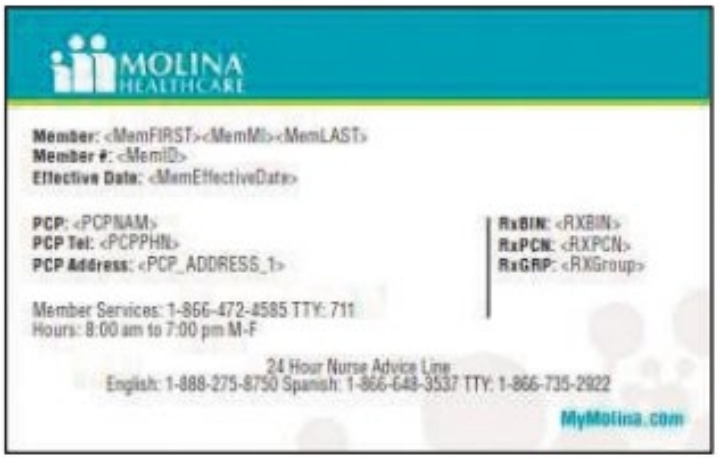
Getting started:

Once you are registered with Availity, ask your administrator for the eligibility and benefits, claims/claim status, medical attachments and messaging roles. You can always visit the Availity Learning Center for training opportunities. You can access training material from within the Availity portal by selecting Help & Training > Get Trained > Sessions.

Member Eligibility Verification

All Members enrolled with Molina Healthcare receive an identification card from Molina Healthcare in addition to the Florida Medicaid ID card. Molina Healthcare sends an identification card for each family Member covered under the plan. Members are reminded in their Member Handbooks to carry both ID cards (Molina Healthcare ID card and Florida Medicaid card) with them when requesting medical or pharmacy services.

Example:



Possession of a Medicaid ID Card does not mean a recipient is eligible for Medicaid services.

It is the Provider's responsibility to ensure Molina Healthcare Members are eligible for benefits and to verify PCP assignment, prior to rendering services.

You may verify eligibility and PCP assignment through our Availity provider portal at https://availity.com/molinahealthcare or call Molina FL Provider Services at 1-855-322-4076

Member Eligibility Verification (Continued)

Medicaid Recipients

Providers can verify eligibility for Medicaid Program recipients by calling the Automated Voice Response System (AVRS) at (800) 239-7560 or by visiting the fiscal agent's website at http://mymedicaidflorida.com. When calling to verify a Member's eligibility, Providers will need their NPI number AND 10-digit Taxonomy number OR Medicaid Provider ID number. They will also need the Member's 10-digit recipient number OR Social Security number AND Date of Birth OR 8-digit classic card control number.

Providers can also access recipient's eligibility information on the Medicaid Eligibility Verification System (MEVS) via the following:

- Provider Self Services Automated voice response (FaxBack) that generates a report with eligibility information for a particular recipient and automatically faxes to the provider's fax machine
- Automated voice response that provides eligibility information using a touch-tone telephone
- X12N 270/271 Health Care Eligibility Benefit Inquiry and Response

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

- Molina Healthcare Provider Services at (855) 322-4076
- Molina Healthcare Availity Portal, https://availity.com/molinahealthcare

Provider Handbook

Molina Healthcare of Florida's Provider Handbooks are written specifically to address the requirements of delivering healthcare services to Molina Healthcare members, including your responsibilities as a participating provider.

Providers may request printed copies of the Provider Handbook, at no cost, by contacting Provider Services at (855) 322-4076, or view/download the handbook on our website:

MMA/LTC/SPECIALTY Provider Manual

- https://www.molinahealthcare.com/providers/fl/medicaid/manual/medical
- Covered Services – Page 42
- Expanded Benefits – Page 52

Marketplace Provider Manual

https://www.molinamarketplace.com/marketplace/fl/en-us/Providers/Provider-Forms

Transportation Services

Molina Healthcare offers its members access to transportation through Access2Care Transportation. To make an appointment for a transportation service, contact A2C Transportation's reservation line at:

- MMA/Specialty/LTC: 1(888) 298-4781 - 8am – 7pm ET

Translation Services

Molina Healthcare offers oral and written translation services to assist members in communicating with providers, Molina Member Services representatives, and case managers.

These services include:

- Oral and written translation services for members with low English proficiency
- Sign language interpretation services for the hearing impaired
- Member materials in Spanish, French Creole, Vietnamese, Braille, or in audio format

Providers may request interpreter services for any Molina Healthcare Member at no cost to the provider or the Member.

If you require translation services for a Molina Member, please contact Member Services at (866)472-4585 or for the hearing impaired, 711, to make an appointment with a qualified interpreter.

Pharmacy

Molina Healthcare's drug formulary requires Prior Authorization for certain medications including injectable medications. The Pharmacy Department can answer questions regarding the formulary and/or drug Prior Authorization requests. They will also facilitate the services of Caremark Pharmacy Services for injectable medications.

Pharmacy Authorizations
Phone: 855-322-4076
Fax: 866-236-8531

Molina's decisions are based upon the information included with the PA request. Clinical notes are recommended. Some medications, such as those listed with (SP) Specialty on the Preferred Formulary require clinical notes for review. If clinical information and/or medical justification is missing, Molina will either fax or call your office to request that the clinical information be sent for review. To avoid delays in decisions, be sure to complete the PA form in its entirety, including medical justification and/or supporting clinical notes.

Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting www.MolinaHealthcare.com or calling Molina at (855) 322-4076.

Molina Pharmacy Prior Authorization Form:
https://www.molinahealthcare.com/providers/fl/PDF/Medicaid/forms_FL_PARequestForm.pdf

Pharmacy (Continued)

Preferred Drug Lists

Molina covers those drugs and dosage forms listed in the formularies below.

Agency For Healthcare Administration's Medicaid Preferred Drug List (PDL):
ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml

Molina Marketplace Preferred Drug List (PDL):
www.molinamarketplace.com/marketplace/fl/en-us/-/media/Molina/PublicWebsite/PDF/members/fl/en-us/Marketplace/formulary-2021.pdf

In Office Labs

Molina's providers' of laboratory services are Quest Diagnostics and LabCorp

Quest Diagnostics
866-MYQUEST (866-697-8378)
www.questdiagnostics.com

LabCorp
800-845-6167
www.labcorp.com

Molina allows only specific laboratory tests in the physician's office. All other medically necessary laboratory testing must be directed to Quest by the ordering physician.

For a list of approved in-office tests, visit Molina's website at www.molinahealthcare.com

This list includes most tests currently performed in the office by our network providers, and tests generally considered essential ("stat") for immediate diagnosis and treatment. Claims for tests performed in the physician office, but not on Molina's list of allowed in-office laboratory tests will be denied.

For more information about In-Network Laboratory Providers, please consult the Molina Provider Directory on our website.

For testing available through In-Network Laboratory Providers, or for a list of In-Network Laboratory Provider patient services centers, please reach out to the In-Network Laboratory Provider.

Emergency Services

Emergency services are covered 24 hours a day, 7 days a week, 365 days a year for all Members experiencing an emergency medical situation.

No authorization is required.

When a Member presents at a hospital seeking emergency services and care, the determination that an emergency medical condition exists shall be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital physician.

If member is being observed or admitted, an authorization is required

Alternatives to the Emergency Room

While MFL covers emergency services, we ask that you tell members about appropriate emergency room use. There are levels of care that may be suited to meet the member's medical need.

Some of these alternative options are:

- Participating Urgent Care Services
- Telehealth Services
- Molina Nurse Advice Line
  - English Phone: (888) 275-8750
  - Spanish Phone: (888) 648-3537

Urgent Care Services

Life-threatening situations require the immediate services of an emergency department.

A PCP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fevers, coughs, colds, and sore throats. If a member calls you after hours asking about urgent care, and you can't fit them in your schedule, refer them to an urgent care center.

Urgent care can provide quick after-hours treatment and is appropriate for infections, fever, and symptoms of cold or flu.

Urgent care services are covered and do not require prior authorization when accessing participating facilities.

Telehealth Services

Telehealth provides care for your patient without an in-person office visit. Telehealth is done primarily online with internet access on your computer, tablet, or smartphone.

Common telehealth care options include:

- Lab test or x-ray results
- Therapy and online counseling
- Recurring conditions like migraines or urinary tract infections
- Skin conditions
- Prescription management
- Urgent care issues like colds, coughs, and stomach aches
- Post-surgical follow-up

Telehealth Provider Requirements

All providers that provide Telehealth services must comply with the following:

- Fraud, Waste & Abuse Policies & Procedures
- Medical Record Documentation Requirements
- Audio/Visual (A/V) Equipment must provider real-time 2-way A/V live communication.
  - ➢ Phone Calls, Faxes, Chart Reviews do not count
- HIPAA and Privacy Laws
- Equipment and operations must comply with the technical safeguards in ***45CFR 164.312***
- Provider Training on Telehealth Requirements

All Molina providers that wish to provide this service must attest that they have reviewed and meet these requirements in order to offer Virtual Health.

The Telehealth Attestation is found on Molina's website at: https://www.molinahealthcare.com/providers/fl/medicaid/forms/fuf.aspx

Nurse Advice Line

This telephone-based nurse advice line is available to all Molina Healthcare Members. Members may call anytime they are experiencing symptoms or need health care information.

Registered nurses are available 24 hours a day, 7 days a week to assess symptoms and help make good health care decisions.

HEALTHLINE 24-Hour Nurse Advice Line
English Phone: (888) 275-8750 Spanish Phone: (866) 648-3537
TTY: (866) 735-2929 or 711 (English) (866) 833-4703 (Spanish)

Behavioral Health Services

Members in need of Behavioral Services can be referred by their PCP for services or members can self-refer by calling Molina's Behavioral Health Department at (855) 322-4076. Molina's Nurse Advice Line is also available 24 hours a day, 7 days a week for mental health or substance abuse needs. The services members receive will be confidential. Additional detail regarding Covered Services and any limitations can be obtained at www.molinahealthcare.com.

Members having a behavioral health emergency who cannot get to a Molina approved provider are directed to do the following:

- Go to the nearest emergency room.
- Call the number on ID card.
- Call Member's PCP and follow-up within 24 to 48 hours.

For out-of-area Emergency Services, plans will be made to transfer Members to an in-network facility when Member is stable.

Substance Abuse Services

Physicians must be familiar with the signs and symptoms of abuse to make the diagnosis and provide therapies for acute intoxication and withdrawal along with resources for long-term treatment. Although many of the signs and symptoms of substance abuse can be caused by other diseases, the differential diagnosis should include drug abuse. PCPs are required to screen members for signs of substance abuse as part of preventative evaluation at the following times:

- Initial contact with a new enrollee;
- Routine physical examinations;
- Initial prenatal contact;
- When the Member evidences serious over-utilization of medical, surgical, trauma or emergency services; and when documentation of emergency room visits suggests the need.

The Behavioral Health Toolkit for Providers was designed to offer guidance regarding mental health and substance use conditions commonly seen in the primary care and community setting.

Assessment and Diagnosis of Behavioral Health Conditions in the Primary Care Setting including:

- Depression
- Suicidality
- Substance Use Disorders (Alcohol and Other Drugs) and Opioid Use Disorders
- Anxiety
- Dementia and Alzheimer's
- Attention Deficit/Hyperactivity Disorder (ADHD)

Substance Abuse Toolkit (molinahealthcare.com)

Behavioral Toolkit (molinahealthcare.com)

Substance Abuse Services

What 24/7 crisis support services are available to members?

- Molina offers 24/7 Telehealth crisis intervention services in partnership with Impower. MMA and SMI members can call (689) 688-9875 to speak with a clinician who will send the member a link to begin a virtual telehealth session.

How are referrals made to BH providers?

- BH referrals do not require a PCP referral. To locate a participating BH provider, use the provider directory at: MFL Provider Directory or call into our Member Call Center **866-472-4585**

How are referrals made to case management and social service programs?

- Maternity: MFLCaseManagement@MolinaHealthCare.Com
- Non-Maternity: MFL-SP@MolinaHealthCare.Com

Screening, Brief Intervention, & Referral To Treatment

Substance Abuse and Mental Health Services Administration (SAMHSA) SBIRT codes have been added to the Medicaid Practitioner Fee Schedule. The codes are applicable to fee-for-service and managed care. At this time, only physicians and physician extenders can render SBIRT services. This includes the following provider types:

25 – M.D. 26 – D.O. 29 – PA 30 – APRN

Code	Description
H0049	Alcohol and/or drug screening
H0050	Alcohol and/or drug screening, brief intervention, per 15 minutes

Procedure Codes

H0049 can be used once per day, as medically necessary and is not limited by age. H0050 is allowed for 0-4 units per day, as medically necessary, and is not limited by age.

The place of service is open for office visits, telehealth, all hospital settings and clinics, and ambulatory surgical centers.

The new SBIRT codes are intended to be used in primary care and other medical settings. These services may be performed and billed in addition to an Evaluation and Management (E&M) service when provided during the same visit.

Behavioral Health Online Screening Tools

Online screening tools that are available

Molina endorses the use of the PHQ-9 (Patient Health Questionnaire 9 Questions), a standardized depression screening tool with established clinical validity. The PHQ-9 screening tool, scoring instructions and description of depression risk levels (low/maintenance level; moderate; high/severe) can be found on the SAMHSA website at https://www.integration.samhsa.gov/clinical-practice/screening-tools

BH Toolkit - Depression Screening and Follow-up (molinahealthcare.com)

SBIRT is Screening, Brief, Intervention, and Referral to Treatment. Molina promotes the use of the CAGE-AID to screen for alcohol and other drug abuse & dependence. You can obtain a copy of the CAGE-AID, as well as background and metrics directly on the SAMHSA website at https://www.integration.samhsa.gov/images/res/CAGEAID.pdf. The CAGE-AID questionnaire is used to test for alcohol and other drug abuse and dependence in adults. The tool is not diagnostic but is indicative of the existence of an alcohol or other drug problem.

Behavioral Toolkit - Assessment and Interventions for Substance Use and Opioid Use Disorders

Psych Hub - A Comprehensive Multimedia Platform for Mental Health Education

Psych Hub is available to all Molina Providers

- It is an online platform for digital mental health education
- Providers can access Psych Hub's free micro-video library containing over 180+ consumer facing, animated videos
- The videos focus on improving mental health literacy and reduce stigma on seeking behavioral health care
- Videos are available with subtitles in English, Spanish, French and Portuguese
- Registration and access is easy
    - Provider Link https://app.psychhub.com/signup/molina-mhp/
    - Select "MENTAL HEALTH PRACTITIONER HUB" to create a profile
    - Search and take courses of interest

Behavioral Health Resources

What telehealth services are available to members?

Provider Contact
www.teladoc.com 800-835-2362
Brave Health - Specialists in behavioral health (bebravehealth.com) 305-902-6347

BH referrals do not require a PCP referral.

- To locate a participating BH provider, use the provider directory
- Call into our Member Call Center **866-472-4585**

How are referrals made to case management and social service programs at Molina?

- Maternity: MFLCaseManagement@MolinaHealthCare.Com
- Non-Maternity: MFL-SP@MolinaHealthCare.Com

Please refer to our provider directory for our network of behavioral health/substance abuse specialists

Assisted Living Services

Effective **March 1, 2023**, Molina Healthcare of Florida manages and pays claims for Assisted Living Facilities services for Long-Term Care and Comprehensive (MMA & LTC) products.

You may mail the claims to:

Molina Healthcare of Florida

PO BOX 22812

Long Beach, CA 90801

or you can register to the provider portal for electronic claim submissions. You can register in the Availity Portal at: provider.molinahealthcare.com

For the Assisted Living Training and Billing guidelines, please visit our provider resource and training section at Resources & Training (molinahealthcare.com)

All services requested must adhere to Molina's Prior Authorization guidelines.

Assisted Living Services (Continued)

Assisted Living Facility Billable Codes

An Assisted living facility (ALF) is designed to provide personal care services in the least restrictive and most home-like environment. ALF services include personal care services, homemaker, chore, attendant care, companion care, medication oversight, and periodic nursing evaluations

Assisted Living Facility Billing Codes:

The Following codes are included below to assist you in billing for ALF services provided. Please refer to your contract with Molina Health Care in order to determine your contracted and covered codes.

Billing Codes:

Procedure Code	Description	Date Span Example	# Of Units
T2030	Assisted Living Services/Month	3/1/23 – 3/1/23	1
T2031	Assisted Living Services/Per Day	3/15-23 – 3/31/23	17
T2033	Bed Hold Days	3/15/23 – 3/28/23	14

Skilled Nursing Facility (SNF)

Billing Guidelines

SNF's should bill in accordance with Florida Medicaid guidelines

Billed Days	Revenue Code
Long Term Care Days	0101
Hospital Leave Days	0185
Home Leave Days (Therapeutic Bed Hold Days)	0182

Home Health, Home Infusion, Durable Medical Equipment (DME)

Coastal Care Services

- Coastal Care Services manages, credentials, and pays claims for DME, Home Health, and Home Infusion services for Molina's Medicaid, Medicare, and MP members.
- Coastal Care Services is not used for Long-Term Care authorizations or claims.
- Please ensure that all services requested adhere to Molina's prior authorization guidelines.
- Claims should be **sent directly to Coastal Care Services**. Any claims for the above services will be denied by Molina and redirected to Coastal Care Services.

Durable Medical Equipment (DME)

Billing Guidelines

All DME, medical supplies must be:

- Medically necessary, and
- Functionally appropriate for the individual recipient, and
- Adequate for the intended medical purpose, and
- For conventional use, and
- For the exclusive use of the recipient

DME items requested or supplied must not duplicate or perform the same function as other durable medical equipment or medical supplies currently in the recipient's possession.

Medical necessity documentation must specify the type, quantity, and frequency of need for consumable medical supplies prescribed by the recipient's treating physician or the treating physician's prescribing ARNP or Physician Assistant.

Home Health Services

Billing Guidelines

- ✓ Remember to bill in accordance with HCPCS description
- ✓ Units billed must be the total time for the Dates of Service
- ✓ Home Health agencies must bill for services on a daily basis.
- ✓ Dates of service may not span over various days.

Doula Services

Doula Services are provided by a professional trained in childbirth who can provide emotional, physical, and educational support to a mother who is expecting, is experiencing labor, or has recently given birth. The doula's purpose is to help women have a safe, memorable, and empowering birthing experience.

Molina Healthcare covers doula services as an expanded benefit for Managed Medical Assistance (MMA), Specialty, and Comprehensive (MMA/LTC) members.

Please review the Doula Billing and Reimbursement Guidelines on our website.

molinahealthcare.com/providers/fl/medicaid/comm/training.aspx

Physical, Speech, and Occupational Therapy

Molina Healthcare of Florida partners with American Therapy Administrators of Florida/Health Network One (ATA-FL/HN1) as its therapy vendor.

All services other than initial evaluations will require prior authorization and providers will be required to follow ATA-FL's Prior Authorization process.

Authorizations may be requested via:

- **Fax:** 1-855-410-0121
- **Phone:** 1-888-550-8800
- **Secure Portal**: asp.healthsystemone.com/pwprequestform/?id=ataflorida

*Excludes Early Interventions Services

Physical, Speech, and Occupational Therapy (Continued)

Claims

All claims for physical, speech and/or occupational therapy services rendered must be submitted to ATA/HN1 in one of the following formats:

- **Electronic (EDI)** – Change Healthcare/Echo Health
  - ATA Payer ID: 65062
  - molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/fl/medicaid/ECHO_HEALTH_PROVIDER_PORTAL_USER_GUIDE.pdf
- **Paper** – CMS 1500 Form

American Therapy Administrators of FL/Health Network One
PO Box 350590
Fort Lauderdale, FL 33335-0590

- **Availity Portal** – provider.molinahealthcare.com/

Therapies are billed in units. A unit of service consists of a minimum of 15 minutes of face-to-face therapy treatment between the therapist or therapy assistant and the recipient.

Ex: 1 Hour/Day = four 15-Minute Sessions/Day = 4 Units/Day

Providers may submit a claim for payment for a Prior Authorized procedure after the service has been approved and provided.

For more information on HN1/ATA-FL, please visit: www.ATAFlorida.com under *Provider Resources*.

Radiology Services

Prior Authorization Requirements

Routine imaging such as X-Rays do not require Prior Authorization*

Imaging such as CT, MRI, MRA, PET, SPECT require Prior Authorization*

Diagnostic procedures are covered when the member is inpatient in the hospital

ALL Elective Services in a Hospital setting will require Prior Authorization.

**Please refer to Molina's Prior Authorization Guide and Codification Document for more information.*

Radiology Services

MCG Auto Auth

Molina Healthcare of Florida has a self-service method for our Medicaid Line of Business to submit Advanced Imaging Prior Authorization requests. This system can be accessed electronically via the provider portal and will be available 24 hours per day, 7 days per week. This method of submission will be an alternative to the existing fax/phone/email process. Clinical information will be submitted for review by our plan. This system will provide more efficient processing of your authorization request, and the status of the authorization will be available immediately upon completion of your submission.

Again, this service will be available only for your Medicaid Advanced Imaging Prior Authorization requests.

If you wish to learn more about MCG Cite AutoAuth, please visit MCG's website at mcg.com or call 888-464-4746.

Case Management Services

- Case Managers are licensed Registered Nurses (RNs) who are educated, trained and experienced in the case management process.
- Arranges individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services.
- Assesses Member appropriateness for the CM program and notifies the PCP of the evaluation results
- Makes recommendation for a treatment plan

The following conditions may qualify a Member for case management:

- High-risk pregnancy, including a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease)
- Preterm births High-technology home care requiring more than two weeks of treatment Member accessing ER services inappropriately
- Children with Special Health Care Needs

Contact us to make a Case Management referral

Phone: (855) 322-4076
Fax: (866) 440-9791

Specialty Plan

This is a Medicaid specialty plan and is part of the Statewide Medicaid Managed Care program specializing in the care of those with Serious Mental Illness (SMI).

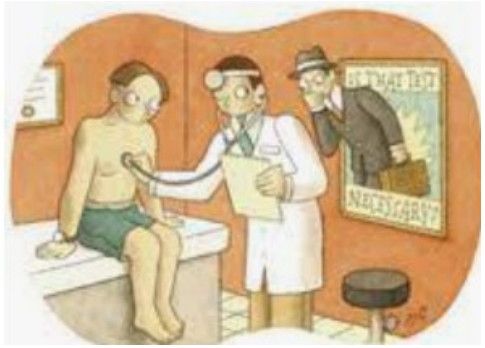
Eligibility Criteria:

- ✓ Member must be eligible for Medicaid and have been diagnosed with a serious mental illness.
- ✓ Member must be age 6 or older
- ✓ Member must be in Region 4, 5, or 7
- ✓ Member must be diagnosed with Schizophrenia, Schizoaffective Disorder, Delusional Disorder, Bipolar Disorder, Major Depression or Obsessive-Compulsive Disorder (OCD) and be treated with a medication commonly used to treat the disorder.

Specialty Plan members receive MFL ID cards reflecting “Specialty Plan”.

Medical Necessity

Pursuant to FS 409.9131 (2) (b)“Medical necessity” or “medically necessary” means any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice.



For purposes of determining Medicaid reimbursement, the agency (AHCA) is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided.

Prior Authorization Requests

Send requests for prior authorizations to the Utilization Management Department using the Molina Healthcare of Florida Prior Authorization Guide and Service Request Form included in your Welcome Kit and also available on our website, at:

Medicaid:

Molina Healthcare MCD 2023 PA Guide

Marketplace:

https://www.molinahealthcare.com/providers/fl/marketplace/forms/Pages/fuf.aspx

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

Medicaid/Marketplace Fax: (866)-440-9791

Prior Authorization Requests (Continued)

Urgent vs Non-Urgent Requests

Urgency is reserved for those tests required to prevent serious deterioration in the member's health or ability to regain maximum function. Urgent status may also be appropriate if, in the opinion of the ordering provider with knowledge of the member's medical condition, delay would subject the member to severe pain that cannot be adequately managed without the care or treatment being requested.

Requests outside of this definition should be submitted as routine/non-urgent.

Molina Healthcare of Florida will process all “non-urgent” requests in no more than 7 calendar days of the initial request. “Urgent” requests will be processed within 72 hours of the initial request.

Providers who request prior authorization approval for patient services and/or procedures can request to review the criteria used to make the final decision.

Providers may request to speak to the Medical Director who made the determination to approve or deny the service request.

Prior Authorization Requests (Continued)

Supporting Documentation

Molina Healthcare requires prior authorization for all elective services rendered in a hospital setting for all lines of business. Authorization for elective services should be requested with supporting clinical documentation at least 7 days prior to the date of the requested service.

Authorization for emergent services should be requested within 1 business day.

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, consultations and/or Plan of Care (PoC)
- ✓ Any other information or data specific to the request

All chart notes relevant to the prescription request **must** be submitted along with the completed Prior Authorization form to avoid delays in processing due to insufficient information or lack thereof.

Please Note: If you receive an Authorization request denial for "*no chart notes submitted*", please attempt to resubmit your request instead of submitting an appeal, as proper clinical review did not take place.

Continuity of Care

Members involved in an active course of treatment have the option to complete treatment with the provider who initiated care. The lack of a contract with the provider of a new member or terminated contracts between Molina Healthcare and a provider will not interfere with this option.

Molina honors any written documentation of prior authorization of ongoing covered services for a period of up to **60 days** after the effective date of enrollment. Written documentation of prior authorization of ongoing medical and behavioral health services shall include the following, provided that the services were arranged prior to enrollment with Molina Healthcare:

- ✓ Prior existing orders
- ✓ Provider appointments (ie transportation, dental appointments, surgeries, etc.)
- ✓ Prescriptions
- ✓ Prior authorizations
- ✓ Treatment plan

Continuity of Care (Continued)

Continuation of care may not exceed six (6) months after the termination date of the provider.

Molina shall continue the entire course of treatment with the recipient's current provider for the following services which may extend beyond sixty (60) days continuity of care period:

- Prenatal and postpartum care
- Transplant services
- Oncology (Radiation and/or Chemotherapy services from the current round of treatment)
- Full course of therapy Hepatitis C treatment drugs

Pregnant members who have initiated a course of prenatal care may continue to receive care from a terminated provider through the completion of pregnancy and postpartum period, regardless of the trimester in which care was initiated.

Requests for continued care should be submitted to the Utilization Management Department at:

Phone: (855) 322-4076
Fax: (866) 440-9791

Continuity of Care may not apply if a provider is terminated for cause.

Encounter Data

Each capitated provider/organization delegated for claims processing is required to submit Encounter data to Molina for all adjudicated claims.

Encounter data must be submitted **at least once per month, and no later than seven (7) days** following the date on which Molina adjudicates the claims in order to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including:

- ANSI X12N 837I – Institutional,
- 837P – Professional, and
- 837D -- Dental

Data must be submitted with claims level detail for all non-institutional services provided. For institutional services, only those services covered by Molina should be reported.
Providers must correct and resubmit any encounters which are rejected (non-HIPAA compliant) or denied by Molina. Encounters must be corrected and resubmitted within **fifteen (15)** days from the rejection/denial.

Claims

Submission

Providers may submit claims to Molina Healthcare on paper or electronically, using a current version CMS-1500/UB-04 or the electronic equivalent. Providers may also use our Availity Portal to submit claims.

Marketplace/Medicaid/LTC Claims Submission Address
Molina Healthcare of Florida
P.O. Box 22812
Long Beach, CA 90801

Medicare Claims Submission Address
Molina Medicare
P.O. Box 22811
Long Beach, CA 90801

EDI Claims Submission – All LOB's
Change Healthcare ID# 51062
Change Healthcare Telephone (877) 469-3263

Availity Portal
https://www.availity.com/molinahealthcare

Claims (Continued)

Timely Filing

F.S. 641.3155 requires that Participating providers submit all claims within six (6) months of the date of service. Network providers must make every effort to submit claims for payment in a timely manner, and within the statutory requirement.

Corrected Claims may be submitted at any time during the timely filing period of the provider contract.

Claims (Continued)

Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service within **6 months** after receipt of Clean Claims.

The receipt date of a Claim is the date Molina receives notice of the Claim.

Electronic Funds Transfer

Providers are encouraged to enroll in Electronic Funds Transfer (EFT) in order to receive payments promptly.

Molina Healthcare's EFT provider is **Change Healthcare/ProviderNet.**

To enroll, visit: https://enrollments.echohealthinc.com/EFTERAInvitation.aspx?tp=MDAzMDg=

To Register for EFT, providers will need the following:

- Last Molina check*
- Name of the Bank Institution
- Bank Routing and Account Number
- Provider NPI
- Provider Tax ID
- Provider Billing Address (pay-to address)
- Voided check

*Providers must have received at least one paper check prior to enrolling for EFT

Balance Billing

Participating providers shall accept Molina Healthcare's payments as payment in full for covered services. Providers may not balance bill the Member for any covered benefit, except for applicable copayments, coinsurance, and deductibles, if any.

Your office is responsible for verifying eligibility and obtaining approval for those services that require authorization.

In the event of a denial of payment, providers shall look solely to Molina Healthcare for compensation for services rendered.

Provider Disputes and Appeals

Any disagreement regarding the processing, payment or non-payment of a claim is considered a Provider Dispute. To file a provider dispute, providers may contact Customer Service at (855) 322-4076, or send the request for review in writing, along with any supporting documentation to:

Molina Healthcare of Florida
Appeal and Grievance Unit
P.O Box 36030
Louisville, KY 40233-6030
Fax: 877-553-6504

Provider disputes must be received within one (1) year of the date of payment or denial of the claim. All provider disputes will be reviewed confidentially, and the outcome will be communicated in writing within sixty (60) days or receipt of the provider dispute.

Provider Disputes and Appeals – Quick Tips

Disputes (Underpayments, Bundling)

Claim disputes are typically disputes related to overpayment, underpayments, untimely filing, missing documents (i.e. consent forms, primary carrier explanation of benefits) and bundling issues.

- Overpayment & Underpayments are based on the individual contract and/or Medicaid Fee Schedules
- Disputes can be submitted via phone, fax, provider portal, or by mail.
- Our Molina provider portal is our preferred method of delivery. It's important that all supporting documents are included.

Disputes impacting more than 10 claims can be submitted via email to:
MFLClaimsDisputesProjects@MolinaHealthCare.com

Appeals (Authorization, Medical Necessity)

- Appeals are those related to denial of authorization.
- Appeals can only be submitted in writing (fax, email, mail) or in-person.
- Our Molina provider portal is our preferred method of delivery. Its important that all supporting documents are included

Appeals can be submitted via email to:
MFL_ProviderAppeals@MolinaHealthCare.com

CD Format are always preferred, in order, to reduce large printing and cost of shipping.

Capitol Bridge

If the Provider Dispute/Appeal results in an unfavorable decision, and the provider has additional documentation supporting their position, the provider may resubmit the Provider Dispute/Appeal for secondary review. Providers may request a review of their original appeal by the State's independent dispute resolution organization:

Capitol Bridge
Email Submissions to: FLCDR@capitolbridge.com
Tel: (800) 889-0549

Quick Facts

- Must be received within (1) year of payment or denial
- Disputes/Appeals shall be resolved within 60 days
- Provider Disputes/Appeals Fax (877)553-6504
- Provider Toll-Free Number (855)322-4076
- New and Corrected Claims* mail to:

P.O. Box 22812
Long Beach, CA 90801

*A corrected claim is not a dispute or an appeal.

Disputes and Appeals Documentation Requirements

Disputes/Appeals Documentation Requirements, including Claims Projects (10 or more affected claims), are as follows:

- Member Name
- Member ID
- Date of Service
- Billed Charges
- Amount Molina has paid
- Account Balance
- Rendering Provider, NPI and Tax ID
- Pay to Group, NPI and Tax ID
- Service code or CPT code
- Comments or category from the provider
- Line of Business
- Claim Number

To avoid delays in processing, all claim disputes/appeals must include supporting documentation (i.e. Proof of Timely Filing, Explanation of Benefits from Primary Carrier (COB Claims), Invoices, Medical Notes, Consent Forms, etc.

What is EVV?

Electronic Visit Verification (EVV) electronically captures:

- That a home care agency employee provided the agreed-upon point-of-care service
- The time that a visit began and ended
- The individual who received the service
- The date and location of the provided service

Other benefits of EVV technology solutions include the ability to:

- Reduce missed visits and late starts
- Improve patient care and client outcomes
- Reduce paper documentation traditionally associated with visit verification
- Increase productivity and efficiency among staff members
- Reduce costs associated with the use of multiple software products

EVV Mandate

Section 12006(a) of the 21st Century Cures Act mandates that Florida implements Electronic Visit Verification (EVV) for all providers enrolled directly in the SMMC program that furnish Home Health services (Home Health visits, Private Duty Nursing, and Personal Care Services) to recipients through the fee-for-service delivery system in accordance with Section 409.9132,(F.S.).

The purpose behind the EVV mandate is to track home health providers and ensure the visits they're reporting to CMS are actually taking place, that patients are getting the care they require, and that Medicaid is being accurately billed.

Long-Term Care (LTC) Home Health and Personal Care providers are required to use EVV.

EVV Claims

Molina has partnered with HHAeXchange as our EVV vendor.

Molina requires providers to use HHAeXchange to submit confirmed visits and bill directly to HHAeXchange through the free HHAeXchange Portal.

HHAeXchange Portal: https://app.hhaexchange.com/hhax/Login.aspx

Providers must register for HHAX's portal by completing a Provider Portal Questionnaire located at: https://hhaexchange.com/fl-provider-reg

HHAeXchange Portal Functionality:

- Accept service authorizations within the portal
- Clock in and out in real-time using EVV mobile devices
- Timesheet is automatically created based on clocking in and out

Provider Directory

Molina Healthcare providers may request a copy of our Provider Directory from their Provider Services Representative or may use the Online Directory on our website.

To find a provider, visit us at www.molinahealthcare.com and click Find a Doctor or Pharmacy.

Provider Directory (Continued)

Provider Data Accuracy and Validation

It is important for Providers to ensure Molina has accurate practice and business information. Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA© required element.

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina in writing (some changes can be made online) at least thirty (30) days in advance, when possible, of changes such as, but not limited to:

- ✓ Change in office location(s), office hours, phone, fax, or email
- ✓ Addition or closure of office location(s)
- ✓ Addition or termination of a Provider (within an existing clinic/practice)
- ✓ Change in Tax ID and/or National Provider Identifier (NPI)
- ✓ Opening or closing your practice to new patients (PCPs only)
- ✓ Any other information that may impact Member access to care

Please visit our Provider Online Directory to validate and correct most of your information. A convenient Provider web form can be found on the POD. You can also notify your Provider Services Manager if your information needs to be updated or corrected.

Subcontractors

Vision	Marketplace **Vision Service Plan (VSP)** (800) 615-1883 www.vsp.com	MMA/Specialty/LTC **iCare Solutions** (855) 373-7627
Laboratory Services	**Quest Diagnostics** 866-MYQUEST (866) 697-8378 www.questdiagnostics.com	**LabCorp** (800) 845-6167 www.labcorp.com
Pharmacy Benefits	**CVS Caremark** (800) 237-2767 www.caremark.com/wps/portal	

Subcontractors

Physical, Speech, and Occupational Therapy	**American Therapy Administrators/Heath Network One (MMA, Specialty, Comprehensive)** (888) 550-8800 Note: PT/OT/ST services for LTC members are managed directly through Molina
Non-emergency Transportation Services	**Access2Care** (888) 298-4781
Durable Medical Equipment, Home Health, and Home Infusion	**Coastal Care Services** **MMA and Specialty Plan** (855) 481-0505 Note: Durable Medical Equipment, Home Health, and Home Infusion services for LTC and Comprehensive members is managed directly through Molina

Credentialing

The Molina Healthcare Credentialing Department is responsible for performing, tracking and monitoring all aspects of the credentialing and re-credentialing process under the purview of the Quality Management Department for providers joining or participating in the Molina Healthcare network. The credentialing process is designed to meet the State of Florida Requirements and NCQA Standards.

Providers have the right to review their credentials file at any time. The provider must notify the Molina Healthcare Credentialing Department in writing and request an appointed time to review their file and allow up to seven calendar days to coordinate schedules.

Credentialing (Continued)

The Credentialing Department will verify provider information that includes, but is not limited to:

- Fully completed CAQH Credentialing application (the cred app must mirror the details in the attested CAQH Data system)
- **Fully completed HDO Credentialing application**
- **Fully Enrolled Medicaid ID (needed to bill Medicaid directly & Molina Healthcare)**
- Limited Enrolled Medicaid ID (Required to bill Molina Healthcare)
- Current, unrestricted license to practice
- Current, valid Drug Enforcement Agency (DEA) certificate
- Education and training
- Work history from the time of medical school graduation
- Board Certification
- Clinical admitting hospital privileges in good standing
- Current, adequate malpractice liability coverage
- All professional liability claims history
- References (if applicable)
- Appropriate (24) hour coverage
- Identify any disciplinary actions and/or sanctions
- Query the National Practitioner Data Bank (NPDB)

Recredentialing

Once a provider or facility is approved for participation in Molina Healthcare's network, re-credentialing is performed every 3 years.

You will receive a re-credentialing application approximately 6 months before your credentialing period is to expire.

The format used is that of a "profile" and only information that may have changed since the last credentialing will be requested.

Information that is reviewed as part of the re-credentialing process includes but is not limited to:

- ✓ Verifying that our providers continue to meet the basic qualifications
- ✓ Information from reported quality performance issues, such as utilization data, member satisfaction surveys and customer service reports
- ✓ A Site Audit is required every 3 years for all rendering Primary Care & Obstetrics, Gynecology Providers Service Locations

Benefits of EMR Access

- Molina will have the ability to download what is needed per measure
- Eliminate the burden from the office staff to Molina
- Transparency with Provider office and Molina
- Limited download of member chart
- Improve compliance & Increase HEDIS Scores
- Limit outreach to the office for additional records
- Extract Supplement Data year around
- COVID-Virus Safety

EMR Access

Molina Healthcare strives to improve HEDIS scores year around through the collection and reporting of data. To achieve high HEDIS scores, the collection of medical records must occur multiple times of the years. Molina is interested in developing a relationship with provider groups by utilizing EMR Remove Access method to efficiently retrieve the necessary records to met HEDIS requirements.

Benefits from EMR Remote Access:

- Reduction in time and office resources
- Removing the need for multiple outreaches from our team to yours
- Mitigating COVID-19 risks associated with going on-site

For more information, please contact your Intervention specialist at

HEDIS: RegionDHEDIS@MolinaHealthCare.com.

In-Network Specialist Referrals

Florida providers are required to submit referrals to in-network specialists**.** PCPs may use *Molina's Paper Referral*, an *Electronic Referral*, or *Internal Referral Form (i.e.: script)*.

For Paper Referrals:

Provider Name: (molinahealthcare.com)

The electronic forms will be available on the web for our providers. Referral details will also be available for our members on the My Molina member portal and Health in Hand app.

PCPs may electronically edit the expiration date and number of visits, as needed for existing Molina Legacy Providers.

In-Network Specialist Referrals (Continued)

Referrals are *not* required for visits to providers with the following specialties: ***Obstetrics and Gynecology, Dermatology, Chiropractic, and Podiatry***. Members may access these specialties directly.

Please Note: The referral requirement does not affect Molina's Prior Authorization guidelines. Therefore, services that require prior authorization will continue to require clinical review and prior approval by Molina and will not be reimbursed without a referral.

Specialists should continue to submit requests directly to Molina for services that require prior authorization, and not direct members back to their PCPs to submit the authorization requests on behalf of the specialists.

Ex.: Non-Par Specialist referrals will still require Prior Authorization.

Coordination of Care

Molina Healthcare's Utilization Management, Case Management and Disease Management will work with providers, members, and member representatives to coordinate care, provide referral assistance and other support for members with chronic, complex, high- risk and catastrophic conditions. It is the responsibility of contracted Providers to assess Members and with the participation of the Member and their representatives, create a treatment care plan. The treatment plan is to be documented in the medical record and is updated as conditions and needs change.

Molina staff assists providers by identifying needs that may not be verbalized by providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care.

Care coordination by Molina staff is done in partnership with Providers and Members to ensure efforts are efficient and non-duplicative.

Timely Access Standards

URGENT

Appointments for ***Urgent*** care services shall be provided:

- Within 48 hours of a request for medical or behavioral health care services that ***do not*** require prior authorization.
- Within 96 hours of a request for medical or behavioral health care services that ***do*** require prior authorization.

NON-URGENT (ROUTINE)

Appointments for ***Non-Urgent*** care services shall be provided:

- Within 7 days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.
- Within 14 days for initial outpatient behavioral health treatment.
- Within 14 days of a request for ancillary services for the diagnosis or treatment of injury, illness, or other health condition.
- Within 30 days of a request for a primary care appointment.
- Within 60 days of a request for a specialist appointment after the appropriate referral is received by the specialist.

Provider Responsibilities

- Coordinate and supervise the delivery and transition of care to and for each assigned Member.
- Ensure newly enrolled Members receive an initial health assessment no later than 180 days following the date of enrollment and assignment to the PCP.
- Ensure 24/7/365 availability for members requiring emergency services.
- Ensure appointment access for all Members in accordance with the Access to Care Standards.
- Maintain a ratio of 1 FTE licensed practitioner per 1,500 members, and 1 ARNP or PA for every 750 members above 1,500.
- Provide Child Health Check-Ups (CHCUP) in accordance with the periodicity schedule referenced in the CHCUP section of this handbook.
- Provide immunizations in accordance with the Recommended Childhood Immunization Schedule for the US, or when necessary for the Member's health.
- Participate in the Vaccines for Children Program (VFC) for Members 18 years old and younger.
- Provide immunization information to the Department of Children and Families (DCF) upon request by DCF and receipt of the Member's written permission, for members requesting temporary cash assistance.
- Provide adult preventive care screenings in accordance with the U.S. Preventive Services Task Force guidelines.

Provider Responsibilities (Continued)

- Utilize Molina Healthcare network providers whenever possible. If services necessary are not available in network, contact Utilization Management for assistance.
- Maintain a procedure for contacting non-compliant Members.
- Ensure Members are aware of the availability of non-emergency transportation and assist members with transportation scheduling.
- Ensure Members are aware of the availability of free, oral interpretation and translation services, including Members requiring services for the hearing impaired.
- Provide a physical screening within 72 hours, or immediately if required, for children taken into protective custody, emergency shelter, or foster care program by DCF.
- Submit timely, complete and accurate encounters for each visit where the PCP sees the Member.
- Submit encounters on a CMS 1500 form/UB-04 (or electronic equivalent)
- Allow access to Molina or its designee to inspect office, records, and/or operations when requested.
- Cooperate in investigations, reviews or audits conducted by Molina, AHCA, or any other state or federal agency.

Marketplace Evidence of Coverage

Molina Healthcare of Florida's Evidences Of Coverage are written specifically to address the requirements of delivering healthcare services to Molina Healthcare Marketplace members, including your responsibilities as a participating provider. Providers may request printed copies of the respective Metal EOC's, at no cost, by contacting Provider Services at (855) 322-4076, or view them on our website, at:

https://www.molinamarketplace.com/marketplace/fl/en-us/Providers/Provider-Forms.aspx

Provider Notifications

Providers must immediately notify Molina, if any of the following events occur:

- Provider's business license to practice in any state is suspended, surrendered, revoked, terminated, or subject to terms of probation or other restrictions.
- Provider has any malpractice claim asserted against it by a Molina member, or any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of provider pursuant to a judgment rendered upon such a claim.
- Provider is the subject of any criminal investigation or proceeding.
- Provider is convicted for crimes involving moral turpitude or felonies.
- Provider is named in any civil claim that may jeopardize financial soundness.
- There is a change in business address, telephone number, ownership, or Tax ID Number.
- Provider's professional or general liability insurance is reduced or canceled.
- Provider becomes incapacitated such that the incapacity may interfere with member care for 24 hours.
- Any material change or addition to the information submitted as part of provider's application for participation with Molina.
- Any other act, event or occurrence which materially affects ability to carry out duties under the Provider Services Agreement.

Duty to Report

Abuse, Neglect and Exploitation

Providers must immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline toll-free telephone number, **(800) 96ABUSE.** Additionally, all providers, including HCBS providers, must report adverse incidents including events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents to Molina Healthcare immediately.

For HCBS providers, Critical Incidents must be reported no more than twenty-four **(24)** hours of the incident. For MMA providers, Adverse Incidents must be reported no more than forty-eight **(48)** hours of the incident.

Documentation related to the suspected abuse, neglect, or exploitation, including the reporting of such, must be kept in a confidential file, separate from the enrollee record. Providers must make the file available to Molina or any other State or Federal Agency upon request.

The Critical Incident Form is located on Molina Healthcare's website at:
http://www.molinahealthcare.com/providers/fl/PDF/Medicaid/forms_FL_CriticalIncidentReportingForm.pdf

To report a critical incident, provider should email the Critical Incident Form to:
MFLQIAlerts@MolinaHealthCare.com

More information on Abuse, Neglect or Exploitation can be found on the Department of Children & Families website at:
http://www.myflfamilies.com/service-programs/abuse-hotline/report-online

Duty to Report (Continued)

Human Trafficking

Sex Trafficking: The recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age.

Labor Trafficking: The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services using force, fraud, or coercion, for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

Human trafficking may occur in:

- Prostitution and escort services
- Pornography, stripping, or exotic dancing
- Massage parlors
- Agricultural work
- Factory work or sweat shops
- Businesses like hotels, nail salons, or home cleaning services
- Begging, street peddling or door-to-door-sales
- Domestic labor (cleaning, childcare, etc.)

Victims of human trafficking may exhibit:

- Evidence of being controlled either physically or psychologically
- Inability to leave home or work
- Inability to speak for oneself or share one's own information
- Loss of control of one's own identification documents
- Having few or no personal possessions
- Loss of sense of time or space, not knowing where they are or what city or state they are in

Duty to Report (Continued)

Important Contacts

Abuse can be reported by calling the Florida Abuse Hotline, a statewide toll-free number:
1-800-96ABUSE (1-800-962-2873)

The National Human Trafficking Hotline helps victims in crisis through safety planning, emotional support, and connections to local resources.

For more information on human trafficking, visit:

www.acf.hhs.gov/opre/topic/human-trafficking

Call 1-888-373-7888
Text: HELP to BEFREE (233733)

Email: help@humantraffickinghotline.org
Visit: www.humantraffickinghotline.org

Critical/Adverse Incident Reporting Exceptions

MMA

Molina Healthcare does not require Critical Incident reporting from the following providers:

- Health Maintenance Organizations and Health Care Clinics reporting in accordance with s. 641.55, F.S.;
- Ambulatory Surgical Centers and Hospitals reporting in accordance with s. 395.0197, F.S.;
- Assisted Living Facilities reporting in accordance with s. 429.23, F.S.;
- Nursing Facilities reporting in accordance with s. 400.147, F.S.;
- Crisis Stabilization Units, Residential Treatment Centers for children and adolescents, and Residential Treatment Facilities reporting in accordance with s. 394.459, F.S.,

Critical Incidents occurring in these licensed settings shall be reported in accordance with the facility's licensure requirements.

LTC

Molina Healthcare does not require Critical Incident reporting from the following HCBS Providers:

- Nursing Facilities reporting in accordance with s. 400.147, F.S.;
- Assisted Living Facilities reporting in accordance with s. 429.23, F.S.

Critical incidents occurring in nursing facilities and ALFs will be addressed in accordance with Florida law.

Fraud, Waste and Abuse

Federal and state resources dedicated to the prevention and detection of health care fraud have increased substantially in the past few years as part of the effort to control federal program expenditures. Molina is committed to working with federal and state regulatory and law enforcement agencies to help prevent and detect fraud, and to recover funds paid for fraudulent claims.

	State	Federal
Abuse	Means provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care. (409.913 F.S.)	Means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR 455.2)
Fraud	Means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law. (409.913 F.S.)	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).
Overpayment	Includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake. (409.913 F.S.)	N/A
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.	N/A

Examples of Fraud, Waste, and Abuse

- Paying or receiving kickbacks for member enrollment or service referrals
- Submitting claims for services not rendered and/or falsifying medical records to increase payment
- Double billing services
- Balance billing members
- Billing services separately that should be billed using a single code (unbundling) or adding modifiers when not appropriate to increase payment
- Use of a medical identification card by someone other than the person identified on the card
- Forgery or alteration of a prescription
- Omitting information or providing misleading or false personal information to obtain health care benefits an individual would not otherwise be entitled to
- Participating in schemes that involve collusion between a provider and a member, such as diverting controlled substance medications for street sales

Reporting Fraud, Waste and Abuse

We offer you the following options to report suspicion of fraud, waste, and abuse or instances of non-compliance. You have the right to report your concerns anonymously and without fear of retaliation.

You may report suspected cases of fraud and abuse to **Molina's AlertLine** at: 866-606-3889. https://molinahealthcare.AlertLine.com

To submit written report to Molina Healthcare of Florida via mail or fax:

Compliance Officer
Molina Healthcare of Florida
8300 NW 33rd St, Suite 400
Doral, Florida 33122
Confidential Fax: 866-440-8591

You may also report directly to the **Florida Medicaid Consumer Complaint Hotline** at: 888-419-3456.
https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

Cultural Competency

Cultural competency is the readiness and ability of delivering services to all members and valuing the importance of culture diversity.

Molina Healthcare recognizes that every patient encounter is unique. Every patient is different in age, sex, ethnicity, religion or sexual preference and will bring to the medical encounter their unique perspectives and experiences. This factor will always impact communication, compliance and health care outcomes.

Our Cultural Competency Plan describes how the individuals and systems within Molina Healthcare will effectively provide services to people of all cultures, races, ethnic backgrounds and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals, and protects and preserves the dignity of each.

For a full copy of our Cultural Competency Plan, visit our website, www.molinahealthcare.com.

You Matter to Molina Program

Molina Healthcare of Florida's "You matter to Molina" program prioritizes connecting directly with our network and supporting their efforts to deliver high-quality and efficient health care for Molina members.

Through the "You Matter to Molina" program, we have a dedicated Provider Service Team to intake and resolve your questions or issues and solicit input and feedback from you, our network providers and administrative staff, about ways Molina can improve our technology, tools and process to minimize administrative hurdles and better support you.

Molina is committed to partnering with our network providers to work together to solve problems quickly and efficiently as to why we have taken the initiative to specifically design new solutions to simplify ways for providers to engage with the health plan.

What do we do with all that feedback, you ask?
We determine whether or not action can be taken—if we can take action, we will—and then we'll tell you about it in the success stories section of the You Matter to Molina Corner of the Provider Bulletin.

Surveys

It Matters to Molina Suggestion Box
Provider Experience Survey
Hospital Experience Survey
Provider Training Survey
Provider Bulletin Survey
Molina Provider Data Validation Survey

[You Matter to Molina (molinahealthcare.com)]

Community Engagement

Coordination with Outside Organizations

Understanding that members will require assistance outside of those services typically provided by physicians and hospitals, and in the spirit of our Mission of removing barriers to care, Molina has developed relationships with various outside organizations to assist in improving the overall health outcome of our enrollees. Molina's Case Managers and Community Connectors are trained to identify hardships that impact enrollees' health, including basic needs such as, proper housing, utilities, food, and clothing. Through partnerships with faith-based and community-based organizations, Case Managers and Community Connectors can assist members in obtaining services they may not know are available.

The MolinaCares Accord and Molina Healthcare of Florida recently partnered with Farm Share to host a drive-thru food giveaway with Molina employee volunteers helping to hand out 38,628 pounds of food to 446 cars supporting 922 families. Florida's largest food bank, Farm Share, estimates 4.5 million Floridians are going hungry each day.

MolinaCares Partners with Farm Share Video:
https://www.youtube.com/watch?v=v4N6WV1alUc

Molina also provides members with the search tool Molina Help Finder to find basic needs within the community https://molinahelpfinder.com

Questions

For a copy of this presentation please email:
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