Molina Healthcare of New Mexico

Medicaid Annual Training: Onboarding Module

TURQUOISECARE

MOLINA® HEALTHCARE

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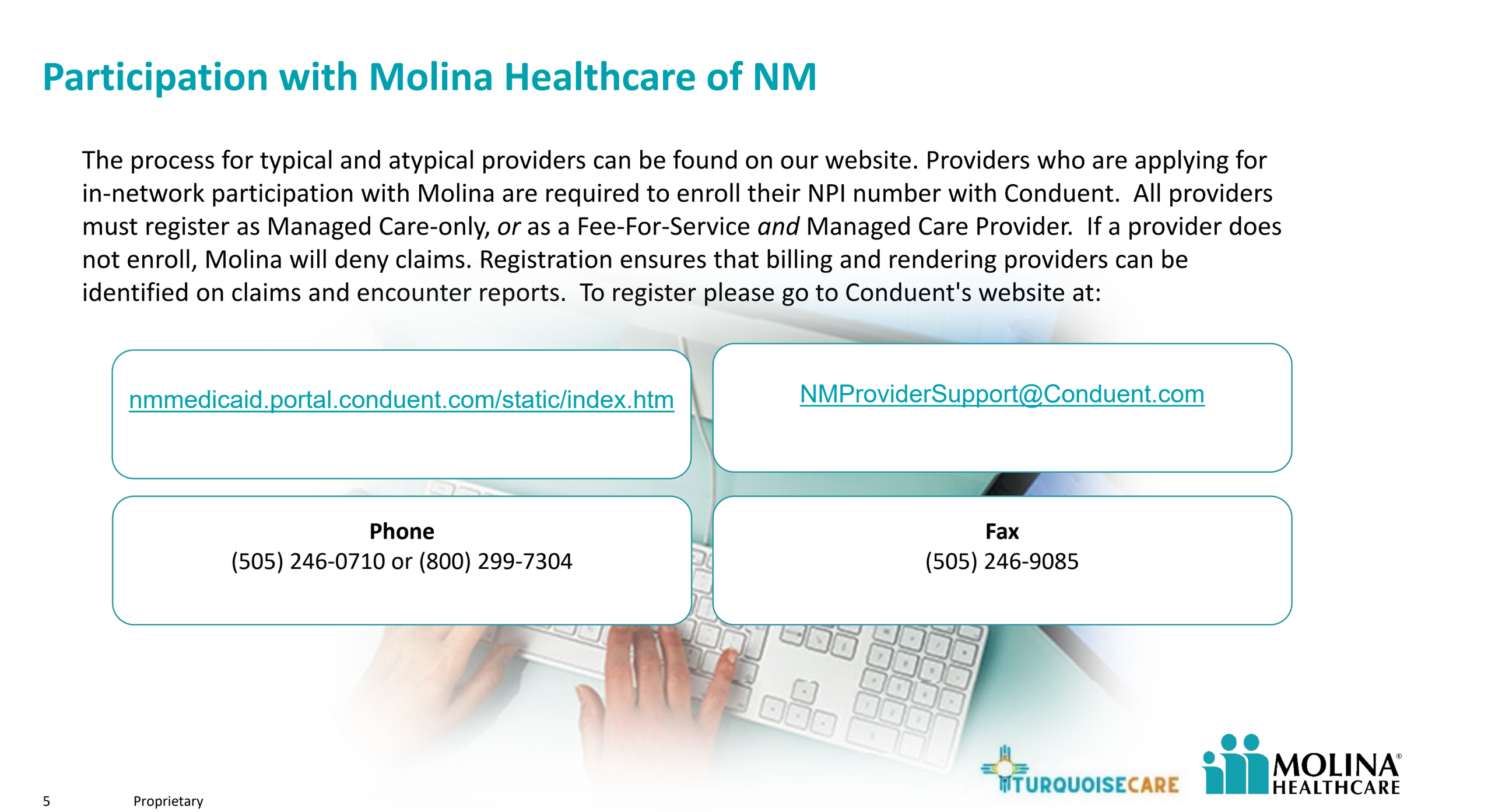
Participating with Molina Healthcare

Participation with Molina Healthcare of NM

The process for typical and atypical providers can be found on our website. Providers who are applying for in-network participation with Molina are required to enroll their NPI number with Conduent. All providers must register as Managed Care-only, *or* as a Fee-For-Service *and* Managed Care Provider. If a provider does not enroll, Molina will deny claims. Registration ensures that billing and rendering providers can be identified on claims and encounter reports. To register please go to Conduent's website at:



nmmedicaid.portal.conduent.com/static/index.htm

NMProviderSupport@Conduent.com

Phone
(505) 246-0710 or (800) 299-7304

Fax
(505) 246-9085

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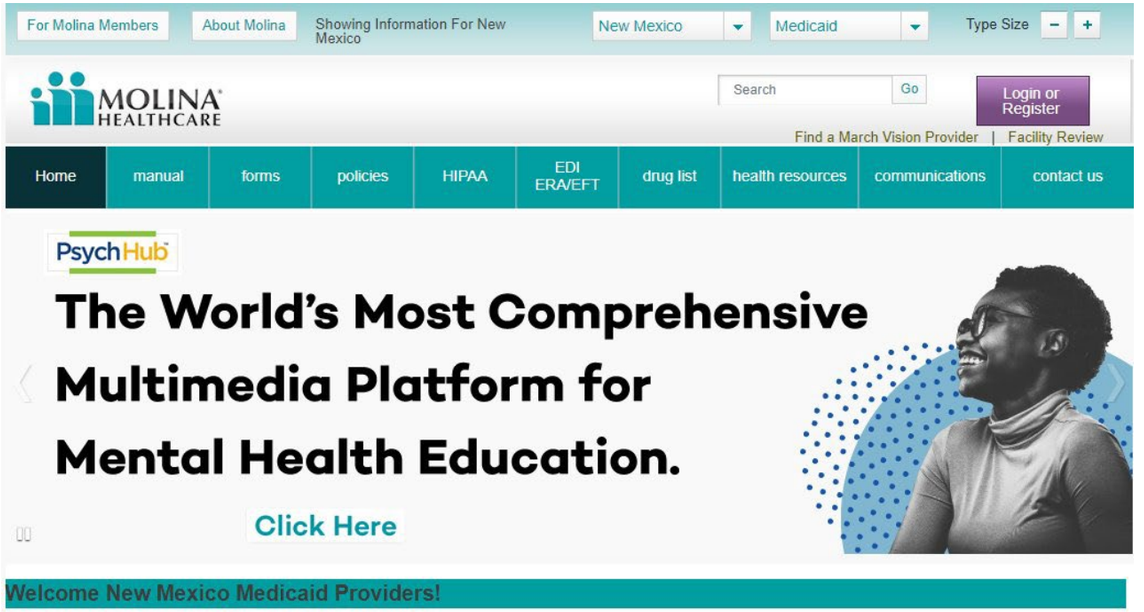
Participation in Credentialing

Providers are required to participate in Molina's credentialing and re-credentialing processes and will satisfy, throughout the term of their contract, all credentialing and recredentialing criteria established by Molina and applicable accreditation, state and federal requirements. This participation includes providing prompt responses to requests for information related to the credentialing or re-credentialing process.

Re-credentialing is required every (3) three years. CAQH will need to be attested and Molina will need to be given permission to access, or a new credentialing application will need to be completed if the provider does not participate with CAQH. You will receive a request to re-credential from Aperture 60 days prior to the credentialing expiration date.



New Mexico Providers Home (molinahealthcare.com)

MHNMCredentialing@MolinaHealthCare.Com

Documentation: Practitioners

- Provider Services Agreement
- W-9
- Roster or Provider Information Form
- Practitioner Application (if practitioner does not have an updated and attested CAQH profile)
- Primary Specialty and Taxonomy Code
- Letter of Intent
- Attestation & Ownership and Control Disclosure Form

Documentation: Organizational/Facility Providers

- Hospital/Facility/Ancillary Provider Services Agreement
- W-9
- Health Delivery Organization (HDO) Form
- Attestation & Ownership and Control Disclosure Form
- Letter of Intent
- Hospital Services Checklist (if applicable)

Disclosure of Ownership and Control Interest Form

Disclosure of Ownership and Control Interest Form is required to be completed and submitted with the Molina Provider Information Form (PIF) and Attestation as a requirement to participate as a credentialed provider. This form needs to be completed by any practitioners or entity with more than 50% interest. This form is emailed to Molina Credentialing:

- At the initial time of credentialing
- Or if there is a change in the information or ownership
- Please submit to Molina credentialing within thirty (30) calendar days of a change in ownership

Provider Rosters

Contracted providers, and groups are required to use the New Mexico Human Services Department- approved roster template for provider additions, terminations, demographic, and location changes.

Participating healthcare providers must validate their provider directory information with Molina every 90 days.Providers must be approved by Behavioral Health HCA for supervisory services. Each agency is responsible for notifying the Managed Care Organization of BHSD approval.

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirements in accordance with SB 137 and Health and Safety Code Section 1367.27, as well as an NCQA-required element. Molina is required to publish and maintain accurate provider directories. Please refer to NMAC 8.321.2.9 for details

Participation in Credentialing

Provider Credentialing			
Initial credentialing with Molina requires: • Adhereance to credentialing requirements, including, but not limited to; an active license that has not been terminated, revoked, or suspended.	Provider Re-Credentialing • Just as credentialing, re-credentialing follows the same guidelines as the initial credentialing process and is completed every three (3) years.	CAQH • CAQH sends providers a notification every one hundred-twenty (120) days. The notification is a reminder to the provider to confirm all information is accurate on their website and Attested to.	On-Site Visits • Some Facilities and most practitioners may require a credentiling on-site visit • Molina PRR will contact the provider to schedule and conduct the on-site visit

Providers are required to participate in Molina's credentialing and re-credentialing processes throughout the term of their contract. Failure to maintain credentialing status can result in provider termination from all lines of business.

Molina's Provider Credentialing Process Model

1. Create & Process Provider Credentialing Application

- Create a new provider application.
- A new provider may need to be credentialed depending on its source i.e., CAQH/Paper/HDO/ Provider Source, status, type or specialty. The Provider application could be Initial or Recredentialing.

2. Collect & Verify Provider Information

- Verify Provider information and collect supporting Credentialing documents.
- Corporate Credentialing department collects all mandatory documentation from CAQH/State websites.

3. Final Decision on Provider Application

- Review provider application and make a final decision
- Application goes through a review process in which information is verified and final decision of Approval/Denial/ Termination/Hold is made.

Regulatory Documents	Examples: Disclosure of Ownership and Control Interest Form, CAQH update, Checklist, EP Staff check, Site visit, Verifications
Reporting	Examples: Dashboard for number of items in queue, Credentialing Reports, other Analytics and Business Intelligence requirements

Contract

The final step will be for Molina to countersign the Provider Agree-ment and provide the provider with a signed executed copy.

Credentialed facilities and/or practitioners will also be loaded into Molina's claims payment system as in-network providers.

The in-network effective date for each facility and/or practi tioner will be the date of credentialing com pletion.

This will be included in the notification that providers receive from Molina's Credentialing department.

Connect

It's important you connect with our contracted vendors. Points of contact and the process for joining our network will differ depending on provider type.

Vision Providers	Please contact our vision vendor, March Vision, for participation at **(844) 496-2724** or by visiting MarchVision.com
Pharmacy Providers	Please contact our Pharmacy benefits manager, CVS Pharmacy, by visiting CVS **Website:** https://rxservices.cvscaremark.com/SelfSignup/SelfSignup **Phone:** (833) 249-8391 **NM PA Fax:** (833)896-0519
Dental	Please contact our dental vendor, DentaQuest, for participation at (800) 341-8478 **Provider Website:** New Mexico Dental Providers (dentaquest.com)

Provider Responsibilities

Provider Data Accuracy and Validation

Beginning January 1, 2022, the federal Consolidated Appropriations Act (CAA of 2021 requires that provider directory information be verified every 90 days by Molina's in-network providers).

A link to the provider directory can be found on Molina's public website at https://www.molinahealthcare.com/members/nm/en-US/pages/home.aspx

Or you may use this link to go directly to Molina's Provider Directory

Updates and changes to information can be submitted within the Provider Directory or submitted to your dedicated Provider Relations Representative or our general email box at MHNM.ProviderServices@MolinaHealthCare.Com

Accuracy Matters

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, and an NCQA required element. Invalid information can negatively impact Member access to care, Member PCP assignments and referrals.

- Current information is critical for timely and accurate claims processing.
- Providers must validate their provider information with us at least once every ninety (90) days in the Molina NM Provider Online Directory.
- Providers must notify us no less than thirty (30) days in advance when they relocate or open an additional office. To notify us of any changes, submit Provider Change Form to your assigned Provider Relations Representative, or MHNMProviderServices@Molinahealthcare.com.
- 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 heal th care facility in your practice.
- Submit changes, including rosters to Molina no later than the 15th of every month.

Training & Education

Molina publishes all training and education materials on our Molina public website and in the Molina Provider Manual.

- Training modules are available for specific provider types, such as behavioral health, physical health, pharmacy, and long-term care providers and includes coverage and benefit information on behavioral health services and long-term care services.
- Additionally, the training modules also include specific information related to Alternative Benefit Plan (ABP), Pregnancy and Family Planning Services, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), Dental, Vision, Telemedicine, and Non-Emergency Medical Transportation.
- Providers may also access eligibility, coverage and benefits information on Molina's provider portal, Availity, or they may contact Molina Provider Services at (855) 322-4078.

Molina Healthcare has a comprehensive strategy to monitor Provider Training activities to ensure contract and regulatory requirements are met.

Training & Resources

As a key partner of Molina, access to the **Provider Reference Manual** and other resources are available to you via the Molina website. Molina provides a wide variety of information that we hope can answer your questions and assist in ongoing education and compliance with state, federal, and regulatory requirements. Please note, the Provider Reference Manual is an extension of the Provider Agreement and providers/vendors are contractually obligated to comply with requirements and operational procedures addressed in the Provider Manual.

Website: https://www.molinahealthcare.com/members/nm/en-US/pages/home.aspx

Molina will develop and implement a Provider Training and Outreach Plan annually to educate providers on Turquoise Care requirements. Collaboration with counties, State agencies, and local governments to provide direct technical assistance regarding contracting, billing, and reimbursement for covered services. Molina will regularly evaluate the training needs of the Providers and will update training programs, when appropriate.

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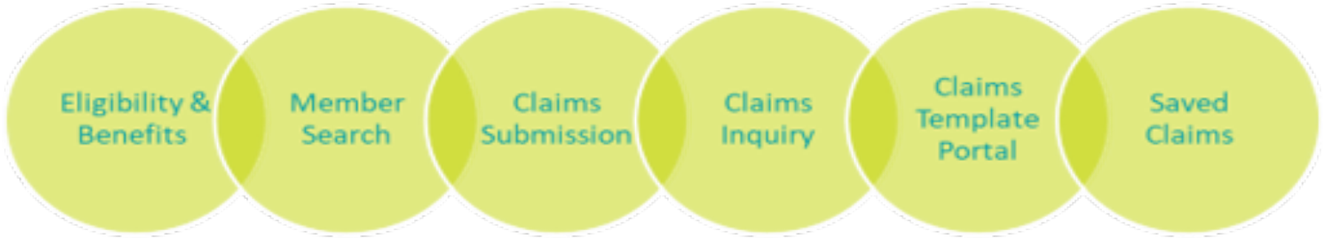
Provider Portal

Register for Availity

Register and get started with Availity Essentials, Molina's Provider Portal https://www.availity.com/molinahealthcare

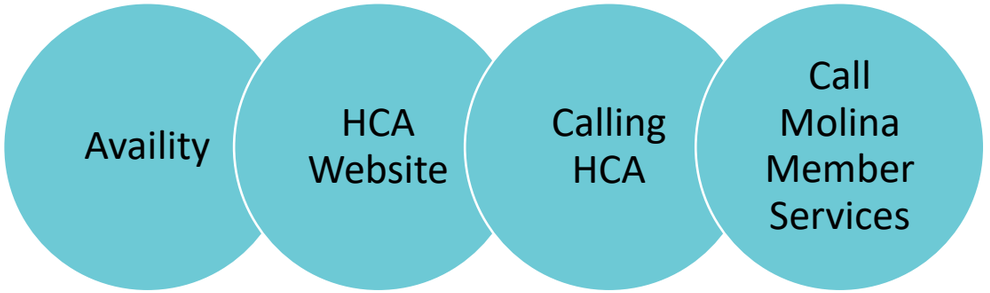


Only the person who will become the organization's primary administrator needs to register. Before you start registering, gather this information about yourself and your organization: Physical and billing addresses, Tax ID (EIN or SSN), NPI, Primary specialty/taxonomy.

To register as a Billing Service, Dental Provider, or an Atypical Provider, please visit Availity's Getting Started Page for additional registration information.

Verify Member Eligibility

Providers should verify eligibility for Molina of New Mexico Members prior to rendering services. Payment for Services rendered is based on enrollment and benefit eligibility at the time of services. Additional information regarding eligibility, enrollment, disenrollment, or grace periods for coverage can be found in our Molina Provider Manual.



Possession of a Molina ID card does not guarantee Member eligibility or coverage. A Provider must verify eligibility each time a Member presents to their office for services. Payment for services rendered is based on enrollment and benefit eligibility. Use Availity as quick and easy way for provider to verify member eligibility prior to rendering services.

Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in our Member materials. Additional details can be found on our website, including our Evidence of Coverage documents.

- Evidence of Coverage materials can be found on Molina Healthcare of New Mexico's website at www.Molinahealthcare.com.
- For additional information, contact us at (855) 322-4078, 8:00 a.m. to 5:00 p.m., MST Monday – Friday. TTY Users, please call 711.

Register for ECHO

Click here to register for ECHO is The link above provides step-by-step instructions on how to register with Change Healthcare/ECHO Health to receive electronic payments, remittance advices, and 835's.

- Any questions during this process should be directed to ECHO Health 888.834.3511 or edi@echohealthinc.com.
- To register for EFT/835s, please visit: https://enrollments.echohealthinc.com/efteradirect/molinaHealthcare.

Access to Care Requirements

The following appointment availability and access guidelines are to be used to ensure timely access to Behavioral Health appointment standards

Routine

- For non-urgent behavioral health care, the request-to-appointment time for an initial assessment shall be no more than seven (7) calendar days, unless the member requests a later time. All non-urgent behavioral health care follow-up appointments shall be available within thirty (30) calendar days of the request;

Urgent

- Primary medical, dental and behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours;

Crisis Services

- For behavioral health crisis services, face-to-face appointments shall be available within ninety (90) minutes of the request;

Access to Care Requirements

The following appointment availability and access guidelines are to be used to ensure timely access to Behavioral Health, Dental and Medical care.

Routine Asymptomatic

- For routine, asymptomatic, member-initiated, outpatient appointments for primary medical care, the request-to-appointment time shall be no more than thirty (30) calendar days, unless the member requests a later time;
- For routine, asymptomatic member-initiated dental appointments, the request-to-appointment time shall be no more than sixty (60) calendar days, unless the member requests a later time;

Routine Symptomatic

- For routine, symptomatic, member-initiated, outpatient appointments for non-urgent primary medical and dental care, the request to appointment time shall be no more than fourteen (14) calendar days, unless the member requests a later time;

Urgent

- Primary medical, dental and behavioral health care outpatient appointments for urgent conditions shall be available within twenty-four 24 hours;

Specialty

- For specialty outpatient referral and consultation appointments, excluding behavioral health, the request-to-appointment time shall generally be consistent with the clinical urgency, but no more than twenty-four (24) hours for urgent appointments, fourteen (14) calendar days for symptomatic appointments, and forty-five (45) calendar days for routine asymptomatic appointments, unless the member requests a later time;
- For maternity care appointments, the request-to-appointment time shall be no more than twenty-four (24) hours for urgent appointments. For routine prenatal care appointments, within fourteen (14) calendar days for the request during the first trimester, within seven(7) calendar days of the request during the second trimester, and within three(3) business days of the request during the third trimester;

Provide Access to Care Requirements

The following appointment availability and access guidelines are to be used to ensure timely access to Diagnostic Laboratory/Imaging and Pharmacy Prescriptions

Diagnostic Laboratory/Imaging

- For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request to appointment time shall be consistent with the clinical urgency but no more than fourteen (14) calendar days, unless the member requests a later time;
- For outpatient diagnostic laboratory, diagnostic imaging and other testing, if a “walk-in” rather than an appointment system is used, the member wait time shall be consistent with severity of the clinical need;
- For Urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than forty-eight (48) hours;

Pharmacy Prescriptions

- The in-person prescription fill time (ready for pickup) shall be no longer than 40 minutes; a prescription phoned in by a practitioner shall be filled within 90 minutes.

Member Rights and Responsibilities

Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Molina's Member materials such as Evidence of Coverage documents (EOC).

Members are provided their rights and responsibilities in the Member Handbook.

For additional information, please contact Molina at (855) 322-4078, 8:00 a.m. to 5:00 p.m. Monday through Friday. TTY users, please call 711.

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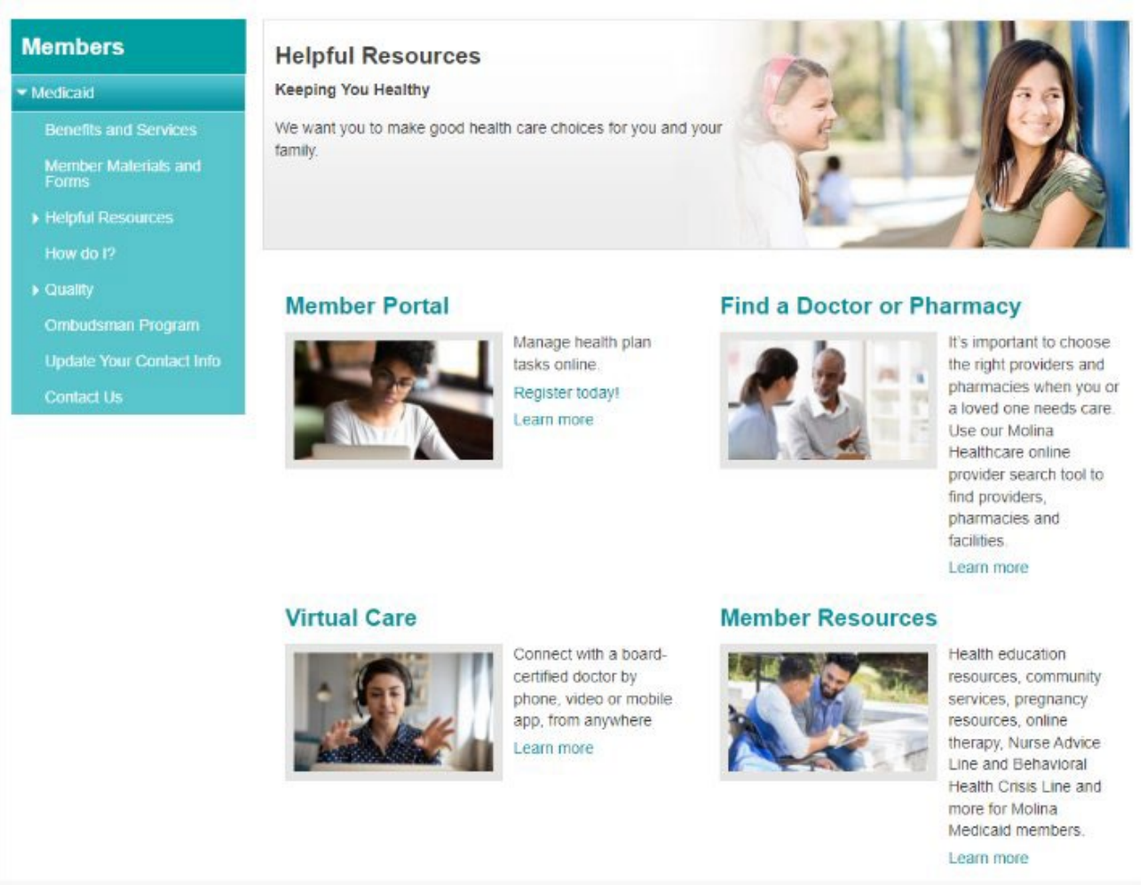
Member Online Resources

Members can find helpful resources on Molina's website:

View Benefits and Services
- Find Member Materials and Forms
- Log into the Member Portal
- Find a Doctor or Pharmacy
- Receive Virtual Care
- ...and much more

Toll Free: (844) 862-4543

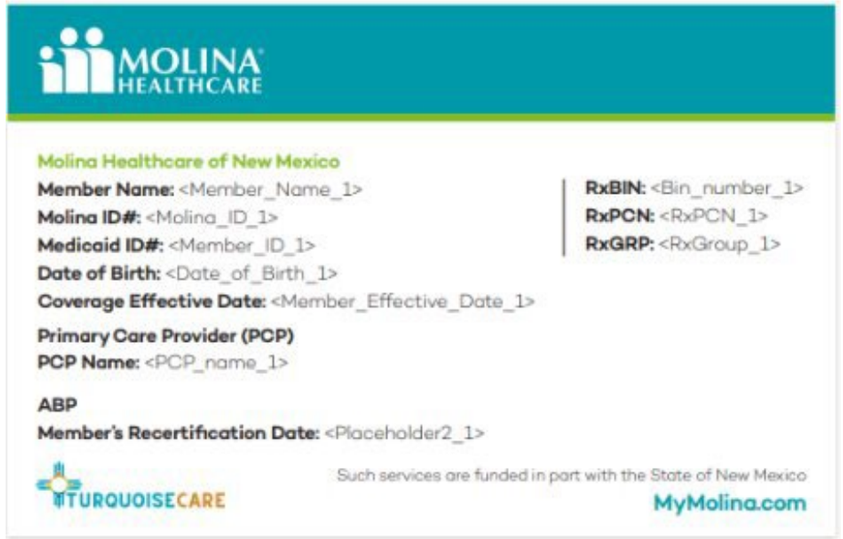


Member Enrollment

Turquoise Care income determination and enrollment processes are completed by the Income Support Division of HCA. Individuals choose a Managed Care Organization (MCO) or are auto assigned to one. Members can change MCOs within the first three (3) months following enrollment. If a member changes MCOs, they will remain with the new MCO until the next open enrollment period. Members may submit request to HCA to change prior to the next open enrollment period for unique or special circumstances.

Member ID Cards

Possession of a Molina ID card does not guarantee Member eligibility or coverage. A Provider must verify eligibility each time a Member presents to their office for services. Payment for services rendered is based on enrollment and benefit eligibility. Use Availity as quick and easy way for provider to verify member eligibility prior to rendering services.



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Primary Care Provider Assignment

Members may select a participating Primary Care Provider (PCP). If a PCP has not been selected within fifteen (15) days from enrollment, members will be auto-assigned to a PCP. Auto-assignment is based on age, gender and zip code. Members may change PCP at any time, for any reason.

Health Risk Assessment (HRA)

Members have the right to **refuse** to participate in Care Coordination. In the event a Member refuses Care Coordination, Molina will have the Member sign an HCA approved Care Coordination declination form.

If there is a change in the Member's health status that warrants the need to reinitiate Member outreach efforts or to perform an updated Health Risk Assessment (HRA) or Comprehensive Needs Assessment (CNA) Molina will make that outreach attempt (3) times.

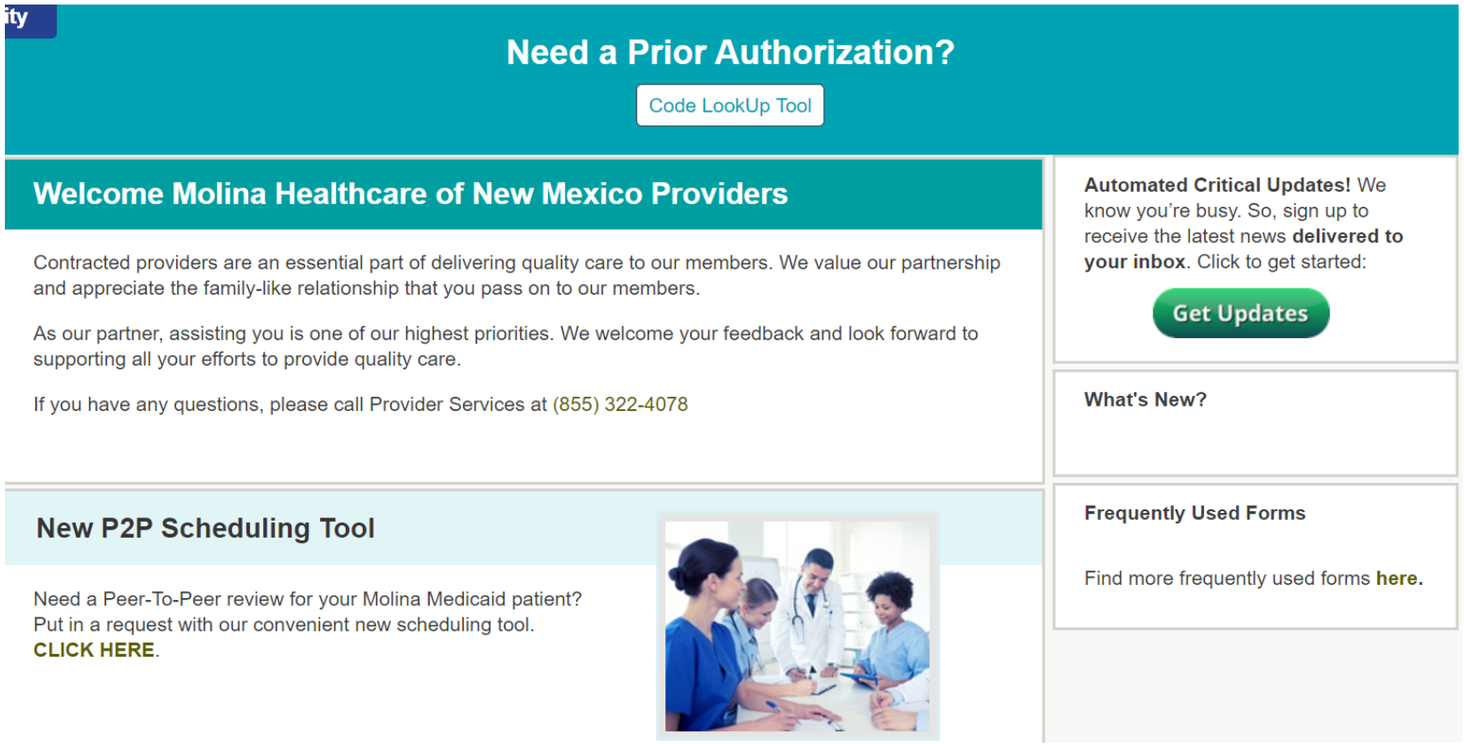
For each Member who has been determined as needing a Comprehensive Needs Assessment (CNA), as part of the CNA for Members who need Community Benefits, the care coordinator must conduct a Nursing Facility Level of Care (NFLOC) determination, administer the Community Benefits Services Questionnaire (CBSQ) and complete the Community Benefits Member Agreement (CBMA), and inform the Member of available Community Benefits, and complete the CNA within (30) calendar days.

In some case the HRA and the CNA may be completed concurrently. Molina will perform the CNA in-person at the Member's primary residence unless the Member is homeless or in a Transition Home; the Member is part of the justice-involved population preparing for release; or the Member is a newborn in an inpatient setting. The in-person visit may occur at another location upon prior written approval from HCA.

Provider Online Resources

Provider Online Resources

- Appeal & Grievance Information
- Provider Online Directories
- Preventative & Clinical Care Guidelines
- Provider Manuals
- Provider Portal
- PsychHub
- Prior Authorization Information
- Pharmacy Information
- HIPAA
- Fraud, Waste & Abuse Information
- Frequently Used Forms
- Communications & Newsletters
- Member Rights & Responsibilities
- Contact Information



[Welcome to Molina Healthcare of New Mexico]

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 Relation 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

Culturally and Linguistically Appropriate Services

Culturally and Linguistically Appropriate Services

Culturally and Linguistically Appropriate Services (CLAS) is a way to improve the quality of services provided to all individual, which will ultimately help reduce health disparities and achieve health equity. CLAS is about respect and responsiveness: **Respect** the whole individual and **Respond** to the individual's health need and preferences.

Providing CLAS is one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language preferences, health professionals can help bring about positive health outcomes for diverse populations.

The pursuit of health equity must remain at the forefront of our efforts; we must always remember that dignity and quality of care are a right of all and not the privileges of a few.

Culturally and Linguistically Appropriate Services

How can organizations implement the National CLAS Standard?

- **Governance, Leadership, and Workforce**
  - Train staff in CLAS
  - Recruit a workforce representative of community served
- **Communication and Language Assistance**
  - Offer comprehensive language assistance services
  - Use advanced technology for interpretation services
- **Engagement, Continuous Improvement, and** Accountability
  - Conduct organizational assessments
  - Incorporate CLAS into mission, vision, and strategic plans

Providers must provide equitable access to and the delivery of services to all Members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, or disabilities; and regardless of gender, sexual orientation, or gender identity.

Annual Cultural Humility Training

Annual Cultural Humility Training is required by the New Mexico Health Care Authority for all providers contracted with Molina. The training is available on our Molina Healthcare of New Mexico website, along with the Cultural Humility Training Attestation.

Molina strives to focus training on priority populations: Maternal Health, Long Term Support Services, Behavioral Health, Native American populations, and Just Involved Individuals.

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Cultural Humility Resources

National CLAS Standards (hhs.gov)

A Practical Guide to Implementing the National CLAS Standards (cms.gov)

Culturally and Linguistically Appropriate Services (CLAS) (hhs.gov)

Covered Services

Alternative Benefit Plan (ABP)

The Alternative Benefit Plan is part of the New Mexico Medicaid Turquoise Care program. Most adults who qualify for the Medicaid category known as the “Other Adult Group” receive services under the New Mexico Alternative Benefit Plan (ABP). The **ABP covers *doctor visits, preventive care, hospital care, emergency department and urgent care, specialist visits, behavioral health care, substance abuse treatment, prescriptions, certain dental services, and more*.** Some recipients will have to pay small co-pays for certain services, depending on their income.

The ABP covers Medicaid-eligible adults ages 19-64 whose income is no more than 138% of the Federal Poverty Level. This also includes the Medicaid Expansion Population and Transitional Medical Assistance categories.

Pregnancy and Family Planning Services

Pregnancy and family planning services are Covered Services that do not require prior authorization (including obstetrical ultrasounds). Members may self-refer for care (including access to Non-Contract Providers). Federal law prohibits restricting access to family planning services for Medicaid recipients.

Services covered for Family Planning include all pregnancy testing, prenatal genetic screening, and any counseling & education. Covered members can self-refer to any Molina contracted *as well as* non-contracted family planning providers in New Mexico, if there are no other contracted providers available. These providers may include PCPs, OB/GYNs, Planned Parenthood clinics and Department of Health clinics.

It is possible to be covered by Medicaid for pregnancy only. This coverage is only for pregnancy and postpartum through the following 12 months after the date of delivery.

Newborns

Important Reminder about Newborns

When a child is born to a mother enrolled with Molina Healthcare, the hospital or other Provider shall complete a Notification of Birth, prior to or at the time of discharge to ensure that the Medicaid eligible newborn is enrolled and medically covered under their Mother’s MCO. New mothers are to be instructed to contact the New HCA ISD caseworker to notify of the newborn. As a reminder, do not submit claims for a newborn with the mother's subscriber's identification number.

EPSDT Services

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental and specialty services.

Early

Assessing and identifying problems early

Periodic

Checking children's health at periodic, age-appropriate intervals

Screening

Providing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems

Diagnostic

Performing diagnostic tests to follow up when a risk is identified

Treatment

Control, correct or reduce health problems found

EPSDT Services: Tot-to-Teen

Primary care providers (PCP), dentists, psychologists, IHS public health clinics, federally qualified health center (FQHC), rural health clinic (RHC), community mental health centers (CMHC), hospitals, school-based clinics, independent certified or licensed nurse practitioners and other health care providers may perform tot-to-teen HealthCheck screens or partial health screenings. A provider must meet the participation requirements specified in applicable sections of NMAC rules. Tot-to-teen HealthCheck screens must be furnished within the scope of the provider's practice, as defined by law.

The MAD Tot-to-Teen HealthCheck periodicity schedule allows for a total of 25 screens. Screenings are encouraged at the following intervals:

- **Under age one:** six screenings (birth, one, two, four, six and nine months)
- **Ages one-two:** four screenings (12, 15, 18 and 24 months)
- **Ages three-five:** three screenings (three, four and five years)
- **Ages six-nine:** two screenings (six and eight years)
- **Ages 10-14:** four screenings (10, 12, 13 and 14 years)
- **Ages 15-18:** four screenings (15, 16, 17 and 18 years)

EPSDT Services: How to Navigate

Navigating Molina's EPSDT process is easy. The steps and links can be found below:

EPSDT Skilled Services	EPSDT Personal Care Services (PCS)
Requested by the Provider	**Requested by the Care Coordinator**
Private Duty Nursing, Physical Therapy, Occupational Therapy, Outpatient Therapy, Speech Therapy	The Member's assigned care coordinator will submit the request and required documentation
Authorization requirements can be found by accessing our PA Lookup Tool or in our Provider Resource Manual. PA Lookup Tool Link: https://www.molinahealthcare.com/members/nm/en-us/health-care-professionals/home.aspx	EPSDT PCS providers must be registered as provider type 324-Nursing Agency, Private Duty

Dental

DentaQuest
a Sun Life company

Dental is a covered service for all Molina Healthcare of New Mexico's members. DentaQuest is our contracted vendor. DentaQuest is a leading dental insurance provider in New Mexico, providing dental coverage to eligible members. They have an oral ecosystem committed to quality patient care, efficient processes and continuous improvement on the fundamentals to help your practice perform at its best.

For Members: Dental Care For Members (dentaquest.com)

Contact Information:

Phone: DentaQuest toll-free (800) 341-8478
Provider Website: New Mexico Dental Providers (dentaquest.com)

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Non-Emergency Medical Transportation

Non-Emergency Medical Transportation (NEMT) is a Covered Service for all Molina Healthcare members. Superior Ambulance is our contracted vendor. Superior Ambulance provides transportation to and from medical appointments. NEMT is **not** for emergencies or transfers between facilities and cannot be used for trips to a pharmacy. NEMT can be coordinated for "non-emergent" discharges from facility, and clinics and request standing order for dialysis or chemotherapy.

For Members: Contact Superior three (3) business days in advance to schedule NEMT.

Contact Information:
Phone: 505-341-0042, or Toll-free, 833-707-7100 (TTY:711)
Provider Website: Contact | Superior Ambulance (superior-nm.com)

Telemedicine

We are pleased to partner with Teladoc Health to offer members virtual care. We encourage our providers to lean on Teladoc when your patients need immediate care or to assist with access standards. Teladoc offers 24/7 access to U.S. licensed doctors by phone or video. Molina Healthcare is committed to offering our providers and members options to ensure positive health outcomes.

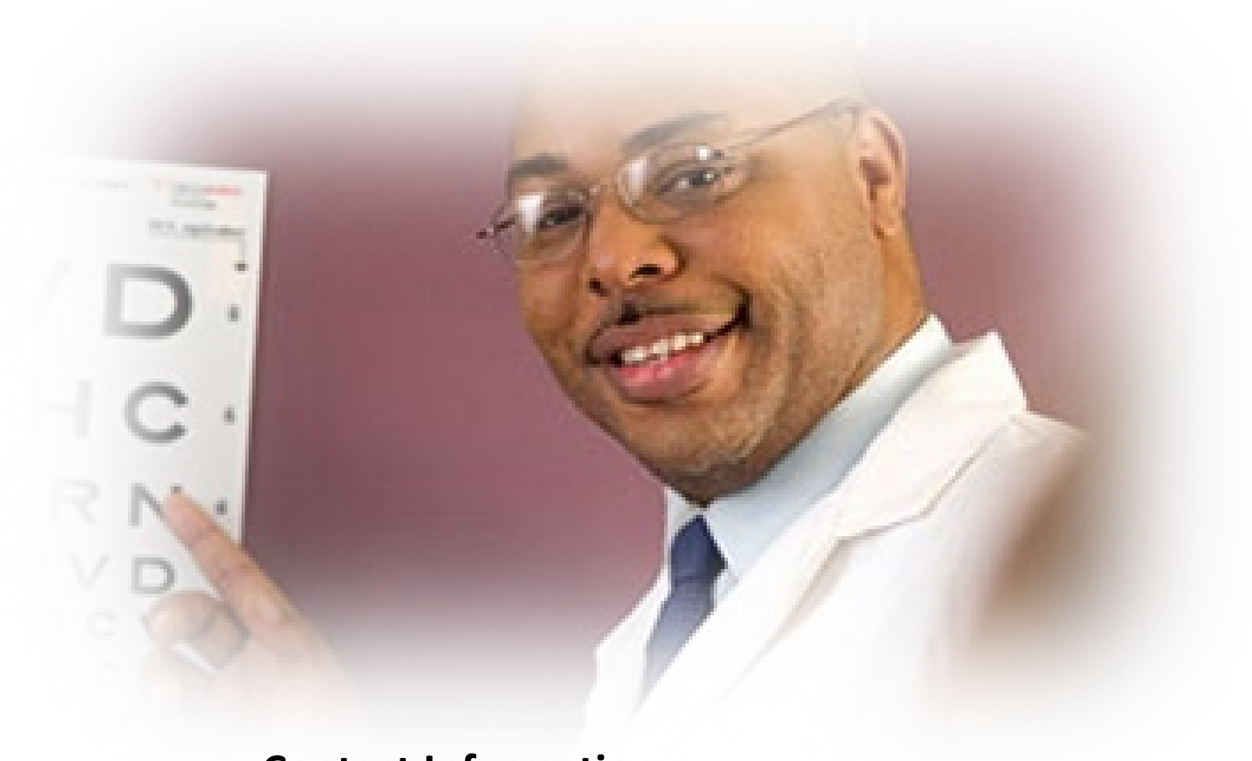
For Members: Teladoc - Account Registration

Vision

MARCH Vision Care

Vision is a covered service for all Molina Healthcare of New Mexico's members. March Vision Care is our contracted vendor. March Vision Care prides itself in providing excellent care to members. They partner with highly trained eye care professionals who share their commitment to vision care that focuses on early detection, education, and management through innovative, member-oriented solutions.

For Members: Vision (molinahealthcare.com)



Contact Information:

Phone: MVC Toll-free (844) 706-2724
Provider Website: eyeSynergy
Email: marchinfo@marchvisioncare.com

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Long-term Support Services (LTSS)

Long-term support services (LTSS) help people with chronic physical and/or behavioral health conditions. When you complete a health risk assessment (HRA), the results of the HRA could show that you may benefit from LTSS. If we see that

LTSS can help you, a care coordinator will schedule and complete an in-home comprehensive needs assessment (CNA) with you.

If you do not require 24-hour care, you may be eligible for community benefits. This allows you to stay in your home and supplement the care you get from natural supports. There are two types of community benefits:

- Agency based
- Self-directed

Pharmacy

Molina will align its pharmacy benefit coverage with the NM HCA Medicaid Preferred Drug list (PDL), including prior authorization status, quantity limits, and daily supply limits. Prior authorization criteria will also align with NM 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* List of CPT & HCPCS codes that require NDC
Preferred Drug List	Molina Healthcare Drug Formulary	Must be on Rebate eligible list Rebatable Drug List for J-Code Billing | NM Health Care Authority
Prior Authorization	States required criteria and forms	Universal Form (must use)
PA Forms Fax	**1-866-472-4578**	**1-833-322-1061**
Approval Process	Pharmacy UM team	Medical UM Team

Value Added Services

Value Added Service (VAS) means any service offered by the Molina that is not a Medicaid covered benefit. Value Added Services are benefits are available to meet the unique, complex, and unmet needs of Molina Members. All VAS requires prior authorization.

Value Added Service	Description	Eligibility	Who to Contact
Enhanced Transportation	Up to $300 per calendar year. Financial support for medical and non-medical transportation use. Provides members the ability to utilize other modes of transportation to grocery shop, pick up medications at the pharmacy, go to work, school, job interviews.	Member must have completed a Health Risk Assessment for the calendar year and participate in Care Coordination. Benefit amount is identified by the Care Coordination team.	Contact Member Services toll free at 844-862-4543 , TTY711 for hearing impaired.
Enhanced Overnight Lodging	Up to $300 per calendar year. Provides overnight lodging to members and their family who are receiving care more than 150 miles from their residence.	Member must have completed a Health Risk Assessment for the calendar year and participate in Care Coordination. Benefit amount is identified by the Care Coordination team.	Contact Member Services toll free at 844-862-4543 , TTY711 for hearing impaired.
Molina Health in Touch	No cost smartphone, including unlimited talk, text and data	All Members. Member must have completed a Health Risk Assessment for the calendar year and participate in Care Coordination.	Contact Member Services toll free at 844-862-4543 , TTY711 for hearing impaired.

Value Added Services (continued)

Value Added Service	Description	Eligibility	Who to Contact
Traditional and Holistic Healing	Support for members to receive traditional and holistic healing services that are aligned with their culture and traditions. May include, but not be limited to: therapeutic massage, acupuncture, traditional ceremonies and services and curanderismo. Up to $300 per calendar year outpatient benefit, and up to $250 per calendar year inpatient benefit.	All Members. Member must have completed a Health Risk Assessment for the calendar year and participate in Care Coordination.	Contact Member Services toll free at 844-862-4543 , TTY711 for hearing impaired.
Women's and Infant Health Supplies	Provides access at no cost to pregnancy tests, women's hygiene items, as well as member identified new baby/new mother items. We support women and infant health by supplying various new mother and new baby items. Examples include but are not limited to: OTC Pregnancy Tests Feminine Hygiene products New Baby Items: cradle boards, a choice of any size car seat, travel crib, or stroller. Up to $500 per calendar year for items for women's health items as well as new mother and new baby items.	Completion of HRA and participation in Care Coordination. For new Baby Items: Pregnant mothers and new mothers who have completed two or more pre-natal well check visits and/or two or more well baby checks.	Contact Member Services toll free at 844-862-4543, TTY711 for hearing impaired.

Value Added Services (continued)

Value Added Service	Description	Eligibility	Who to Contact
Enhanced Services for LTSS member	Additional support for LTSS members. Examples include but are not limited to: home modifications/environmental modifications; additional respite, remote home-based monitoring, home-maker services, personal care services for newly discharged members in need of short-term assistance and support. Up to $2000 per calendar year.	Molina members who have completed a Health Risk Assessment and are participating in Care Coordination	Contact Member Services toll free at 844-862-4543 , TTY711 for hearing impaired.
Workforce Development	Up to $350 per calendar year. Services can include: Supplemental services and supplies to support member education and workforce opportunities and development. Examples include, but are not limited to: books, tools, technology, uniforms, GED vouchers.	Molina members who have completed a Health Risk Assessment and are participating in Care Coordination	Contact Member Services toll free at 844-862-4543 , TTY711 for hearing impaired.
Housing Assistance	Up to $1000 per calendar year, per household. Housing support, including, but not limited to: rental deposit assistance, pest control, and needed home goods. Supports members in need of housing assistance, including home good items.	Molina members who have completed a Health Risk Assessment and are participating in Care Coordination	Contact Member Services toll free at 844-862-4543 , TTY711 for hearing impaired.
BeMe	BeMe Health is a digital behavioral health mobile application that delivers mental health interventions designed specifically for teens up to 19.	Molina members who have completed a Health Risk Assessment and are participating in Care Coordination	Contact Member Services toll free at 844-862-4543 , TTY711 for hearing impaired.

Value Added Services (continued)

Value Added Service	Description	Eligibility	Who to Contact
Activities Bucks	Up to $300 per calendar year. Financial support for fees and related expenses associated with participation in activities such as sports leagues, 4H, marital arts, dance, and cheer. Expenses may include the cost of camps or Travel/Club Teams, uniforms, shoes, and travel expenses.	Molina members who have not completed a Health Risk Assessment and are participating in Care Coordination.	Contact Member Services toll free at 844-862-4543 , TTY711 for hearing impaired.
Enhanced Vision	Financial support for additional vision services, including frames and lenses. Up to $300 per calendar year	Molina members who have completed a Health Risk Assessment and are participating in Care Coordination	Contact Member Services toll free at 844-862-4543 , TTY711 for hearing impaired.
Enhanced Dental	Supports members in accessing additional dental services. Up to $500 per calendar year	Molina members who have completed a Health Risk Assessment and are participating in Care Coordination	Contact Member Services toll free at 844-862-4543 , TTY711 for hearing impaired.
Court Record Expungement	Financial support towards court filing fees necessary to complete a court record expungement of minor criminal offenses removes a barrier to employment. Up to $200 lifetime benefit.	Molina members who have completed a Health Risk Assessment and are participating in Care Coordination	Contact Member Services toll free at 844-862-4543 , TTY711 for hearing impaired.

Prior Authorizations

Referrals and Service 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 Service 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.

Service Authorization and Referral Process

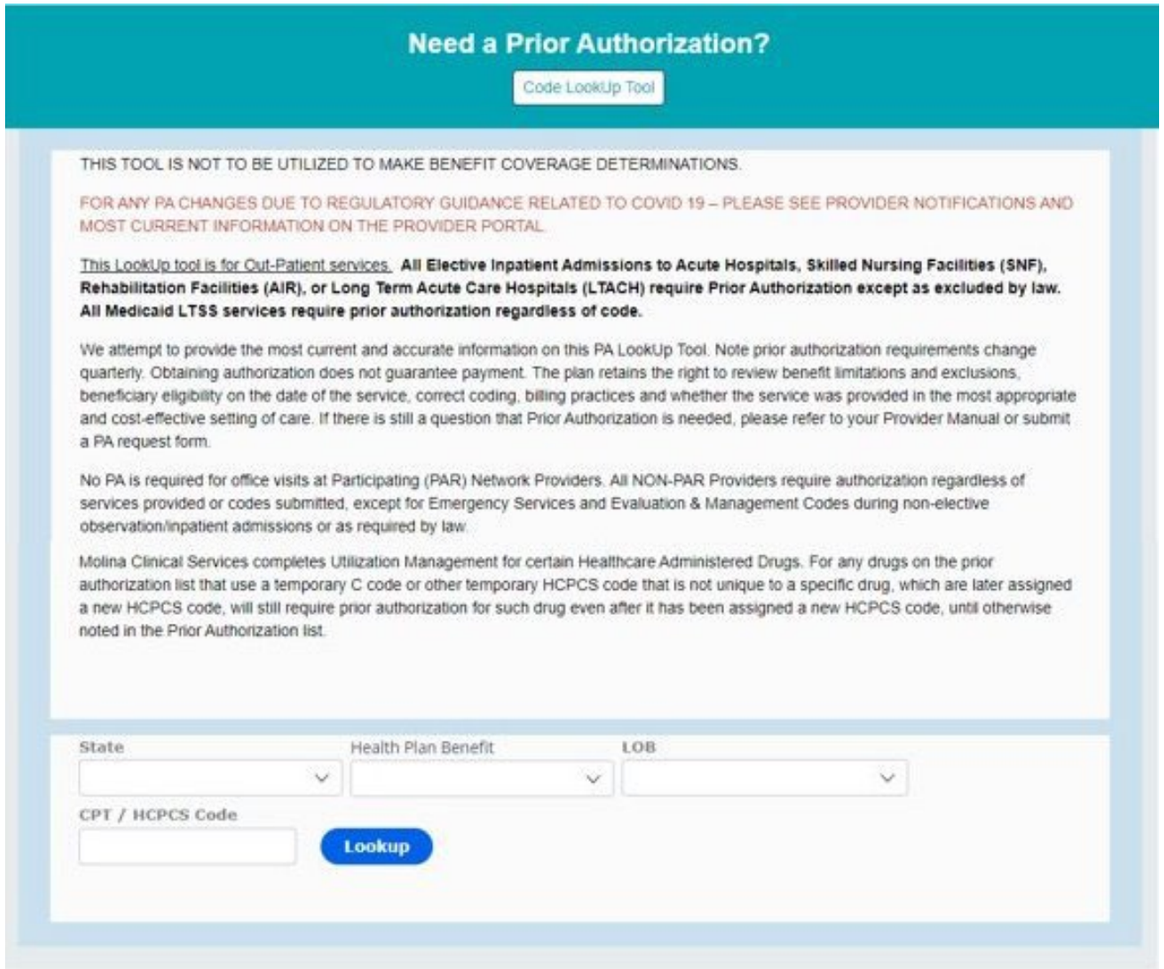
Navigating Molina's Referral process is easy. Covered and non-covered referrals can be found below:

Primary Care Providers (PCPs)	Specialty Outpatient Referral	Family Planning Providers	Non-Contracted Providers
No prior auth needed in network	No prior auth needed in network	No prior auth needed	Prior auth needed out-of-network
Primary Care Provider (PCP) means an individual who is a Contract Provider and has the responsibility for supervising, coordinating, and providing Primary Care to Members, initiating referrals for specialist care and maintaining the continuity of the Member's care.	Consultation, excluding Behavioral Health, request-to-appointment time should be triaged according to the clinical urgency • twenty-four (24) hours for urgent appointments, • fourteen (14) Calendar Days for symptomatic appointments, a nd • forty-five (45) Calendar Days for routine Asymptomatic appointments, • unless the Member requests a later time;	Each adolescent and Adult Member may use their own PCP or go to any family planning provider for family planning services without requiring a referral. Each Member shall also have the right to self-refer to a Contract Provider women's health specialist for Covered Services.	Members should always be directed to in-network providers, unless there is not an in-network provider available. Referrals to out-of-network providers require a Single Case Agreement to be reimbursed for services.

Service Authorization Look Up Tool

Providers should always refer to Molina's Provider Website or Prior Authorization Lookup Tool/Matrix for specific codes that require authorization. Failure to obtain authorization when required will result in denial of payment for services rendered. In cases where the provider did not know, nor reasonably could have known the patient was a Molina Member, or there was a Molina error, a Medical Necessity "post-service" review can be performed for consideration of payment. Decisions in this circumstance will be based on medical need appropriateness of care guidelines defined by UM policies and criteria, regulation, and guidance and evidence-based criteria sets. Prior Authorization Lookup Tool

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



Service Authorization

Obtaining Authorization

Providers should always refer to Molina's Provider Website or Service Authorization Lookup Tool/Matrix for specific codes that require authorization.

- Failure to obtain authorization when required will result in denial of payment for services rendered. In cases where the provider did not know, nor reasonably could have known the patient was a Molina Member, or there was a Molina error, a Medical Necessity "post-service" review can be performed for consideration of payment. Decisions in this circumstance will be based on medical need appropriateness of care guidelines defined by UM policies and criteria, regulation, and guidance and evidence-based criteria sets.
- Link to our Service Authorization Lookup Tool: Prior Authorization Lookup

Behavioral Health Service Authorization

Please refer to the Molina Provider Reference Manual for a list of services requiring prior authorization.

Behavioral Health request may be applied for via Fax:

- Molina Healthcare of New Mexico Behavioral Health Outpatient Treatment Request Form
- Phone: (800) 377-9594
- Fax: (888) 295-5494
- Local Fax: (505) 924-8237

Service Authorizations

Submitting a Prior Authorization Request

Providers are required to complete our New Mexico Uniform Prior Authorization Form when an authorization is needed. Submission can be done electronically or by facsimile. Submission information can be found on the Prior Authorization Form.

- Prior Authorizations do not apply to ER, unless the ER provider is non-participating/contracted.
- Link to our Authorization Form: Prior Authorization Form
- Link to our Authorization Guide: Prior Authorization Guide
- Link to our Authorization Lookup Tool: Prior Authorization Lookup Tool

Second Opinions

Molina Members or their Representatives have the right to seek a second opinion from a qualified health care professional within Molina's network. Providers and Members can also request that Molina arrange for the Member to obtain a second opinion outside the network (this will require prior authorization for any out-of-network services), at no cost to the Member. A second opinion may be requested when the Member or the Member's Representative needs additional information regarding recommended treatment or believes the provider is not recommending necessary care.

Telemedicine

Telemedicine

Telemedicine provides your patients with convenient access to health care professionals. We encourage the use of telemedicine. This technology improves access and quality to care.

Telemedicine (also referred to as "telehealth") means the use of electronic information, imaging, and communication technologies (including interactive audio, video, and data communications as well as store-and- forward technologies) to provide and support health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education in accordance with NMAC 8.310.2.12.M.

Telemedicine Services

Members may obtain Covered Services by Participating Providers, using Telehealth and Telemedicine Services:

- Services are a method of accessing Covered Services, and not a separate benefit
- Services are not permitted when the Member and Participating Provider are in the same physical location
- Services do not include texting, facsimile or email
- Member cost sharing associates to the Summary of Benefits and Coverage, based upon the Participating Provider's designation for Covered Services. (i.e., Primary Care, Specialist or another type of Practitioner).
- Covered Services provided through Store and Forward technology, must include an in-person office visit to determine diagnosis or treatment.

Telemedicine Software and Hardware Requirements

Interactive telemedicine communication systems must include both interactive audio and video and be delivered on a real-time basis at the originating and distant site. The software and hardware requirements include:

- **Bandwidth** – Visit HealthIT.gov healthit.gov\faq\what-recommended-bandwidth-different-types-health-care-providers for more information.
- **Camera** – may be external or integrated into your device
- **Computer or Mobile Device** – providers should confirm which devices and operating systems are compatible with their software vendor.
- **Internet Connection** – must be a wired connection or secure Wi-Fi
- **Secure Telemedicine Software** – FaceTime and Skype are not HIPAA compliant.
- **Comply –** With all relevant safety laws, regulations and codes for technology and technical safety, as well as those required by HIPAA's Security Rule and HITECH Act.

Telemedicine Definitions and Requirements

- **Distant site:** is the location where the telehealth provider is physically located at the time of the telemedicine service
- **Originating site:** is the location of the eligible recipient at the time the service is being furnished using an interactive telehealth communications system
- **Telehealth providers** (such as any provider groups, facilities, and agencies or organizations). Health professionals providing telemedicine services must:
    - Providers must ensure compliance with current legislation, all regulations and accreditation requirements for supporting patient/client decision-making consent, including the confidentiality of the patient's protected health information (PHI);
    - Providers must comply with all safety laws, regulations and all codes for technology and technical safety, as well as HIPAA's Security Rule and HITECH Act.

Originating Site

An originating site is any medically warranted site or location type. Medicare's geographic restrictions for the locations and types of eligible originating sites DO NOT apply to New Medicaid managed care.

- **Telehealth providers** - Health professionals providing telemedicine services must:
  - Providers must ensure compliance with current legislation, all regulations and accreditation requirements for supporting patient/client decision-making consent, including the confidentiality of the patient's protected health information (PHI);
  - Providers must comply with all safety laws, regulations and all codes for technology and technical safety, as well as HIPAA's Security Rule and HITECH Act

- **Originating Site providers** can bill Q3014 for telemedicine services using a CMS-1500 form.
  - For reimbursement, the member must participate in the telemedicine visit. A patient no show is not reimbursable by Molina.
  - Telemedicine services must be received by the member at a provider location OR a location that includes a provider staff person accompanying the member.
  - The distant provider must be at a separate location from the originating site if the telehealth services are provided by a different provider off-site.

Distant Site

Same rate as when services provided are furnished without use of telecommunication system. Procedure codes must be billed with the appropriate modifier GT, GQ, G0 (letter G and number zero), or 95.

- GT: Modifier is used for telehealth services; via interactive audio and video telecommunication systems
- GQ: Modifier is used for telehealth services; via asynchronous telecommunications system
- G0 (letter G and number zero): Telehealth services are used for diagnosis, evaluation or treatment of symptoms of an acute stroke
- 95: indicates a synchronous telemedicine service that is provided to the member via a real-time interactive audio and video telecommunications system.

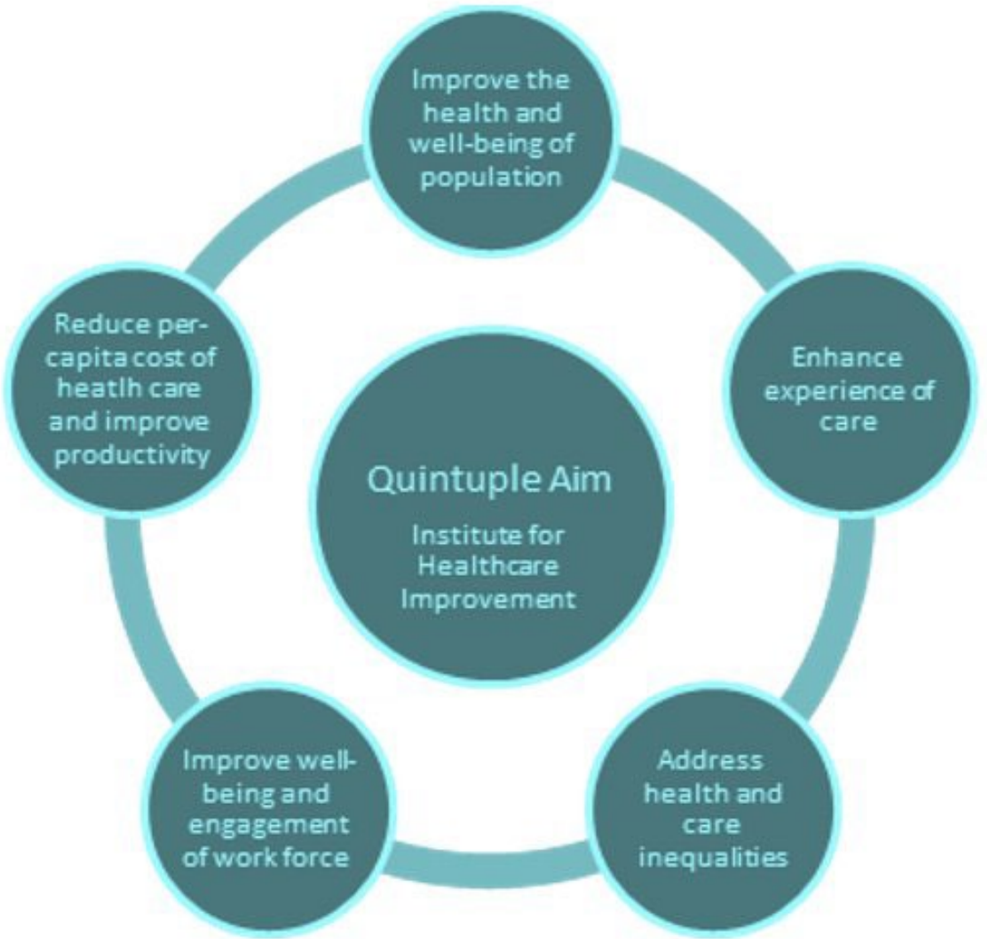
Post PHE Telehealth Services

- Post PHE telehealth services will be covered as defined in NMAC 8.310.2
- Telephone visits will continue to be allowed as they have been during the PHE, including in a member's home.
- This flexibility ends **December 31, 2024.**

Quality Improvement

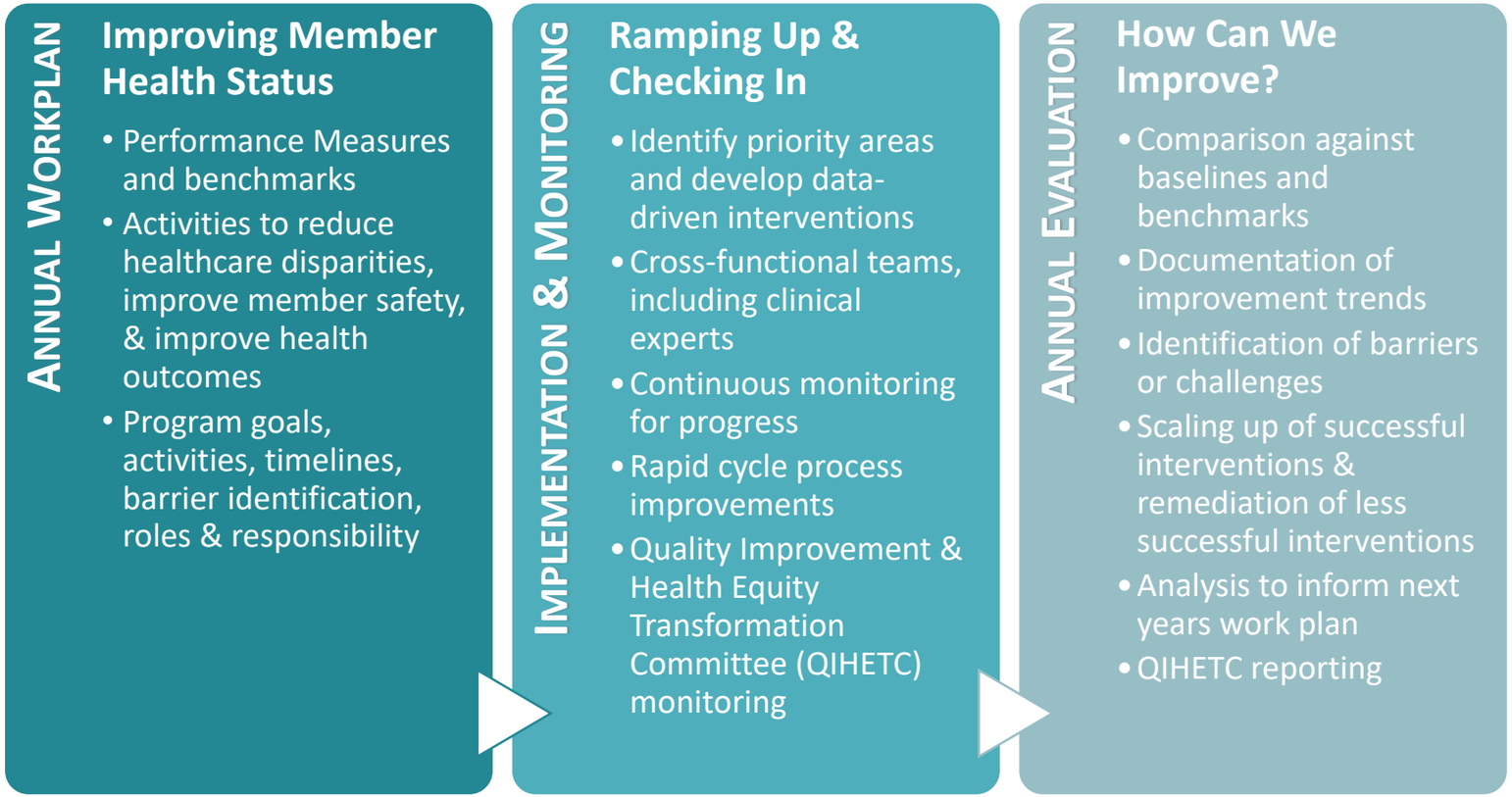
Continuous Quality Improvement

The Molina Healthcare of New Mexico, Inc. (Molina Healthcare) Quality Improvement (QI) Program is a comprehensive framework for continuous assessment and focused improvement of all aspects of health care delivery and service. We annually assess the effectiveness of the QI Program to provide the structure and key processes that enable us to plan and implement our care and service goals on an ongoing basis. The QI Program is an evolving program that is responsive to the changing needs of our members and the advances and changes in clinical practice. The current QI Program activities focus on critical areas for improving the service to and health status of our membership based on ongoing measurement and analysis of our programs.



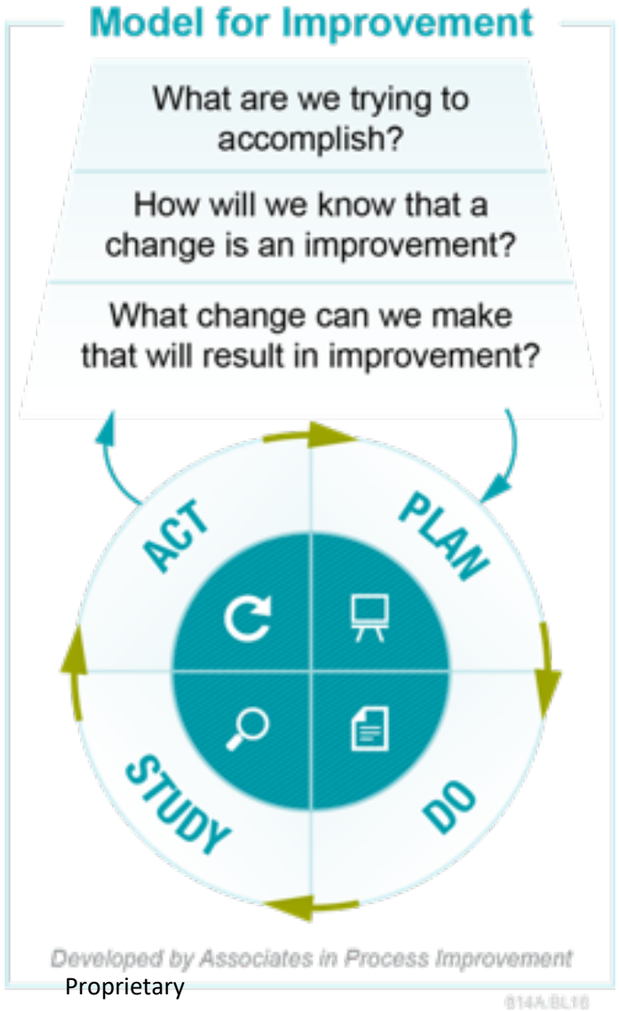
Molina Healthcare Quality Improvement Strategy

Progress in Action



Continuous Quality Improvement Cycle

Progress in Action



Medicaid Measures in Focus: Health Data & Information Set (HEDIS®)

Progress in Action

Diabetes Care

- HbA1c Control (<9%)
- Retinal Eye Exam
- Kidney Health Evaluation

Prevention & Screening

- Breast Cancer Screening
- Immunizations for Adolescents
- Lead Screening in Children
- Oral Evaluation, Dental Services

Access/Availability of Care

- Timeliness of Prenatal Care
- Postpartum Care

Utilization

- Well Child Visits : first 30 months
- Well Child Visits: Age 3-21 years

Behavioral Health

- Follow-up care for children prescribed ADHD Medication
- Follow-up after Hospitalization for Mental Illness
- Pharmacotherapy for Opioid Use Disorder

Provider Roles in Quality Improvement

Progress in Action

Engage with assigned membership, especially after acute hospitalization or emergency room events

Follow Clinical Practice Guidelines

Utilize Provider Portal for exchange of information

Submit Supplemental Data for measure completion

Utilize Syncronys, New Mexico's Statewide Health Information Exchange

Participate in Value-Based Contracts

Review Care Gap lists

Provide input on improving member satisfaction and care in Joint Operating Committees (JOCs) and other meetings

Population Health Management

Population Health Management

Population Health Program

Molina's data-driven Population Health Program serves all Members, in all aspects of their lives, by holistically understanding the Members we serve; the diseases that impact local populations; social dynamics and health inequities; and disparities within the populations. Our overarching strategy aligns with the Institute for Healthcare Improvement's (IHI's) Quadruple Aim: improve population health, enhance the care experience, reduce costs, and address the needs of the healthcare provider. Our Population Health Management Plan goals and objectives mirror and support HCA Turquoise Care priority population streams and population health needs. Molina tailored our population health management strategies to address NM-specific health inequities. Having identified our population streams and their needs, we then develop objectives and strategies for our annual population health management work plan.

Women's Health	INCREASE	Access to contraception • Preventive screenings including STI, CCS, and BCS screening • **Number of Molina Healthcare at Home for pregnant and postpartum members****
	DECREASE	Preterm birth and low birth weight • Infant and Maternal Mortality • Birth outcome disparities for minority populations
Seniors and Members with LTSS Needs	INCREASE	# of providers in LTSS VBP • # of members with care plan • **LTSS caregiver workforce****
	DECREASE	Avoidable ED/IP use
Members with BH Conditions	INCREASE	SBIRT for BH and SUD conditions • F/U after hospitalization • Adherence to antidepressants • Adherence to antipsychotic medications • SDOH screening and referral for services • **Access to BH and BH crisis services (e.g., CCBHC) ****
Native American Members	INCREASE	**Access to culturally competent services** • Broadband access
	DECREASE	Prevalence DM • Incidence alcohol related trauma • Suicide rate • Health inequities
Justice-involved Individuals	INCREASE	Preventive screenings • Access to trauma informed care • Access to SDOH support upon release • **Access to MAT services****
	DECREASE	Recidivism rates
Children's Health and Wellness	INCREASE	Well child visits, EPSDT, developmental screenings • Immunizations • Weight assessment and counseling • **Percentage with regular source of Primary Care****
Adult Health and Wellness	INCREASE	Age appropriate preventative screening • **Percentage with regular source of Primary Care****
	DECREASE	Obesity rate • Tobacco, alcohol, and substance abuse •

**** Turquoise Care Goals**

136.NM22

TURQUOISECARE MOLINA HEALTHCARE

Population Health Programs

	Primary Care	Maternal and Child Health	BH	Chronic Condition Management	Native Americans	Hospitals/LTSS Providers
Program	Promote coordination of care and investment in quality to improve health outcomes	Perform outreach and care coordination to improve birth outcomes and immunization rates	Drive integrated care to holistically address whole-person functional outcomes	Reduce avoidable acute events and costs by stabilizing and improving chronic condition management	Incentivize coordination of care with I/T/U Providers to improve health outcomes	Drive improved quality and reduce avoidable costs while improving health outcomes
Provider Types	• PCPs • PCMHs • FQHCs/RHCs • Virtual ACOs • Dentists • Nonclinical support	• OB/GYNs • PCPs • PCMHs • FQHCs/ RHCs • Virtual ACOs • Midwives/doulas • SUD Providers • Nonclinical support • Maternal Health Homes	• Outpatient BH Providers • CMHCs and CSAs • Public health clinics • FQHCs/RHCs • CCBHCs • Virtual ACOs • SBHCs • Nonclinical support	• Specialty Providers (e.g., cardiology, endocrinology, and pulmonology) • Pharmacy • Nonclinical support	• I/T/Us • Nonclinical support • Native American Health Homes	• Hospitals • NFs • Home health agencies • Personal care Providers • Nonclinical support
Targeted Performance Measures	• HEDIS rates • Member HRAs • Medication compliance • Potentially preventable events • Total cost of care • Telehealth utilization	• HEDIS/EPSDT rates • Member HRAs • Prenatal screenings • Tobacco cessation • Postpartum depression screenings • Potentially preventable events • C-section rate • Low birthweight babies	• HEDIS rates • Member HRAs • Prenatal screenings • Tobacco cessation • Postpartum depression screenings • Potentially preventable events • C-section rate • Low birthweight babies	• HEDIS rates • Medication compliance • Potentially preventable events • Condition-related measures • Physical and BH coordination • Remote/telehealth screenings • Total cost of care related to condition	• GPRA/HEDIS rates • Member HRAs • Care coordination • Medication compliance for preventive care • Potentially preventable events • Claims submission/ accuracy effectiveness	• HEDIS rates • Member HRAs • Medication compliance • Potentially preventable events • Preventive screenings • Baby-friendly designation • Total cost of care

Fraud, Waste and Abuse

Fraud, Waste and Abuse

Fraud, Waste and Abuse is defined as:

"Fraud" means an intentional deception or misrepresentation by a person or an entity, 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.

"Waste" means the overutilization of services or other practices that result in unnecessary costs.

"Abuse" means provider practices that are inconsistent with sound fiscal, business, medical or service-related practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary Services or that fail to meet
professionally recognized standards for health care. Abuse also includes Member practices that result in unnecessary cost to the Medicaid program pursuant to 42 C.F.R. § 455.2.

The Molina Healthcare Alert Line is available 24/7. To report an issue:

- By telephone, call toll-free at (866) 606-3889
- Online, visit: https://molinahealthcare.alertline.com/

Critical Incident Reporting

Critical Incident Reporting Requirements

Under Turquoise Care, the State of New Mexico Health Care Authority (HCA) requires that all Molina Healthcare New Mexico's contracted Providers, Practitioners, Caregivers and Subcontractors report, respond to, and document Critical Incidents and the resulting follow-up activities. Allegations must be reported to HCA through the Critical Incident Reporting Portal at: HSD Critical Incident Reporting: Login (state.nm.us) or MNM_BH_CI@molinahealthcare.com

Suspected abuse of members should be reported immediately. Providers are mandated by law to contact:

- Adult Protective Services by phone at 866-654-3219 or via fax at 855-414-4885; or
- Children, Youth & Families Department at 855-333-7233; and/or
- Contact law enforcement or the appropriate tribal entity.
- For more information and helpful training documents on what and how to report, visit: hsd.state.nm.us/providers/critical-incident-reporting/
- Behavioral Health Critical Incident Reporting Fax: 1-833-616-4830

Please refer to our Provider Reference Manual for additional information.

Critical Incident *means a reportable incident that may include, but is not limited to: Abuse; neglect, exploitation; death; environmental hazard; law enforcement intervention; emergency services; severe harm; abduction; elopement; sexual abuse or assault; and flame or unanticipated smoke, heat, or flashes occurring during an episode of Member care.*

Care Coordination

Care Coordination

Care Coordination Processes

Molina health care services department assists Providers by identifying needs and issues that may not be identified 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, Members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative that result in unnecessary costs pursuant to 42 C.F.R. § 455.2.

- The **first** occurs when a new Member enrolls in and needs to transition medical care to Molina contracted Providers. Within the enrollment process, Molina identifies and reaches out to the members to assist in obtaining authorizations, DME vendors, approval for prescriptions, or other services.
- The **second** coordination of care process occurs when a Member's benefits will be ending, and they need assistance in transitioning to other care. The process identifies Molina Members whose benefits are ending and will need continued care.
- Molina health care services staff work with Providers in the referral process from PCP, Specialist, Member/Member's Representative Self-Referral, and request from internal staff and HCA.

Types of Care Coordination

Integrated Care Approach

Molina Health Care Services Staff work with Providers to assist with coordinating referrals, services and benefits for these Members. Molina offers a robust program for our Medicaid members to help meet their health care needs for Medicaid Covered Services:

- Acute and long-term care
- Behavioral health care
- Home and community-based services. A member must meet Nursing Facility Level of Care criteria to be eligible for home and community-based services.
- High-risk pregnancies and Postpartum period

Health Risk Assessment (HRA)

Health Risk Assessment (HRA) is the HCA approved and standardized health screening questionnaire, used by the Molina to provide individual Members with an evaluation of their health risks and identification of their current health needs.

The purpose of the HRA is to introduce Molina to the Member, obtain basic health and demographic information about the Member, and confirm the need for a Comprehensive Needs Assessment (CNA).

HRA's are performed for

- All Members who are newly enrolled in Turquoise Care, including those with retroactive eligibility
- Members who are in (Care Coordination L0) CCL0 and who have a change in circumstance or health condition that requires an assessment for a higher level of care; and
- Members transitioning from another MCO without a CCL span, or with an expired CCL span, per HCA guidelines and processes.

The HRA is completed within thirty (30) Calendar Days of the notification to Molina by HCA of the Member’s enrollment. Molina attempts to reach each member at least (3) times to schedule the HRA. If we are unable to reach the member, we will send a letter to the member's last known address.

Care Coordination

Comprehensive Needs Assessment (CNA)

Care plans are identified by areas of need and developed prior to CNAs face-to-face assessment in the member's home.
This activity includes the member and several team members such as providers, school representatives, homemakers, family members and others who are part of the member's life.

- Care Coordinator will conduct CNA assessment within three (3) calendar days of transition to identify any needs.
- The Care Coordinator will facilitate the development and implementation of a transition plan. This plan will be labeled “Transition of Care Plan”. May be a stand-alone document or included in CCP
- PCPs and members will have a copy of the care plan
- Can be performed outside of the home if HCA has granted an exception

Claims & Billing

Claims

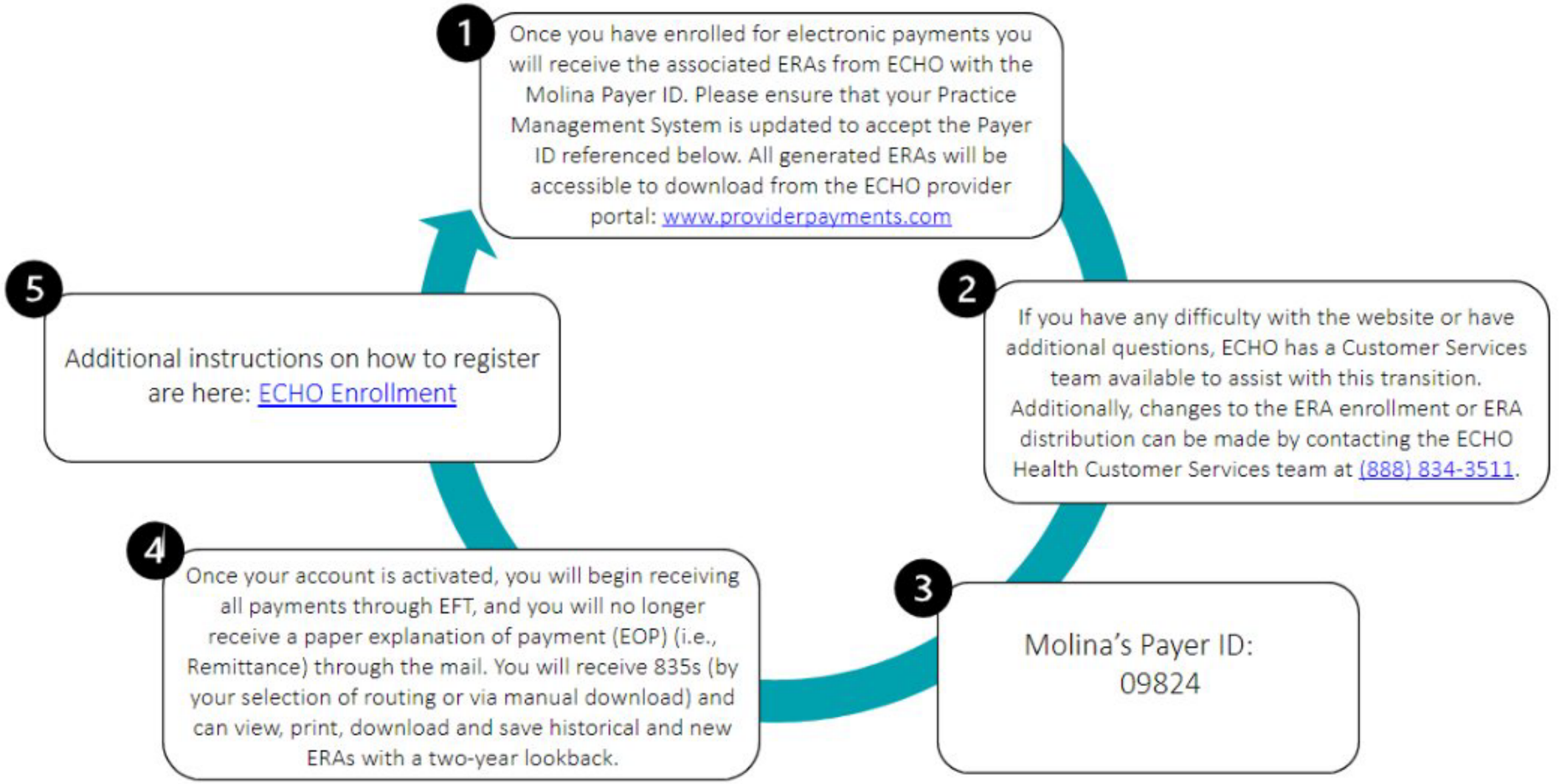
Molina requires participating providers to submit claims electronically, via a clearing house or Molina's Provider Portal, Availity. Claim submission types include: Electronic Data Interchange (EDI), Electronic Fund Transfers (EFT), Electronic Remittance Advice (ERA), Paper Claims, Claim Forms, Timely Filing, and Corrected Claims.

- Claims submission, status and claim details can conveniently be found on Molina's Provider Portal link: https://www.availity.com/molinahealthcare.
- EDI Payer ID: 09824
- Additional claim information can be found in Molina's Provider Reference Manual. If you are unable to submit electronic claims, paper submission will be accepted (must be submitted on CMS-1500 or CMS 1450 (UB-04) claim forms. Mail to:

Paper Claims:
P.O. Box 22801
Long Beach, CA 90801

- To speak with a representative, contact Provider Relations at (855) 322-4078.

Electronic Payment Requirement



Timely Filing

Claims must be submitted to us within ninety (90) days and for out-of-network providers one hundred twenty (120) calendar days after discharge or date of service.

Claims cannot be submitted before the discharge date for inpatient services or the Date of Service for outpatient services.

Indian Tribal Urban providers have up to two (2) years from the date of service to file claims.

Corrected claims are considered NEW claims and the same timely filing standards apply.

Claim Submission: Best Practice

Standard Edits

- Molina Healthcare with external vendors performs prepayment claim audits. These vendors use Medicare (i.e., CMS) claim edits and other industry standard coding guidelines
  - Current Procedural Terminology (CPT)
  - Health Care Procedure Coding System (HCPCS)
  - Evidence-based clinical edits to ensure proper handling of claims.
- It's important to apply industry standard edits appropriately

Clean Claims

- Molina requires clean claims submitted timely on CMS-1500 (professional) and UB-04 (technical/facility) forms
- The following items must be included to be considered a clean claim:
  - Member's name, gender and date of birth
  - Provider's National Provider Identifier (NPI)
  - Complete diagnosis code carried out to the highest degree (4^{th} or 5^{th} digit)
  - Date of Service
  - Current Procedural Terminology (CPT) code or Health Care Procedure Coding System (HCPCS) code
  - Valid Revenue (REV) codes
  - Valid modifiers (if appropriate)
  - All other requirements specified by CMS

Balance Billing

Providers and subcontractors of providers agree that in no event, including but not limited to, nonpayment by Molina, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member or persons or acting on their behalf of the Member for services provided. Participating providers are prohibited from collecting any payment for non-covered services from their member.

Providers must not bill members or accept payment from members for noncovered services unless all requirements of Section 8.302.1.16 NMAC have been satisfied: (1) provider advised member before furnishing a noncovered service that it is not covered; (2) provider gave member information about necessity, options and charges for the non-covered services; and (3) member agreed in writing to receive the non-covered services with knowledge that they will be financially responsible for payment.

Claim Submission: Helpful Reminders

Claim Submission

- Molina requests that contracted providers submit all claims **electronically**.
- Providers may use the Clearinghouse of their choosing. (Note that fees may apply).
- *SSI* is Molina Healthcare's chosen clearinghouse.
- High dollar (claims that will pay $100k or greater), require an itemized statement and/or medical records. A written notification will be mailed to explain what is needed and the requested items should be attached in Availity as a corrected claim if the claim has already paid.

- **Coordination of Benefits (COB)**
- Molina Healthcare Turquoise Medicaid is always the payer of last resort
- Claims are to be submitted with the complete primary insurance Explanation of Benefits (EOB)
- 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

Appeals and Grievances

If a member, member's authorized representative or a participating provider has a problem with medical care or our Molina services, you have a right to file a grievance or appeal.

An Appeal can be filed when you do not agree with Molina's decision to:

- Stop, suspend, reduce or deny a service
- Deny payment for services provided

By Fax:
Provider Disputes/Grievances: (855) 378-3642
Provider Appeals: (855) 378-3643

Appeals & Grievance Address
P.O. Box 182273
Chattanooga, TN 37422

Types of grievances may include:

- You have a problem with the quality of your care.
- Wait times are too long.
- Your doctors or the doctor's staff behaves badly.
- You cannot reach someone by phone.
- A doctor's office is not clean

Claim Reconsideration

Disputes

- Providers seeking a redetermination of a claim previously adjudicated must request such action within ninety **(90) calendar 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 Provider Reconsideration Review Request Form (PRR). This form can be found on the Molina Provider website.

- The item(s) being resubmitted should be clearly marked as reconsideration.

- Describe the issue in as much detail as possible and attach copies of the supporting documentation as applicable.

- The Claim number clearly marked on all supporting documents.

Claim Reconsideration and Appeals

Contacts and Important Addresses:

Claim Inquiry

- Claim Status can be reviewed in our Provider Portal, Availity:
  Molina Healthcare's Provider Portal
- Call our Provider Services Contact Center at (855) 322-4078
- Contact your dedicated Provider Service Representative: NM Network Team (If multiple claims need review, claims can be submitted on the Claim Research Template. It's important to include claim numbers for faster review.)

Provider Reconsideration Review

- For claim denials and/or payment disputes, complete the **P**rovider **R**econsideration **R**eview request form and fax it to our review team at (855) 378-3642.
- PRR form is needed to submit

Formal Appeals

- Appeals are to be submitted via our Provider Portal, Availity:
  Molina Healthcare's Provider Portal
- By Fax
  (855) 378-3643
- By Mail
  Molina Healthcare of New Mexico
  Attn: Appeals & Grievances
  PO Box

Appeals and Grievances – Provider Responsibilities

Member Appeals & Grievances:

- Providers should instruct members to contact Member Services at the number listed on the back of their Molina Healthcare of New Mexico ID card if they have a complaint or concern.

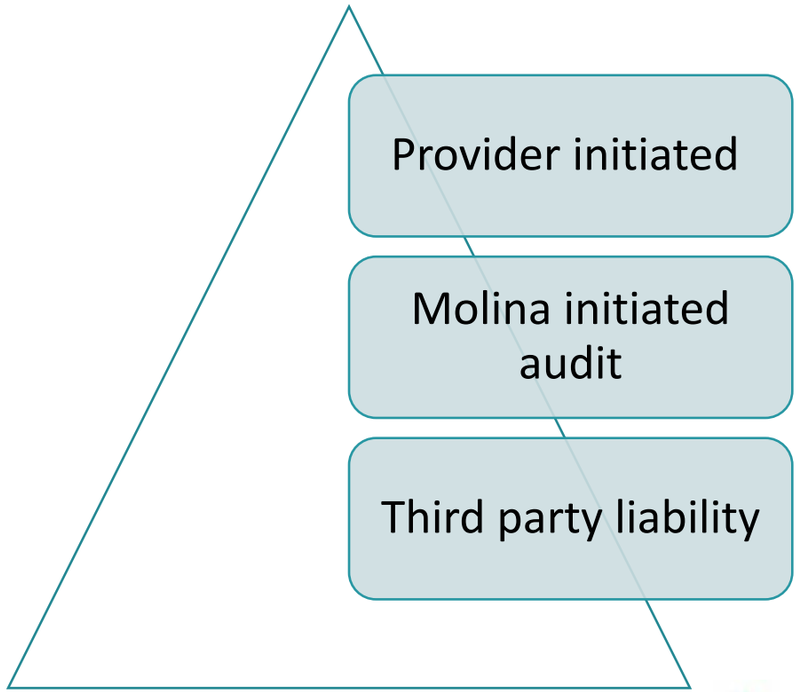
- Providers must cooperate with Molina Healthcare of New Mexico in providing pertinent information to resolve the appeal or grievance as soon as possible and within the required time frames.

Recoupment of Overpayments

Which claims can be recovered?

Any claims within 12 months from the date of service which Molina has overpaid to the provider.

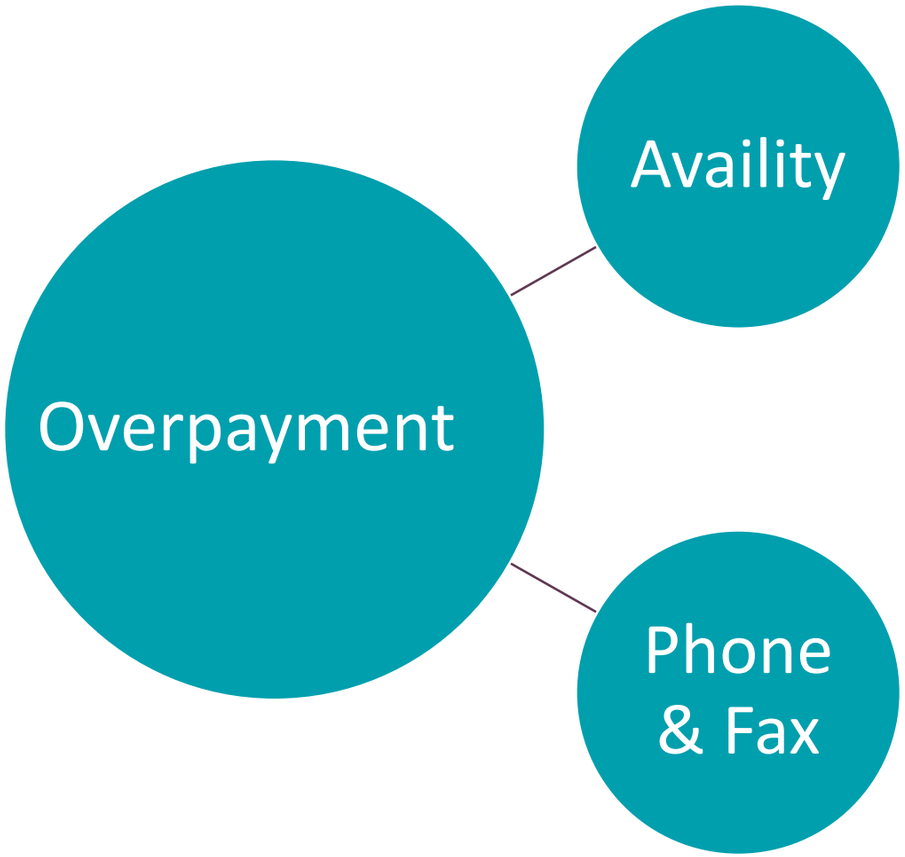
Types of Recoveries



Recoupment of Overpayments

Provider Initiated

Claims found to be overpaid by the provider can be reported to Molina in two (2) ways.



- Claims overpayments
- https://www.availity.com/molinahealthcare

- Contact Phone/Fax numbers for provider questions
- P: 866-642-8999
- F: 888-396-1516

Recoupment of Overpayments

Molina Audit Recoupments

While our preference is to process a future claim payment offset, should you decide to issue a refund please remit check payment along with a copy of the refund letter to the following address:

Molina Healthcare Of New Mexico
P.O. Box 741766
Los Angeles, CA 90074-1766

If you disagree with any of the overpayment determinations, please provide a written dispute response within 45 days of the overpayment notification. Submit your dispute along with a copy of the notification either via fax or mail to the following address:

Molina Healthcare of New Mexico
Attn: Corporate Claims Recovery
PO Box 2470
Spokane, WA 99210-2470

If you have already refunded any of the overpayments, please fax a copy of the recovery letter with refund check details to (888) 396-1516.

Recoupment of Overpayments

Third Party Liability Recoupments

What are TPL refunds?

TPL refunds are refunds received by Payment Integrity from sources other than directly from the provider. Typically, they are from a members primary insurance carrier or other such source.

How are TPL claims indicated on Molina Explanation of Payment (EOP) and 835's?

- When a reversal claim or an adjustment claim is processed during a payment run, a provider's Explanation of Payment will indicate a Refund Amount and a remit message indicating that the refund was the result of Coordination of Benefits or Third-Party Liability Recovery.
- This is also totaled at the end of the Explanation of Payment in the Payment Adjustment section. As displayed at both a claim level and payment total, the net result of these refund postings is $0.00.
- On the 835, this refund amount will be included with the totals of any other refund claims in the PLB segment of the 835. There will be 72 adjustment code for the refund amounts on the payment. There will be a WO adjustment code in the PLB for the reversal claim amount. These will net out to $0.00.

Reminder: Molina is not recovering any funds from TPL. A provider's payment is never negatively impacted by the visibility of these claims on their EOP. Suppressed or displayed, the providers payment remains unchanged.

Important Reminders

Billing Audits
Molina will conduct both announced and unannounced site visits and field audits to contracted providers defined as high-risk providers with auto-billing activities, providers offering behavioral health and transportation services, durable medical equipment and home health services to ensure the services you provide are rendered and billed correctly.

Encounter Reporting
Molina is required by HCA to report all services rendered to Turquoise Care Members.

National Drug Code (NDC)
11-digit NDC, units of measure and units are all a requirement.

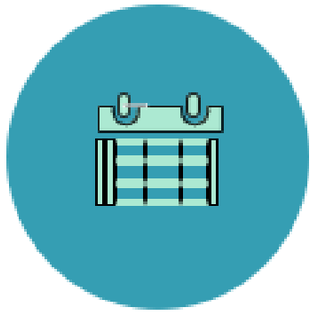
Medicaid Reimbursement Methodology
Molina follows New Mexico Medicaid Fee Schedules as standard.

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 New Mexico Provider Referen ce 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.

High-Volume Providers

High-Volume Providers

High-Volume Providers are specialists that Molina Members are referred to by PCPs and have high volume claim submissions and payments. High-Volume Specialty Care Providers (HVSCP) and High-Volume Behavioral Health Practitioners/Providers (HVBH) are determined annually by a high-volume claims report. In addition to mandatory inclusion of Obstetrics/Gynecology, specialties analyzed can include, but are not limited to:

- Behavioral Health specialties such as Psychiatrist, Clinical Psychologist, Substance Abuse Counselor and Marriage and Family Therapist
- Other Specialties included but not limited to Orthopedist, Cardiologist, Otolaryngology/Ear, Nose and Throat, Oncology, General Surgeons, and Neurologists
- Some specialties are identified by geographic locations and member ratio

Children in Custody of the State/Tribal Custody or Under Tribal Supervision

Children in Custody of the State/Tribal Custody or Under Tribal Supervision

Molina will ensure service requirements for CISC or children in Tribal custody. The enrollment of Native American CISC recipients is voluntary. They may choose another Managed Care Organization, (MCO) from the designated MCO Presbyterian Health Plan, (PHP). All other CISC members will be managed by PHP for CISC services. The enrollment effective date will be the first day of the month when the child was taken into State custody. Once the member has been enrolled and in state custody, they will not be able to select a different MCO. In addition, when the member has left state custody, they will be disenrolled effective the last day of the month.

Children in Tribal custody or under Tribal supervision receive a Behavioral Health screening within twenty-four (24) hours of a referral to a Behavioral Health Contract Provider and receive a Behavioral Health assessment, Medically Necessary Covered Services and Care Coordination as appropriate. Members who are identified as CISC are required to have a comprehensive well-child checkup within thirty (30) days of coming into state custody.

If requested by an Indian Tribe, Nation, or Pueblo located partially or wholly in New Mexico, the Molina will negotiate agreements to develop assessment and treatment protocols and procedures to ensure that services are provided to children in Tribal custody or under Tribal supervision who are in need of such services. Should a Tribe, Nation, or Pueblo choose not to enter into such agreements, Molina shall not be liable for providing Covered Services to those children.

The delivery of services to CISC or children in Tribal custody, including but not limited to, issues related to consent, progress reporting and potential for court testimony; The provisions and limitations of the ABP; Provider identification of SUD and SMI; Trauma Responsive Training, approved by HCA; and Provider trainings specific to the no reject and no eject provision for CISC, meaning that the Provider must accept the referral for eligibility and medical necessity determination.

Children in Custody of the State (CISC)

No Reject, No Eject Provision

No reject *means that the provider must accept the referral for eligibility and medical necessity determination. If the member is Medicaid eligible, meets the Serious Emotional Disturbance (SED) criteria, and meets medical necessity, the provider must coordinate all needed services through CCSS and HFW service providers for CISC. A provider will not discriminate against nor use any policy or practice that has the effect of discriminating against an individual on the basis of health status or need for services.*

No eject *means that the provider must continue to coordinate services and assist member in accessing appropriate services and supports.*

Providers are required to inform Molina if a child in state custody who is enrolled with Turquoise Care is not accepted into service(s) or if a child in state custody is prematurely discharged. These cases will be evaluated and if it is determined providers are not accepting, or are prematurely discharging, member for reason other than medical necessity or other exclusionary criteria, such as age, gender, provider specialty, and bed availability. Cases of non-compliance must be reported to HCA and CYFD. Provider training, education, and/or appropriate measures will be taken.

- **Accredited Residential Treatment**
- **Residential Treatment Centers (RTCs)**
- **Group Homes**
- **Treatment Foster Care (TFC)**

Contact Us

Provider Escalation Steps

- **Do you have a question? We can help!**

1

Call Provider Services Contact Center

Phone: (855) 322-4078
Hours: Monday-Friday 8am-5pm MST

2

Contact Availity

Availity Essentials: Molina Provider Portal
Provider can inquire via **Secure Claims Messaging** or **Claims Inquiry Tool**
(please note: this tool will connect you to the dedicated Molina NM Analyst Team)

3

Reach out to your Provider Relations Representative

Providers should visit the Regional Map to locate their personal rep for their county:
Molina NM Rep Map
Providers can contact the provider services general box: MHNM.ProviderServices@molinahealthcare.com

4

Reach out to your Molina EVV team

Providers can contact the provider services general box: NMEVV@MolinaHealthCare.Com

Contact Health Plan Leadership Directly

Marlene Driscoll – Manager, Provider Relations: Marlene.Driscoll@MolinaHealthCare.Com

Thank you!