Network Provider Orientation

2026 | Molina Healthcare of Nebraska

AGENDA

- Introduction to Molina Healthcare
- Provider Responsibilities
- Provider Resources
- Availity Essentials Portal
- Quality
- Pharmacy
- Healthcare Services
- Claims and Billing Information
- Value Based Contracting
- Compliance

Introduction to Molina Healthcare

INTRODUCTION TO MOLINA HEALTHCARE

The Molina Story – Welcome to the Family!

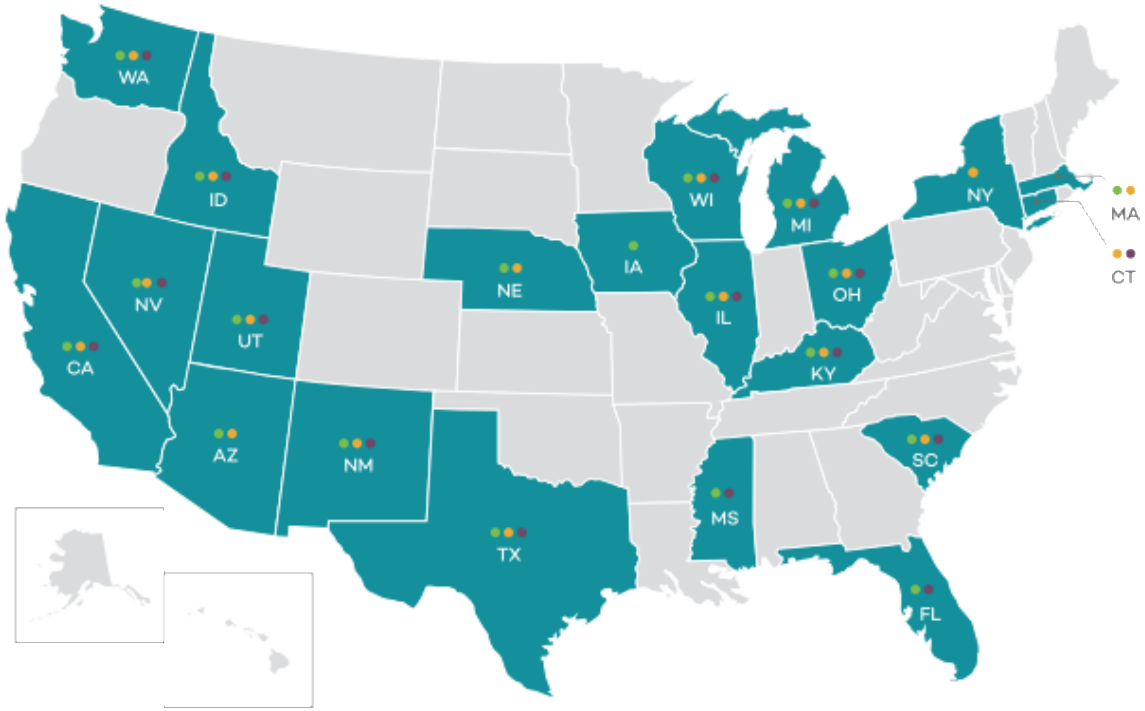
Molina Healthcare, Inc, a FORTUNE 500 company, provides managed health care services under the Medicaid and Medicare programs, and through the State's insurance marketplaces.

Through its locally operated health plans, Molina served approximately 5.2 million members nationwide as of June 2023 across 19 states.

Medicaid: Provides range of quality healthcare services to families and individuals who qualify for government-sponsored programs

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

Marketplace: The Individual Marketplace Exchange are plans designed to cover individuals and families that do not have insurance offered by their employer and do not qualify for Medicaid or Medicare.



Medicaid	Medicare	Marketplace
4,774,000 Members	267,000 Members	690,000 Members

5,746,000 Total members

INTRODUCTION TO MOLINA HEALTHCARE

About Molina Healthcare

Our Mission

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

Our Vision

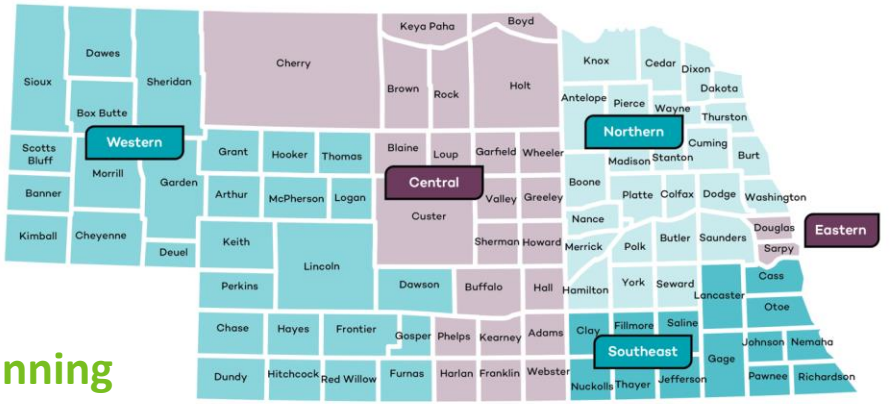
We will distinguish ourselves as the low cost, most effective and reliable health plan delivering government-sponsored health care.

Our Values

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

MOLINA HEALTHCARE IN NEBRASKA

Product Offerings and Eligible Populations



Offering Medicaid, D-SNP, and CHIP to eligible populations across the state beginning in 2024

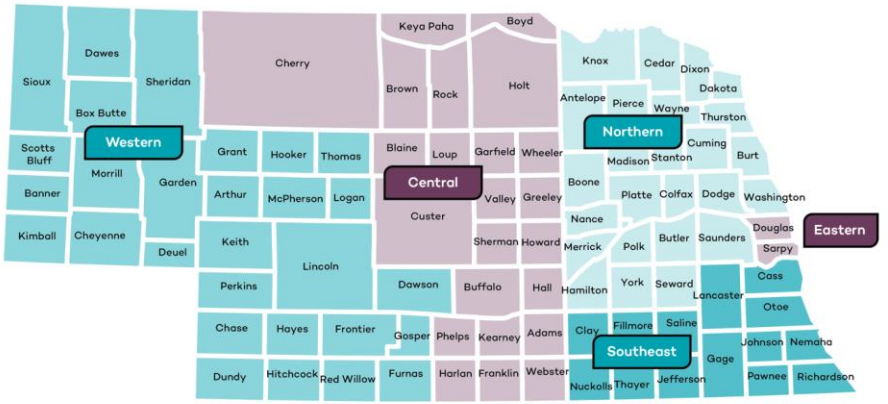
Medicaid Services

Nebraska's Medicaid eligible population includes:

- Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act (SSA) or related coverage groups;
- Children, adults, and related populations who are eligible for Medicaid due to blindness or disability;
- Medicaid beneficiaries who are age 65 years or older and not members of the blind/disabled population or members of the Section 1931 adult population;
- Low-income children who are eligible to participate in Medicaid in Nebraska through Title XXI (CHIP);
- Medicaid beneficiaries who are receiving foster care or subsidized adoption assistance (Title IV-E), are in foster care, or are otherwise in an out-of-home placement
- Individuals who qualify under Medicaid waivers such as Traumatic Brain Injury (TBI), Home and Community-Based Services (HCBS) and other groups covered under Section 1931 of the Social Security Act (SSA) 1915c waiver. The HCBS eligible population includes:
    - Aged persons, and adults and children with intellectual disabilities or related conditions;
    - Members receiving targeted case management through the DHHS Division of Developmental Disabilities
- Individuals eligible for Medicaid under the State Disability program under Nebraska Revised Statute 68-1005
- Individuals who qualify under the Medically Needy Share of Cost Program
- Women who are eligible for Medicaid through the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Every Woman Matters)
- Refugees who are eligible for Medicaid through the Refugee Resettlement program under Title IV of the Immigration and Nationality Act
- Medicaid beneficiaries for the period of retroactive eligibility, when mandatory enrollment for managed care has been determined
- Members eligible during a period of presumptive eligibility
- Members covered in the HHA Expansion Program, including adults ages 19–64 years with incomes up to 138% of the federal poverty level
- Members with continuous eligibility who have a share of cost

MOLINA HEALTHCARE IN NEBRASKA

Product Offerings and Excluded Populations



Medicaid Services

Excluded populations include:

- Non-citizens, who are eligible for Medicaid under the Emergency Medical Services Assistance (EMSA) for non-citizens program; and,
- Beneficiaries, who have excess income or who are required to pay a premium, and are intermittently eligible; and,
- Beneficiaries, who have received a disenrollment or waiver of enrollment; and,
- Participants in the Program for All-Inclusive Care for the Elderly; and,
- Beneficiaries with Medicare coverage, where Medicaid only pays co-insurance and deductibles; and,
- Inmates of public institutions.

Medicare

Model of Care Training

- Molina Healthcare of Nebraska is required to provide annual training regarding our Model of Care program for Medicare DSNP enrollees. The Model of Care is the foundation for Molina's care management policy, procedures, and operational systems for our DSNP population.
- To ensure that Molina remains compliant with Centers for Medicare and Medicaid (CMS) regulatory requirements for Model of Care training, please complete the required training and Attestation Form.

What you need to do:

- Complete the Model of Care Training, found on the Molina website at: www.molinahealthcare.com/-/media/molina/publicwebsite/2025ModelofCareProviderTraining.pdf
- Complete the Attestation Form at the link below. This same link is also located at the end of the Model of Care Training Deck. www.molinahealthcare.com/providers/common/MOC/2025/NE
- ***Note:*** *If one Attestation form is being returned for a group or clinic, it must be signed by an individual with the authority to sign on behalf of the group/clinic and an attendance roster indicating which providers completed the training must be attached.*
- Return the completed Attestation Form (and roster, if applicable) to Molina Healthcare in one of two ways:
  - Select the "SUBMIT" button at the bottom of the Attestation Form, or
  - Send the completed Attestation Form to NEProviderRelations@molinahealthcare.com.

Provider Responsibilities

PROVIDER RESPONSIBILITIES

Overview of Health Care Service Delivery Responsibilities

Molina expects our providers to adhere to the responsibilities highlighted below.

For additional information view the “Provider Responsibilities” section of the Provider Manual, located at MolinaHealthcare.com under the Provider Resources > Provider Materials section. Topics include:

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

PROVIDER RESPONSIBILITIES

Non-Discrimination of Health Care Service Delivery

Nondiscrimination in Health Care Service Delivery

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

Facilities, Equipment, and Personnel

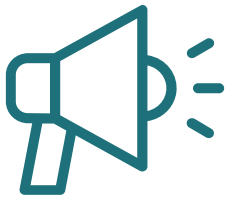
The Provider's facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

PROVIDER RESPONSIBILITIES

Provider Data Accuracy and Validation

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA required element. Invalid information can negatively impact Member access to care, Member PCP assignments and referrals. Additionally, current information is critical for timely and accurate Claims processing.

Providers must, in accordance with Federal laws, validate their Provider information on file with Molina at least once every 90 days for correctness and completeness.
Additionally, in accordance with the terms specified in your Provider Agreement, Providers must notify Molina of any changes, as soon as possible, but at a minimum 30 calendar days in advance of any changes in any Provider information on file with Molina. Changes include, but not limited to:



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

For Provider terminations (within an existing clinic/practice), Providers must notify Molina in writing in accordance with the terms specified in your Provider Agreement.
Please visit our Provider Online Directory at **https://molina.sapphirethreesixtyfive.com//?ci=ne-molina** to validate your information. Providers can make updates through the CAQH portal, or you may submit a full roster that includes the required information above for each health care Provider and/or health care facility in your practice. Providers unable to make updates through the CAQH portal, or roster process, should contact their Provider Services representative for assistance.

PROVIDER RESPONSIBILITIES

Keeping Your Provider Agreement Current with DHHS

Providers should always keep their provider agreement current. This includes name, email, phone number, addresses, owners, managing employees, group members, banking information, and other identifying information.

Mental Health Providers also need to make sure their Provider Type is always current. Whenever a mental health provider license type changes, the applicable enrollment in Medicaid needs to be ended immediately and an updated enrollment must be submitted for the new license type effective on the license effective date. Failure to do so in a timely manner may result in denial of a retroactive enrollment/disenrollment request, claim rejections, or payment at the incorrect rate.

All Providers of Managed Care Organization (MCO) covered services need to make sure their enrollment with Nebraska Medicaid matches their enrollment with each MCO (i.e., practice locations, NPIs, taxonomy codes, etc.). Providers must be enrolled Medicaid providers (via Maximus) before they can be reimbursed through the MCOs. Failure to do so will impact/delay reimbursement.

To complete electronic provider enrollment or update your existing agreement, visit **Maximus's website**.

PROVIDER RESPONSIBILITIES

National Plan and Provider Enumeration System (NPPES) Data Verification

- Nebraska Medicaid requires all MMIS Providers, with the exception of Non-Emergency Medical Transportation (NEMT) Providers, to obtain and enroll with a National Provider Identifier (NPI). The Department is permitted by 45 CFR Part 162 to require all healthcare providers to obtain an NPI for provider screening, enrollment and billing purposes. HCBS providers do not currently need to have an NPI.

- To request an NPI through the National Plan & Provider Enumeration System (NPPES) registry please go to this site: nppes.cms.hhs.gov

- Once the necessary NPI(s) is/are obtained, you must complete the necessary actions to update or start your Provider Agreement through the Department's Provider Screening and Enrollment vendor (Maximus). They can be reached at 844-374-5022 or nebraskamedicaidpse@maximus.com.

- Each enrollment can have a single NPI associated with it. Regulatory support for this requested action can be found at 471 NAC 2 005.01 (16) and 471 NAC 3-003 (Billing Requirements).

- Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQ) document published at the following link: cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

PROVIDER RESPONSIBILITIES

Electronic Solutions/Tools Available to Providers

- Molina requires all contracted Providers to utilize electronic solutions and tools whenever possible and participate in and comply with Molina's Electronic Solution Requirements, which include, but not limited to:
  - Electronic submission of prior authorization requests and prior authorization status inquiries; and,
  - Health plan access to electronic medical records (EMR); and,
  - Electronic claims submission; and,
  - Electronic fund transfers (EFT), electronic remittance advice (ERA); and,
  - Electronic claim appeals; and,
  - Registration for and use of the Availity Essentials portal.
- Electronic Claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Availity Essentials portal

  *Paper claims may be submitted to the following:

Paper Claim Submissions:
Molina Healthcare of Nebraska, Inc.
PO Box 93218
Long Beach, CA 90809-9994

- Any Provider entering the network as a Contracted Provider will be encouraged to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the Availity Essentials portal within 30 days of entering the Molina network
- Molina is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers (TCI) standards
  - Providers must comply with all HIPAA requirements when using electronic solutions with Molina. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including claims submitted to Molina.
  - Providers may obtain additional information by visiting Molina's HIPAA Resource Center located on our website at MolinaHealthcare.com.

PROVIDER RESPONSIBILITIES

Providers Marketing Rules and Guidelines

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and approved by Molina prior to use, which includes:

1. All forms of marketing in a Provider's office must have written consent from the Provider on file with Molina.
2. Molina does not require Provider to distribute Molina-prepared marketing communications to the Member.
3. Molina does not incentivize Providers or provide giveaways to Providers to distribute marketing materials to Molina Members or potential Members.
4. Molina prohibits Providers from soliciting enrollment or disenrollment in a particular Managed Care Organization (MCO) or to distribute MCO-specific materials.
5. Molina is prohibited from providing printed materials to Providers with instructions on how to change a Member to another MCO.
6. Participating Providers who wish to let their patients/Members know of their affiliations with one or more Managed Care Organization (MCO) must list each MCO with whom they contract.
7. Participating Providers may display and distribute health education materials for all contracted MCOs, or they may choose not to display and distribute for any contracted MCOs. Health education materials must adhere to the following guidance:
    - Health education posters cannot be larger than 16 x 24 inches;
    - Children's books, donated by Molina, must be in common areas; and
    - Materials may include the Molina's name, logo, telephone number and website address.

PROVIDER RESPONSIBILITIES

Providers Marketing Rules and Guidelines *cont'd*

8. Providers are not required to distribute and/or display all health education materials provided by each MCO with whom they contract. Providers can choose which items to display as long as they distribute items from each contracted MCO and that the distribution and quantity of items displayed are equitable.
9. Providers may display marketing materials for Molina provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all MCOs with whom/which the Provider has a contract.
10. Providers may display Molina participation stickers but must display stickers for all contracted MCOs or choose not to display stickers for any contracted MCOs.
11. MCO stickers indicating that the Provider participates with a particular MCO cannot be larger than five (5) x seven (7) inches and cannot indicate anything more than "The MCO is accepted or welcomed here."
12. Providers may inform their patients of the benefits, services, and specialty care services offered through the MCOs in which they participate. However, Providers may not recommend one MCO over another, offer patients incentives for selecting one MCO over another, or assist the patient in deciding to select a specific MCO in any way, including, but not limited to, using a phone, computer, or fax machine in the office.
13. On actual termination of a contract with Molina, a Provider who/that has contracts with other MCOs may notify their patients of the change and the impact of the change on the patient, including the date of the contract termination. Providers must continue to see current patients enrolled in Molina through the termination date, according to all terms and conditions specified in the contract between the Provider and the Molina.

APPOINTMENT AVAILIBILITY

Providers Requirements

MLTC established the access and appointment time requirements and its Molina's job to ensure their network adheres to it. Access and appointment time requirements ensure members receive medical and behavioral health services within a time period appropriate to their medical health condition.

Molina Healthcare of Nebraska providers are expected to meet the following minimum standards for appointment availability:

- Emergent care must be available immediately upon presentation, 24-hours a day, 7 days per week.
- Urgent care must be provided within 24 hours of member contact
- Routine or Preventive dental care must be scheduled within 6 weeks of member contact

Wait times for scheduled appointments should not routinely exceed forty-five (45) minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If the wait time is anticipated to be more than 90 (ninety) minutes, the Member should be offered a new appointment.

APPOINTMENT ACCESS

Providers Requirements - Medical and Behavioral Health

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

Medical Appointment Types	Standard
Non-urgent, preventive	Within 4 weeks
Non-urgent, sick	Within 48 hours, or sooner if condition becomes urgent
Urgent Care	Same day, provided by PCP or as arranged by Molina
Maternity Care	First Trimester: Within 14 calendar days Second Trimester: within 7 calendar days Third Trimester and High-Risk: Within 3 calendar days Emergency: Immediately
Family Planning	Within 7 calendar days
Laboratory and X-Ray	Within 3 weeks for routine and 24 hours for urgent, or as clinically indicated
After Hours Care	24 hours/day; 7 day/week availability
Specialty Care (High Volume)	Within 30 calendar days
Specialty Care (High Impact)	Consultation within 1 month of referral, or as clinically indicated
Urgent Specialty Care	Within 24 hours
Emergency Services	Immediately upon presentation, 24 hours a day, 7 days per week
BH Emergency Services	Referral within 1 hour (2 hours in designated rural areas)

Members over-utilizing the emergency department will be contacted by Molina Case Managers to provide assistance whenever possible and determine the reason for using Emergency Services.
case managers will also contact the PCP to ensure that Members are not accessing the emergency department because of an inability to be seen by the PCP. All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a twenty-four (24) hour phone service, seven (7) days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an Emergency to hang-up and call 911 or go immediately to the nearest emergency room.

Provider Resources

MOLINA HEALTHCARE

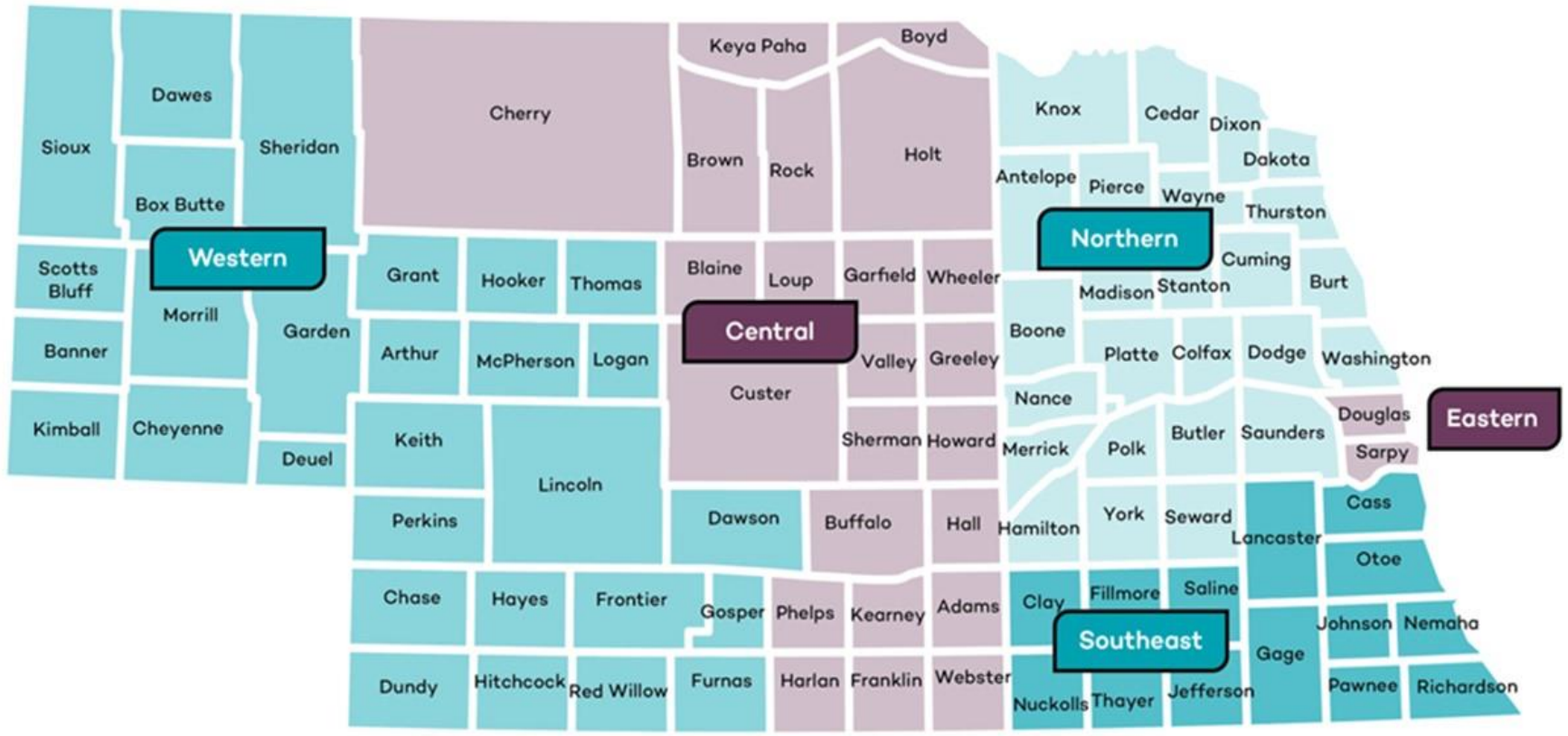
HERITAGE HEALTH

PROVIDER RESOURCES

Nebraska Provider Relations Representatives

Molina Healthcare maintains a strong commitment to meeting the needs of our providers. Our Provider Relations team is dedicated to enhancing network provider relationships and ensuring that day-to-day experiences with Molina are positive. Molina has designated Provider Relations Representatives across Nebraska. These are subject matter experts who are available to provide education and orientations for you. Additionally, they partner with our providers to problem-solve and offer solutions for each practice's individual needs.

Molina also offers a dedicated **Provider Contact Center**, which can be reached at **(844) 782-2678,** 7 a.m.-6 p.m. CT, Monday-Friday. This line is your resource for claims inquiries, demographic changes, panel inquiries and general questions. You may also email the Provider Relations team at NEProviderRelations@molinahealthcare.com



PROVIDER RESOURCES

Provider Services

Contact Provider Services

Phone:
(844) 782-2678
Monday – Friday 7am-6pm CT

Satisfaction

- Provider Services Representatives and Engagement Teams
- Annual Assessment of Provider Satisfaction
- The *You Matter to Molina* program that includes monthly forums, surveys, and an information page on the Provider Website

Communication

- Provider Notices and Provider Newsletters
- Online Provider Manuals
- Online Trainings, Health Resources, and Provider Resource Guides
- Interactive Voice Response (IVR) Phone System

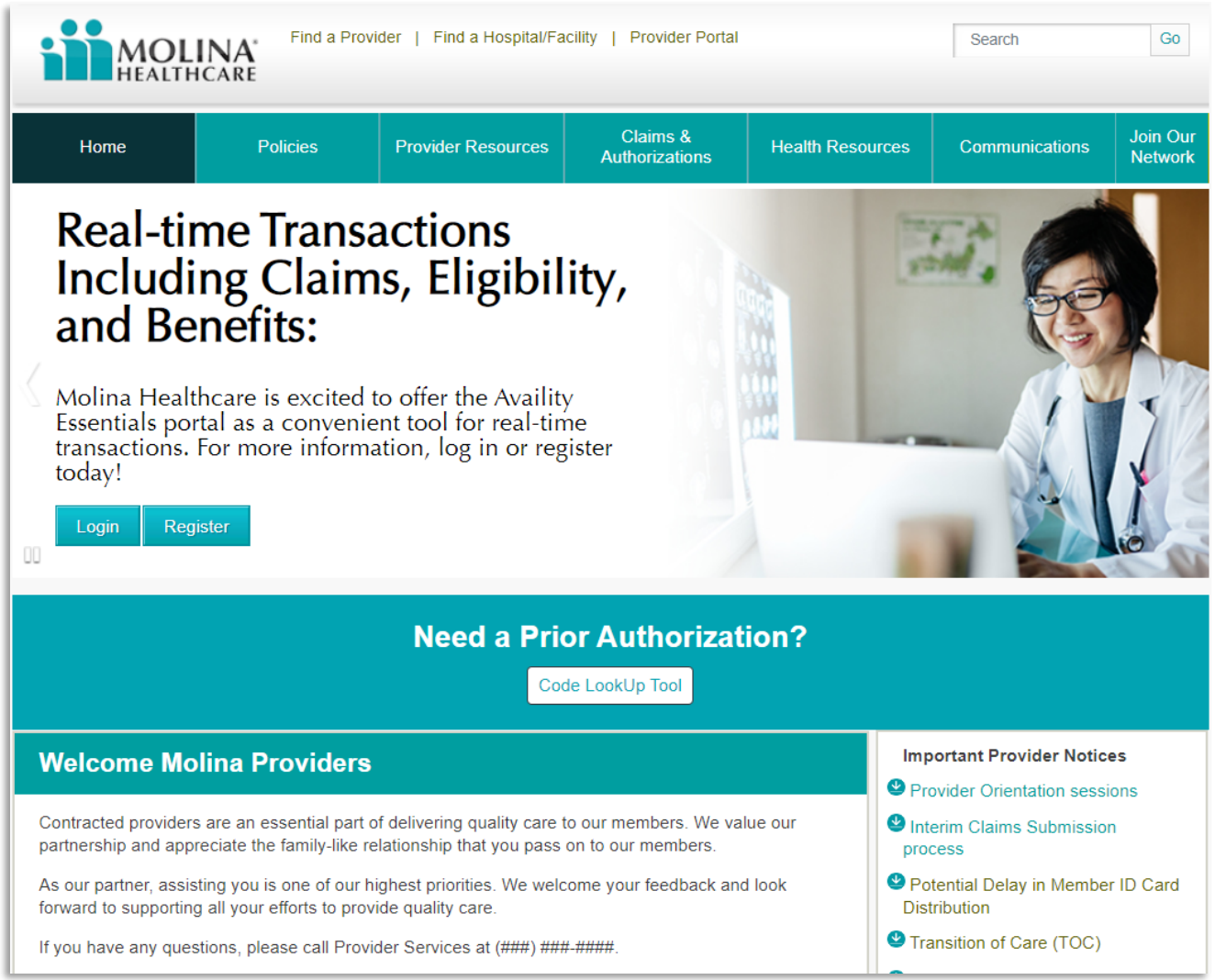
Technology

- 24-hour Provider Portal
- Electronic Funds Transfer and Electronic Remittance Advice
- Online Prior Authorization and Claim Appeal Submission
- Supplemental Prior Authorization Lookup Tool on Provider Portal and Provider Website

PROVIDER RESOURCES

Molina's Provider Website

- Provider Online Directories
- Preventative & Clinical Care Guidelines
- Provider Manuals
- Web Portal
- Prior Authorization Information
- Advance Directives
- Behavioral Health Toolkit
- Model of Care Training
- Claims Information
- Pharmacy Information
- HIPAA
- Fraud Waste and Abuse Information
- Frequently Used Forms
- Communications & Newsletters
- Contact Information



MolinaHealthcare.com

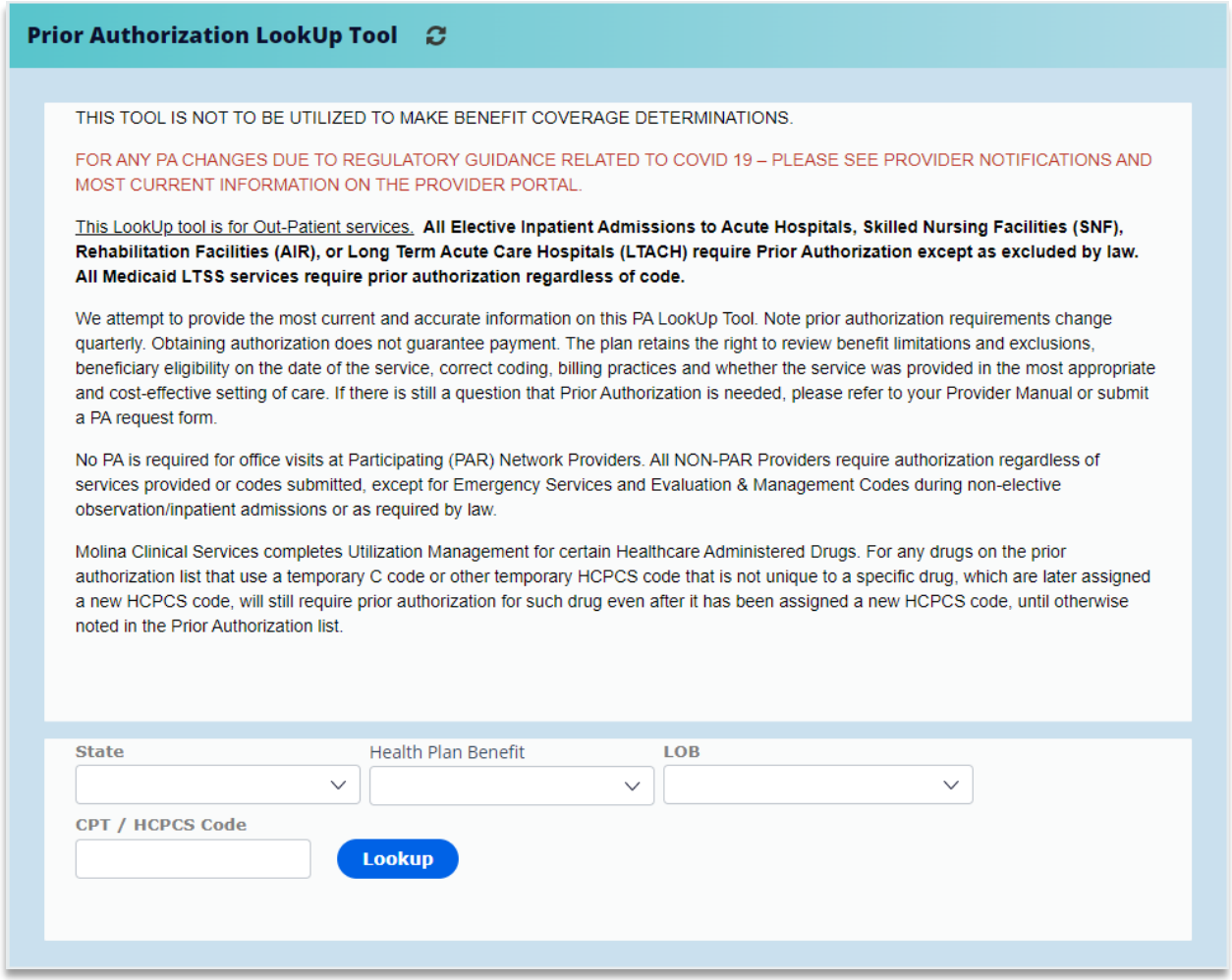
PROVIDER RESOURCES

Prior Authorization Look-Up Tool

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

Please note that the Prior Authorization Look Up Tool does not make benefit coverage determinations. While a service may show Prior Authorization is not required, if the service is not covered under Nebraska Medicaid, then it is not payable. Please refer to Nebraska DHHS (Department of Health and Human Services) for information on benefit coverage and benefit limits. Medicaid Provider Rates and Fee Schedules.

To access the Prior Authorization Look-up Tool visit **www.MolinaHealthcare.com** and click on Health Care Professionals



PROVIDER RESOURCES

Provider Manual & Highlights

Molina's Provider Manuals are written specifically to address the requirements of delivering healthcare services to our members, including the responsibilities of our participating providers. Providers may view the Provider Manual on our provider website at www.MolinaHealthcare.com/NEProviders, select Provider Resources, then select Provider Guides.

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

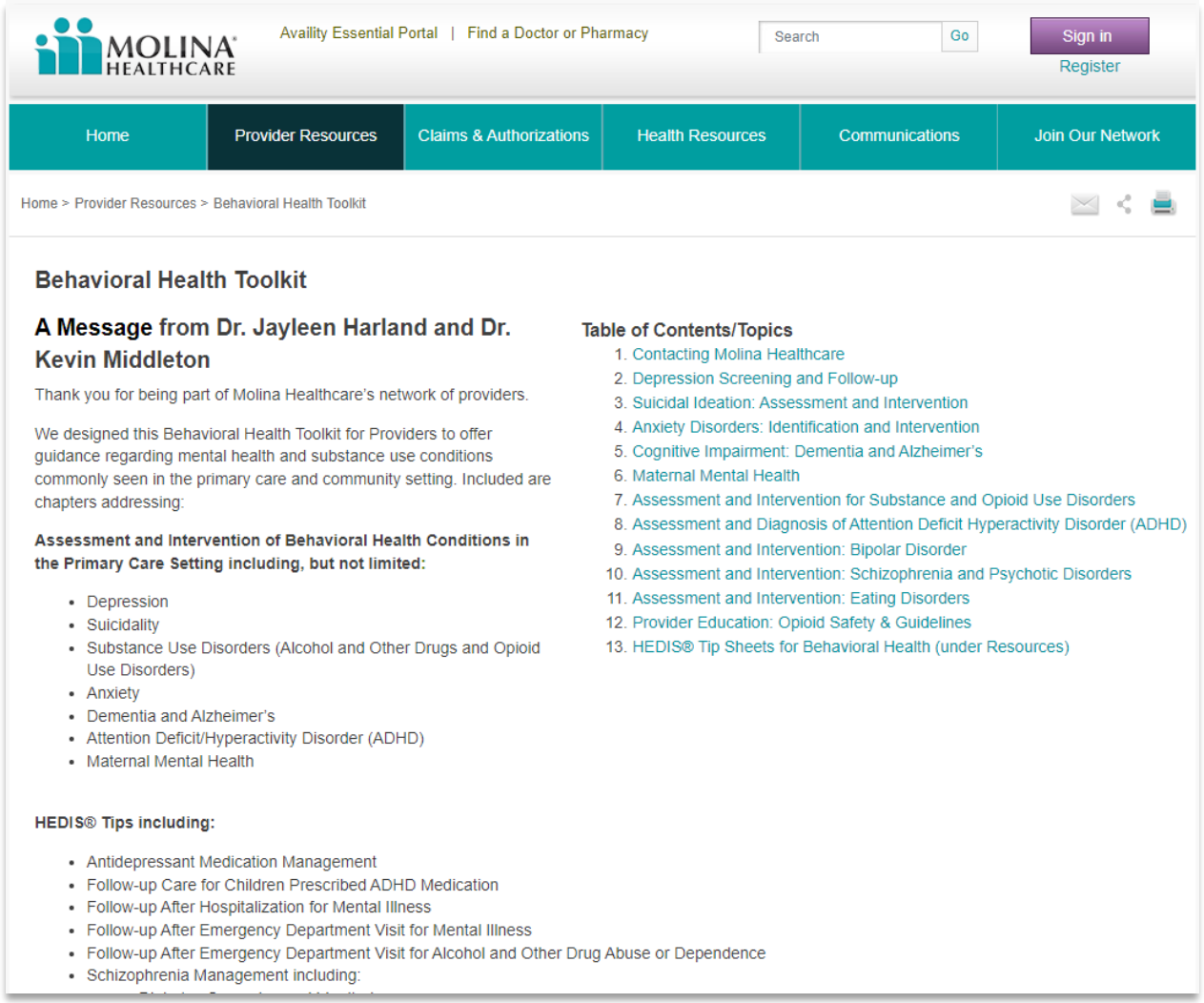
PROVIDER RESOURCES

Behavioral Health Toolkit

To support providers in offering best practice behavioral health interventions in the health care setting, we have the Behavioral Health (BH) Toolkit on the Provider website.

Our BH Toolkit for Providers highlights common conditions that may present in various health care settings, including recommended standardized screening and assessment tools, interventions, and resources.

The BH Toolkit includes newly added conditions for consideration and updated resources to support the delivery of best practices and standards of care to this population.



PROVIDER RESOURCES

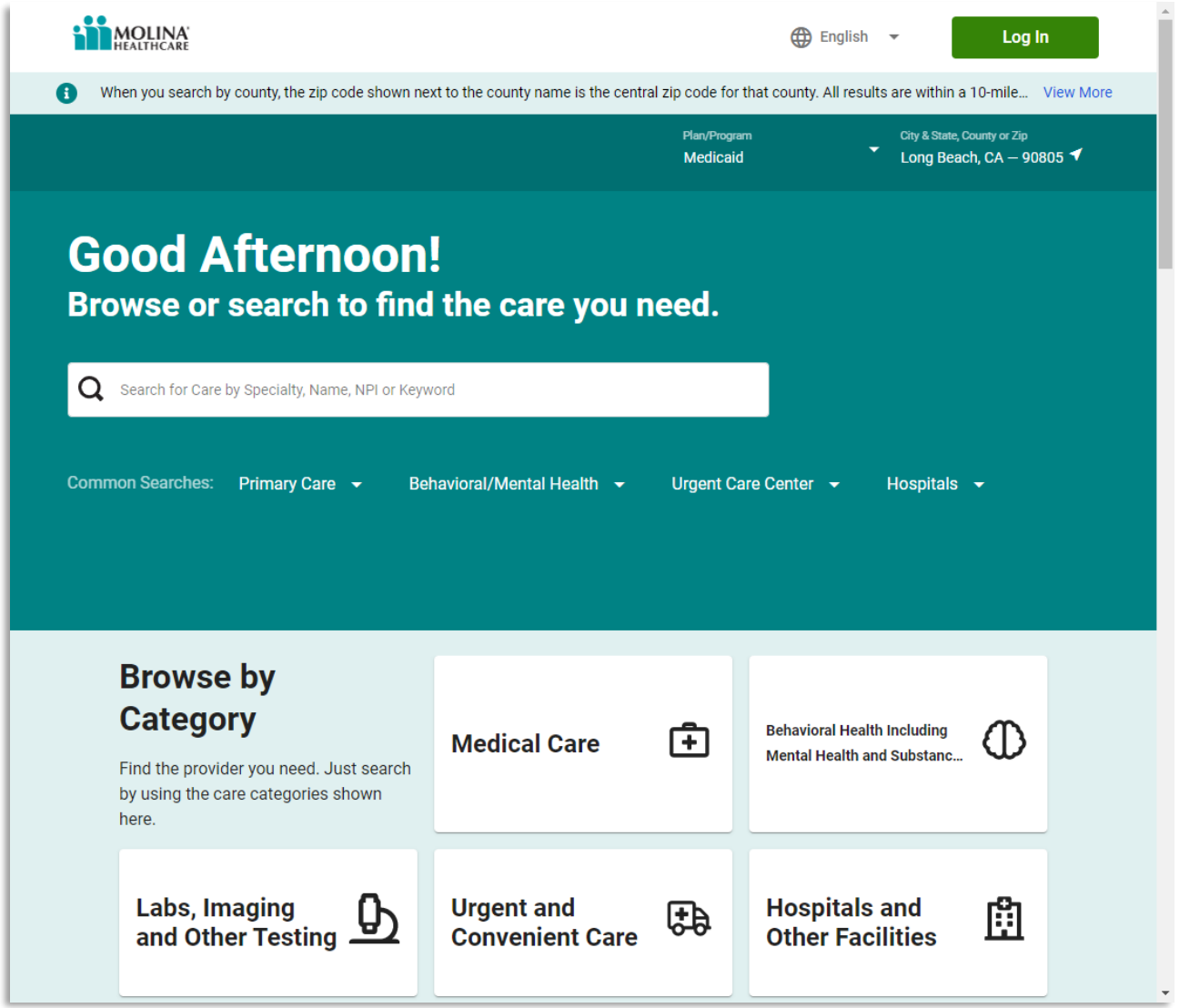
Provider Online Directory

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

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

Key benefits include:

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

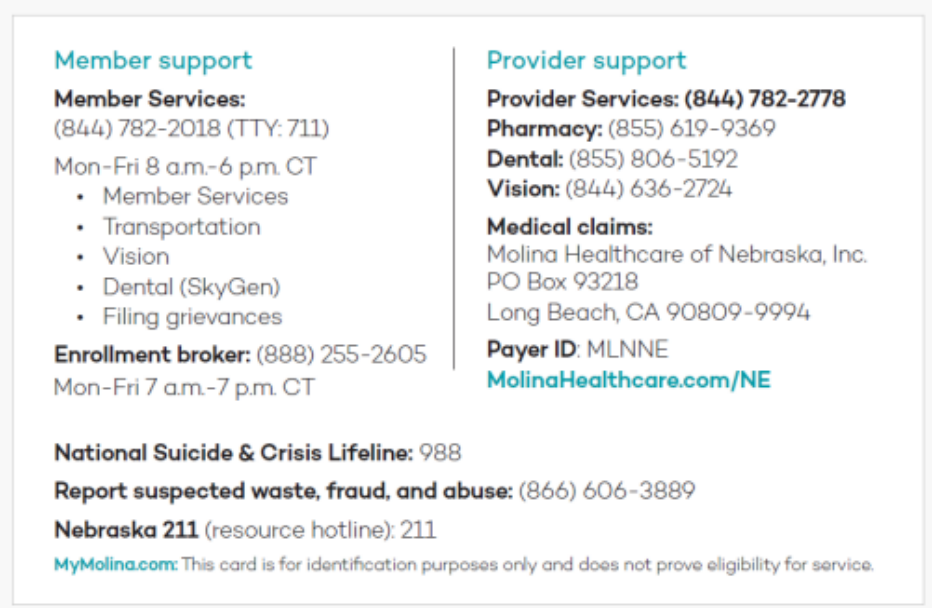


PROVIDER RESOURCES

Molina Medicaid Member Identification (ID) Card

MEMBER MEDICAID ID CARD

Card Front



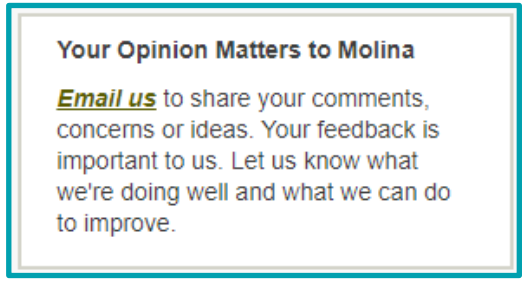
Card Back

PROVIDER RESOURCES

You Matter to Molina

Your feedback is important, and You Matter to Molina

Molina wants your feedback! Please take your time to share feedback with us about your experience working with Molina. Please let us know what we are doing well, and what we can do to improve your experience. Please share training ideas that would benefit your practice. We would love to collaborate and help develop future trainings or quick reference guides!



Ways to provide feedback include:

- Click on the "**Email us**" link under "**Your Opinion Matters to Molina**" at the top of our Provider Website
- Email your Provider Services Team
- Take one of our post-training or general feedback surveys located on the **You Matter to Molina** page
- Join our Provider Advisory Committee

Monthly You Matter to Molina Provider Forum:

Molina offers monthly You Matter to Molina Provider Forums with either a set presentation topic, or as an open question and answer session between our provider partners and Molina subject matter experts. Find a list of upcoming trainings on the **You Matter to Molina** page.

Availity Essentials Portal

MOLINA HEALTHCARE

HERITAGE HEALTH

AVAILITY ESSENTIALS PORTAL

Molina Provider Portal – Availity Essentials

Molina Healthcare of Nebraska utilizes Availity for our Provider Portal. Providers may register for access to our Provider Portal for services that include self-service member eligibility, claim status, provider searches, and submitting claims and prior authorization requests.

Services offered by Availity and Molina Complete Care include:

- Claim submission/resubmission
- Claim status
- Remittance viewer
- Obtaining Member eligibility & benefits
- Submitting authorization requests
- Information

Organization Registration Resource – http://www.availity.com/registration-tips
Availity Payer Name: Molina Healthcare of Nebraska

AVAILITY ESSENTIALS PORTAL

Core Functionalities

Availity Essentials Portal is secure and available 24 hours a day, seven days a week.

Self-service options include:

- Online Claims Submission
- Claims Status Inquiry
- Corrected Claims
- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Member Eligibility Verification and History
- Secure Messaging
- Online Claim Reconsideration Requests
- Explanation of Payments (EOPs)
- Submit and Check Status of Authorization Request
- View PCP Member Roster
- Care Coordination Portal
- Manage Overpayment Request

Quality

MOLINA HEALTHCARE

HERITAGE HEALTH

QUALITY

Quality Improvement

Molina has established a Quality Improvement Program that complies with regulatory requirements and accreditation standards. The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service and health of our members. In our quality program description, we describe our program governance, scope, goals, measurable objectives, structure, and responsibilities.

Molina requires Providers to comply with the following core elements and standards of care:

- Have a Quality Improvement Program in place.
- Comply with and participate in Molina's Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® (Healthcare Effectiveness Data Information Set) review process and during potential Quality of Care and/or Critical Incident investigations.
- Cooperate with Molina's quality improvement activities that are designed to improve quality of care and services and Member experience.
- Allow Molina to collect, use, and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service, and access and availability.
- Allow access to Molina Quality personnel for site and medical record review processes.

For more information on Molina's Disease Management Program, call the Health Education line at (866) 472-9483

For more information about Molina's Quality Improvement initiatives, reach out to Provider Services at (844) 782-2678

View Molina's Clinical Practice Guidelines and Preventive Health Guidelines on the Provider Website

QUALITY

Measurement of Clinical and Service Quality

Molina monitors and evaluates the quality of care and services provided to Members through the following mechanisms:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS ®)
- Behavioral Health Satisfaction Assessment
- Member Advisory Committee
  *Providers are welcome to attend meetings to provide quality information and suggestions
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

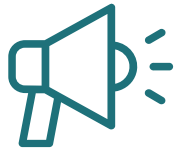
Find out more in the Quality chapter of the Provider Manual.

QUALITY

Provider Advisory Committee

Please consider joining our Provider Advisory Committee, where providers and Molina share ideas and collaborate. Your voice can impact policy, member care and much more.

- Collaborative committee with representation from:
  - Large provider organizations
  - Individual providers
  - Provider Associations
  - Medical, behavioral health and pharmacy providers
  - Molina leadership



For additional information, please contact your Provider Services Representative at **NEProviderRelations@MolinaHealthcare.com** or visit the **Provider Resources** section of the Provider Manual located at **www.MolinaHealthcare.com/NEProviders**.

Pharmacy

MOLINA HEALTHCARE

HERITAGE HEALTH

PHARMACY

Drug Formulary

- The Molina Drug Formulary was created to help manage the quality of our members' pharmacy benefit
- The Drug Formulary is the cornerstone for a progressive program of managed care pharmacotherapy
- Prescription drug therapy is an integral component of a member's comprehensive treatment program
- The Drug Formulary was created to ensure that members receive high-quality cost-effective and rational drug therapy
- Prescription Drug Monitoring Program (PDMP) is a federal program that shows all prescriptions dispensed to a member in NE. Providers are required to check the PDMP before prescribing certain controlled substances.

The Molina Healthcare of Nebraska Drug Formulary for each line of business is available on the Provider Website at :
www.MolinaHealthcare.com/NEProviders

PHARMACY

Benefit Manager – CVS/Caremark

CVS/Caremark is the Pharmacy Benefit Manager for Molina.

Contact CVS/Caremark:
Phone: (855) 619-9396
Drug Prior Authorization Fax: (877) 281-5364

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

Online:
CoverMyMeds Portal:
https://www.covermymeds.com/epa/caremark/

Surescripts Portal:
https://providerportal.surescripts.net/providerportal/cvs

Fax:
Molina Prior Authorization Fax
(877) 281-5364

*Prior Authorization Request Form can be found in your Orientation Kit or on our website at www.MolinaHealthcare.com/NEProviders

Healthcare Services

HEALTHCARE SERVICES

Healthcare Services Team

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

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

Utilization Management

Case Management

Behavioral Health

HEALTHCARE SERVICES

Utilization Management

Our Utilization Management (UM) program functions by:

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

HEALTHCARE SERVICES

Request for Prior Authorization

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

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

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

- Current (up to 6 months), adequate patient history related to the requested services
- Physical examination that addresses the problem
- Lab or radiology results to support the request (Including previous MRI, CT, lab or x-ray report/results)
- PCP or Specialist progress notes or consultations
- Any other information or data specific to the request

HEALTHCARE SERVICES

Submitting Prior Authorization Requests

Providers may submit **medical and behavioral health** prior authorization requests to Molina's Utilization Management department in a variety of ways today; however, this is changing soon.

As part of our ongoing commitment to improve operational efficiency, enhance security, and align with state and federal interoperability initiatives, Molina is decommissioning fax-based submission channels for prior authorization requests. Our goal is to transition to a secure, digital intake method via Availity in the first quarter of 2026.

Online:
Availity Essentials Portal
Availity.com

Fax:
Medicaid - Medical and Behavioral
(833) 832-1015

HEALTHCARE SERVICES

Referrals and Prior Authorization

Referrals are made when medically necessary services are beyond the scope of the PCPs practice. Most referrals to in-network specialists do not require an authorization from Molina.

Information is to be exchanged between the PCP and Specialist to coordinate care of the patient.

American Indians and Alaskan Native Members are permitted to obtain covered services from out of network I/T/U providers.

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

- Assist in benefit determination
- Prevent unanticipated denials of coverage
- Create a collaborative approach to determining the appropriate level of care for Members receiving services
- Identify Case Management and Disease Management opportunities
- Improve coordination of care

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

A list of services and procedures that require prior authorization is included in our Provider Portal Availity and posted on our website at: www.molinahealthcare.com

HEALTHCARE SERVICES

Prior Authorization Review Guide

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

For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department.

Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate inpatient review and discharge planning.

We require that the notification includes:

- Member demographic information; and,
- Facility information; and,
- Date of admission; and,
- Clinical information sufficient to document the Medical Necessity of the admission; and,
- Emergent inpatient admission services performed without meeting notification and Medical Necessity requirements.

Failure to include all needed documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient admission.

Molina performs concurrent inpatient review to ensure patient safety, Medical Necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Molina will request updated original clinical records from inpatient facilities at regular intervals during a member's inpatient admission. This information is due from the inpatient facility within twenty-four (24) hours of the request.

HEALTHCARE SERVICES

Prior Authorization Member Appeals

A “Member Appeal” is to dispute an Adverse Benefit Determination of a pre-service decision, such as the denial of a request for service authorization. Members*, or providers acting on behalf of the member (and with written consent)*, may file an appeal requesting a review of the adverse benefit decision. If the provider is submitting this type of Member appeal (on behalf of the member), this is called an “**Appointment of Representative**,” and the form is required.

We offer an AOR form located here www.MolinaHealthcare.com/Providers/NE/Medicaid/Resources/Forms.aspx. Providers may use their own form if it specifies that the member gives approval for the provider to appeal denials on their behalf. It is acceptable for the form to be signed prior to the denial of the service.

If a claim appeal is inadvertently denied for missing the AOR Form, please notify your Provider Relations Representative and we will work with our Appeals Team to ensure education is provided, and have that appeal reworked.

HEALTHCARE SERVICES

Retroactive Authorizations

If a provider performs a service without authorization, UM will advise providers to submit their claim and follow the claims appeal process. For extenuating circumstances within 180 days from the date of service, UM will handle retro authorization through the UM side:

- Provider did not know nor reasonably could have known that patient was a Molina Healthcare member at the time the service was rendered; or,
- Provider did not know or reasonably could have known that patient needed a service that required authorization prior to the service being rendered; or,
- Retro Eligibility; or,
- Molina Healthcare error

HEALTHCARE SERVICES

Timeliness of Utilization Management Decisions

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation and in accordance with Federal, State and NCQA requirements.

For a standard authorization request, Molina makes the determination and provides response within seven (7) calendar days.

For an expedited request for authorization, Molina will make a determination as promptly as the member's health requires and no later than seventy-two (72) hours after Molina receives the initial request for service. In the event a provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a member's life or health, Molina will process such requests as expedited as well.

HEALTHCARE SERVICES

Transition of Care

Transition of Care (TOC) is when a member moves from one health care setting to another, usually during an acute health care episode, including members transitioning to/from IHS or other tribal agencies.

Examples:

- Hospital → Rehab/Skilled Nursing Facility
- Hospital/Rehab/Skilled Nursing Facility → Home

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

During an episode of illness in a facility, members may receive care in multiple discharge settings, which can result in fragmented and poorly executed transitions. The Molina Healthcare TOC Program is designed to proactively identify those members at a higher risk for readmission and implement interventions to provide a safe discharge, with the goal preventing readmissions or ED visits within the first 30 days post discharge.

The TOC program provides members with a TOC Coach who follows the member closely during the first 30 days post discharge and makes a minimum of 4 contacts over the 30-day period. Contacts usually occur as follows:

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

Additional contacts are made based on member needs.

HEALTHCARE SERVICES

Case Management

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

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

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

HEALTHCARE SERVICES

Case Managers

Case Managers (CM) are nurses, licensed BH staff and social workers who conduct health risk assessments either by phone or face-to-face to identify member needs and develop specific interventions to help meet those needs.
Molina Case Managers use information from the assessment process to develop and implement individual care plans with the member based on member's own identification of primary health concern and an analysis of available data on the member's medical condition and history.

All Nebraska Medicaid Members are eligible for Case Management services; different levels of interventions are based on the individual needs and conditions of each individual:

- **Disease Management** - Disease Management is focused on disease prevention and health promotion. It is provided for members whose lower acuity chronic conditions put them at risk for future health problems.
- **Case Management** - Case Management is provided for members who are at high risk for re-hospitalization post TOC intervention with case management needs that warrant triage. These services are designed to improve the member's health status and reduce the burden of disease through education and assistance with the coordination of care including LTSS.
- **Complex Case Management** - Complex Case Management is provided for members who have experienced a critical event or diagnosis requiring the extensive use of resources and need additional support navigating the health care system. The primary goal of Complex Case Management is to help members improve functional capacity and regain optimum health in an efficient and cost-effective manner.
- **Intensive Needs Case Management** - Level 4 focuses on members having an end-stage diagnosis that would otherwise meet criteria for palliative care or hospice services. This level includes members at high risk for re-hospitalization post TOC intervention with continued need for stabilization, comfort care or other high intensity, highly specialized services.

HEALTHCARE SERVICES

Nurse Advice Line

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

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

(844) 782-2721 TTY/TDD: 711

Note: The Nurse Advice Line telephone number is also printed on member ID cards.
Includes Behavioral Health: BH Crisis Line only

HEALTHCARE SERVICES

Molina Partners

Molina Healthcare of Nebraska is partnering with the following vendors for our Medicaid Members:

Vision Services - March Vision

Toll Free #: (844) 636-2724

https://www.marchvisioncare.com/

Telehealth and Virtual Care - Teladoc

Virtual Care Page with Teladoc services FAQs

https://www.molinahealthcare.com/members/ne/en-us/mem/medicaid/helpful-resources/virtual-care.aspx

Dental Services - SKYGEN

Toll Free #: (855)891-5192

https://www.skygenusa.com/

Non-Emergency Transportation – Medical Transportation Management (MTM)

Toll Free #: (888) 889-0421

https://memberportal.net

CVS/Caremark – Pharmacy Services

Toll Free #: (800) 237-2767

https://www.caremark.com/

HEALTHCARE SERVICES

Molina Partners - Lab

Molina Healthcare of Nebraska has partnered with national lab companies to provide services for our Nebraska members – Quest Laboratories. We also have other local lab partners.

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

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

If you have questions about Quest Diagnostics services, test menus, and patient locations, please call 866-MY-QUEST to request a consultation with a Quest Diagnostics Sales Representative. Quest Client Services is available at this number 24 hours a day, 7 days a week.

Claims and Billing Information

CLAIMS AND BILLING INFORMATION

Claims

Molina employs a dedicated Provider Claims Service Unit to assist with medical and behavioral health claims questions and concerns.

For all claims-related inquiries please contact the Provider Claims Service Unit at:

Phone:
(844) 782-2678
Monday – Friday, 7am-6pm CT

Online:
www.Availity.com

In Writing:
Molina Healthcare of Nebraska, Inc.
PO Box 93218
Long Beach, CA 90809-9994

Tip!

When calling, please make sure to have your TIN/NPI, Medicaid number, and DOS ready for the customer service representative.

CLAIMS AND BILLING INFORMATION

Paper and Electronic Claim Submission

Molina accepts electronic submissions of the CMS-1500 or UB04 claim forms for **medical and behavioral health** services. We highly encourage all in-network providers to submit claims electronically. Providers may submit initial and corrected claims via the methods listed below.

Electronic Claim Submissions:

Electronic Data Interchange (EDI):

Payer ID: **MLNNE**

Molina uses SSI/Claimsnet as its gateway clearinghouse. Providers can also continue to submit claims to their usual clearinghouse. Molina accepts EDI transactions through SSI/Claimsnet via the 837P for Professional and 837I for institutional. In order to ensure all data submitted to our gateway is received properly your submitter must utilize the latest version of the 837 standard. Please ensure your office is tracking electronic transmissions using the acknowledgement reports. The reports assure claims are received for processing in a timely manner.

Paper Claim Submissions:

Molina Healthcare of Nebraska, Inc.
PO Box 93218
Long Beach, CA 90809-9994

For EDI claim submission issues please contact:

EDI Customer Service:

Email: EDI.claims@molinahealthcare.com

Online Via Molina's Provider Portal, Availity Essentials (preferred):

www.availity.com

CLAIMS AND BILLING INFORMATION

Claim Status Inquiries

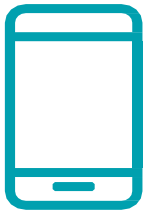
Molina offers various avenues to obtain claim status for medical and behavioral health claims. We encourage providers to utilize online/ electronic tools to obtain claim status.

Electronic Claim Status Batch Inquiry/Response (276/277):

For 276/277 eligibility batch inquiry/response via SSI/ClaimsNet, please use Payer ID: **MLNNE**

Online Via Passport's Provider Portal, Availity Essentials:

www.availity.com



Phone:

(844) 782-2678

Monday – Friday 7am-6pm CT

CLAIMS AND BILLING INFORMATION

Timely Filing and Resubmissions

Timely Filing

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

All claims shall be submitted in a form acceptable to and approved by Molina Healthcare and shall include any and all medical records pertaining to the claim if requested by Molina Healthcare or otherwise required by Molina Healthcare's policies and procedures.

Claims must be submitted by provider to Molina Healthcare within one hundred eighty (180) calendar days after the following have occurred: discharge for inpatient services or the date of service for outpatient services.

If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit Claims to Molina within one hundred eighty (180) calendar days after final determination by the primary payer.

Initial Submission (clean claim)	Resubmissions/Corrections
180 calendar days from the discharge for inpatient services or the Date of Service for outpatient services	**180 calendar days** of the Date of Service

Corrected Claims

Corrected claims are considered to be new claims. When submitting a corrected claim, please use the correct coding to denote a replacement of a prior claim or a resubmission code for claims corrections. Please refer to billing guidelines in the Provider Manual for more information.

CLAIMS AND BILLING INFORMATION

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

Molina utilizes Change Healthcare/ECHO Health for electronic payments. Providers are encouraged to register for Echo Health within 30 days of receiving their first reimbursement check from Molina.

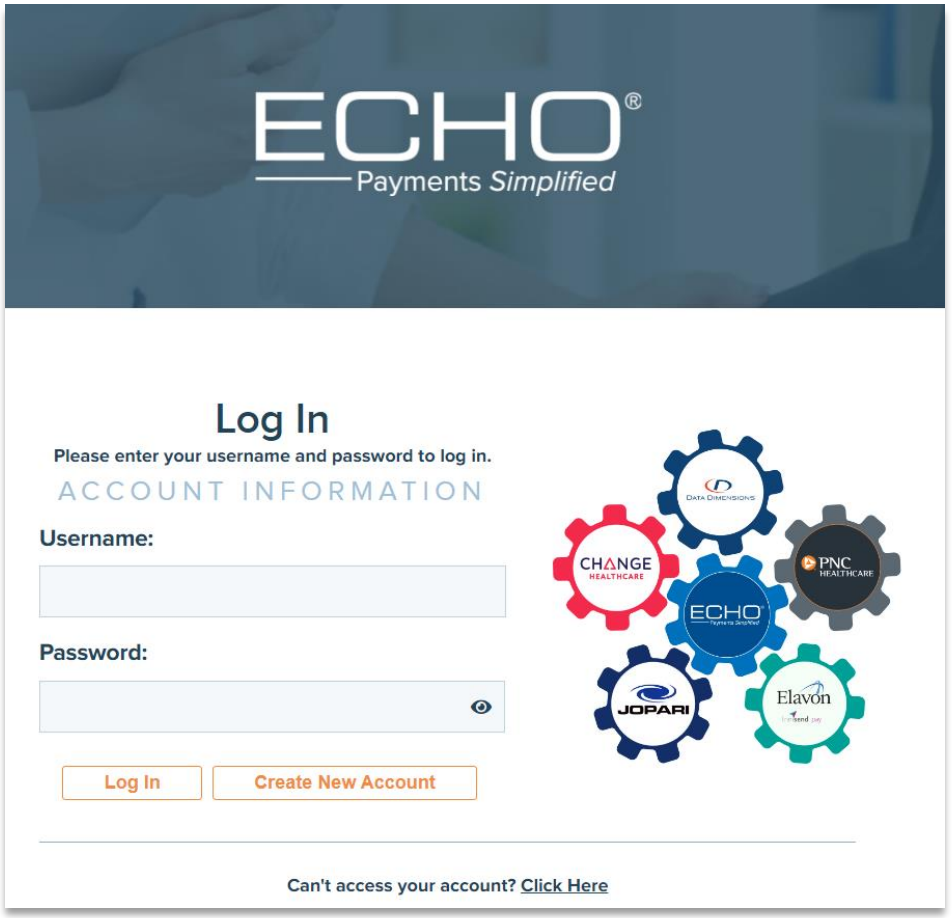
Benefits of EFT/ERAs:

- Quicker Payment
- Ability to search historical ERAs with ease
- View, download, print and save ERAs for quick reference

How to enroll with ECHO Health:

To register please visit:
https://enrollments.echohealthinc.com/efteradirect/MolinaHealthcare.

Questions? Contact ECHO Health at (888) 834-3511 Mon-Fri, 7am- 6pm CT



CLAIMS AND BILLING INFORMATION

Provider Grievance and Claim Appeal Process

Grievance

A Provider complaint that is not related to a Claim is considered a Provider Grievance.

Provider grievances may include, but are not limited to, dissatisfaction with a policy, procedure, the quality services provided, timeliness or processing of an authorization, and aspects of interpersonal relationships such as rudeness of an employee.

Provider grievances are accepted verbally, in-person, and in writing within **thirty (30) calendar days** from the date the grievance occurred, or Provider becomes aware of the grievance occurring. Molina will acknowledge the Provider Grievance within 3 business days from receipt. Molina will address each Provider Grievance, resolve, and provide written notice within **thirty (30) calendar days**.

Provider Claim Appeal

A Provider complaint that is related to a Claim, such as processing, payment, or non-payment of a Claim, is considered a Provider Claim Appeal

Provider Claim Appeals are requests to investigate the outcome of a finalized claim, which are typically related to underpayments, untimely filing, and bundling issues, or due to denial of services because of lack of prior authorization or insufficient information provided to meet medical criteria and necessity.

Provider Claim Appeals are accepted electronically and in writing within **ninety (90) days** from the date on the Explanation of Payment (EOP) or the Provider Remittance Advice (PRA). Molina will acknowledge Provider Claim Appeals within 3 business days from receipt. Molina will address each Provider Claim Appeal, resolve, and provide written notice within 30 calendar days. The outcome of a Provider Claim Appeal will be updated to a paid or denied status within **thirty (30) business days** of receiving notice of a resolution. All applicable claims adjustments associated with the Provider Claim Appeal will be updated within the thirty (30) business days.

CLAIMS AND BILLING INFORMATION

Provider Claim Appeals

Providers are encouraged to submit claim appeals electronically, using the Availity Essentials portal. Alternatively, claim appeals may be submitted using the form located on the MolinaHealthcare.com website. The item(s) being resubmitted should be clearly marked as reconsideration and must include the following documentation:

- Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request.
- The Claim number clearly marked on all supporting documents.

Claim reconsiderations shall be submitted at:

Availity Essentials portal: https://provider.molinahealthcare.com/
Fax: (833) 635-2044
Email: MolinaHC.NE.AnG@molinahealthcare.com
Mail: Molina Healthcare of Nebraska, Inc
Appeals & Grievances Unit
PO Box 182273
Chattanooga, TN 37422

Please Note: The Provider will be notified of Molina's decision in writing within 30 calendar days of receipt of the Appeal request.

Overpayment disputes should be received based on the number of days on the overpayment notification letter and should be mailed to:

Molina Healthcare of Nebraska, Inc.
Appeals & Grievances Unit
PO Box 182273
Chattanooga, TN 37422

CLAIMS AND BILLING INFORMATION

Coordination of Benefits and Third-Party Liability

Coordination of Benefits (COB)

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

- Provider should inquire with Members to learn whether Member has health insurance, benefits or Covered Services other than from Molina Healthcare,
- Provider must immediately notify Molina Healthcare of any other coverage,
- Provider will be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to exceed Molina Healthcare's contracted allowable rate,
- Provider must include a copy of the other insurance's EOB with the Claim,
- Provider can submit claims with attachments, including EOBs and other required documents, by utilizing Molina's Provider Portal.

Third-Party Liability

Molina Healthcare, as payer of last resort, will make every effort to determine the appropriate third-party payer for services rendered.

- Molina may deny claims when a third-party has been established and will pay claims for covered services when probable Third-Party Liability (TPL) has not been established or third-party benefits are not available to pay a claim; and,
- 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.

CLAIMS AND BILLING INFORMATION

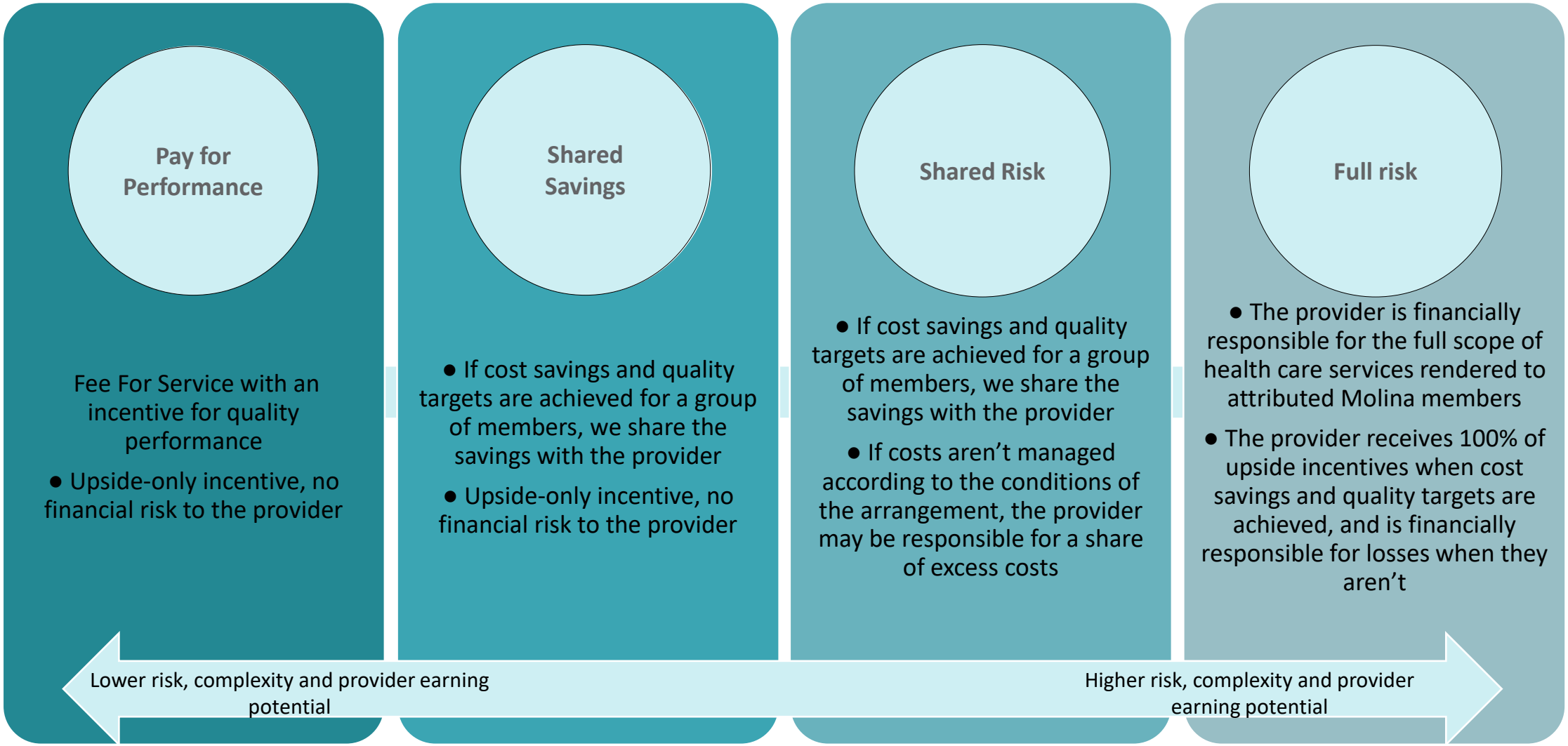
Balance Billing and Claims Payment

- **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 Provider Manual located on the website at www.MolinaHealthcare.com/NEProviders.
- In the event of a denial of payment, providers shall look solely to Molina for compensation for services rendered, except 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.

Value Based Contracting

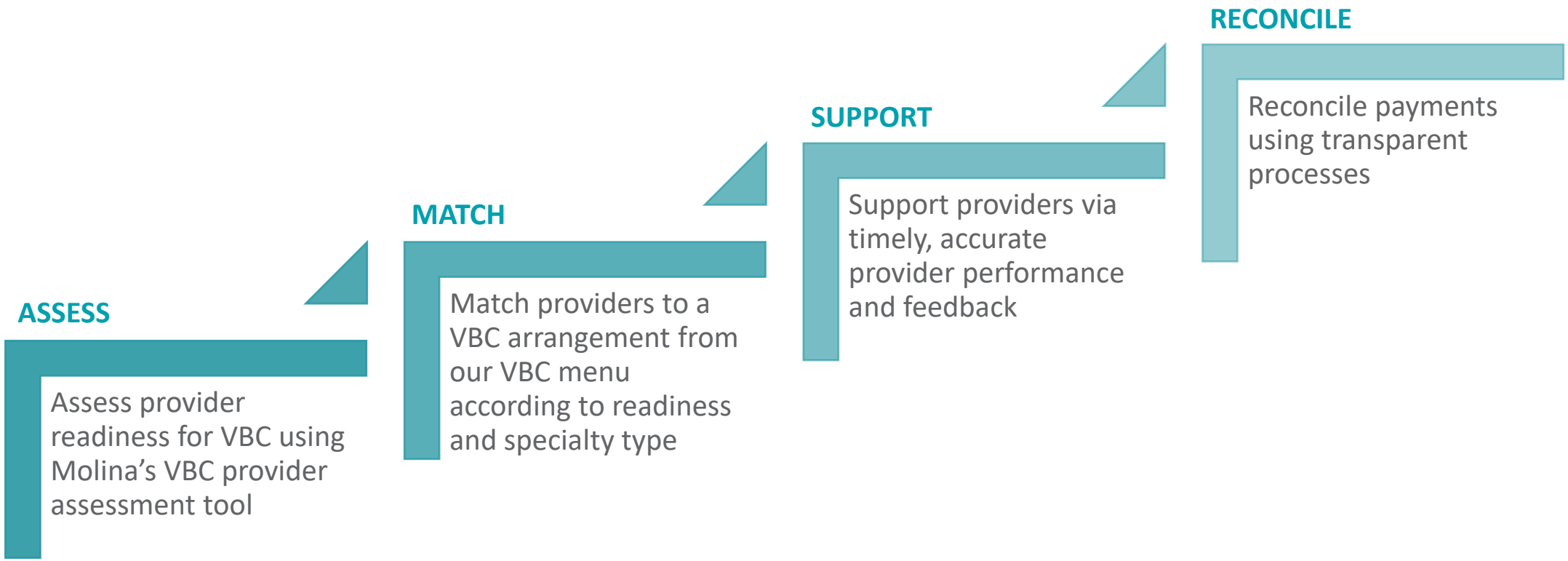
VALUE BASED CONTRACTING

Molina's VBC Continuum



VALUE BASED CONTRACTING

Molina's Path to value-based purchasing success



PROVIDER ENGAGEMENT: Dedicated staff guide and partner with providers throughout the process to promote provider success

Compliance

MOLINA HEALTHCARE

HERITAGE HEALTH

COMPLIANCE

Cultural and Linguistic Expertise

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

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

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

Additional Cultural and Linguistic Resources are available to providers on the Availity website and include:

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

COMPLIANCE

Cultural and Linguistically Appropriate Services (CLAS) Standards for Providers

Communication and Language Assistance

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

COMPLIANCE

Fraud, Waste, & Abuse

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

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

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

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

COMPLIANCE

False Claims Act, 31 USC Section 3279

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

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

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

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

- Knowingly making false statements
- Falsifying records
- Double-billing for items or services
- Submitting bills for services never performed or items never furnished
- Otherwise causing a false claim to be submitted

COMPLIANCE

Deficit Reduction Act

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

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

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

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

COMPLIANCE

Deficit Reduction Act (continued)

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

- Presents or causes to be presented to DHHS a Medicaid claim for payment where the person receiving the benefit or payment is not authorized or eligible to receive it.
- Knowingly makes a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program.
- Knowingly makes a claim under the Medicaid program for a service or product that was not provided.

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

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

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

COMPLIANCE

Examples of Fraud, Waste & Abuse

Health care fraud includes but is not limited to the making of intentional false statements, misrepresentations or deliberate omissions of material facts from, any record, bill, claim or any other form for the purpose of obtaining payment, compensation or reimbursement for health care services.

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

COMPLIANCE

Detecting Fraud, Waste and Abuse

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

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

COMPLIANCE

Reporting Suspected Fraud, Waste & Abuse

Suspected fraud, waste and abuse can be reported by telephone, online, in writing or directly to the State of Nebraska Department of Human and Health Services (DHHS). When reporting, the following information should be included:

- Nature of complaint.
- The names of individuals and/or entity involved in suspected fraud and/or abuse, including address, phone number, Molina Member ID number and any other identifying information

Reporting FWA to Molina

Molina Healthcare Compliance Alert Line:
(866) 606-3889

Report an Issue Online:
www.molinahealthcare.alertline.com

Report an Issue in Writing:
Molina Healthcare of Nebraska, Inc.
Attn: Compliance
200 Oceangate Blvd, Ste 100
Long Beach, CA 90802

Reporting FWA to State of Nebraska DHHS

Medicaid Recipients Suspected Fraud Line:
(402) 595-3789

Report an Issue via Email:
dhhs.investigationsSIU@nebraska.gov

Report an Issue in Writing:
Nebraska Department of Health and Human Services
Attn: SIU
1033 O Street, Ste 500
Lincoln, NE 68506

Questions?

MOLINA HEALTHCARE

HERITAGE HEALTH