Marketplace Provider Orientation

Presented by: Provider Services

2023

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Agenda

- About Health Insurance Marketplace and Enrollment
- Member Information and Resources
- Provider Roles and Responsibilities
- Provider Tools and Resources
- Billing and Claims Information
- Health Care Services
- Quality
- Pharmacy
- Compliance

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About Health Insurance Marketplace

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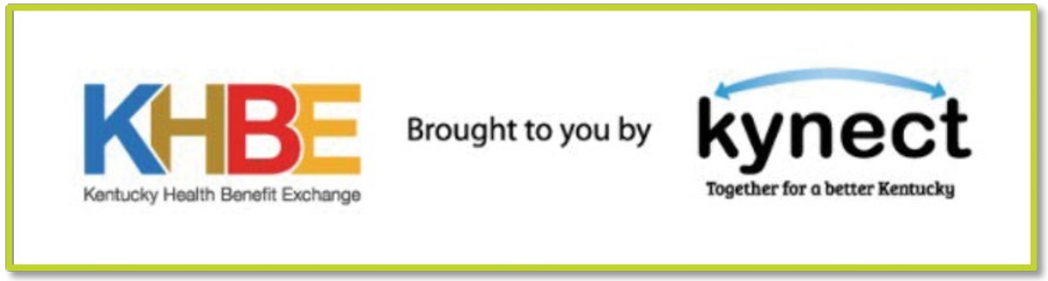
Introduction to Health Insurance Marketplace

The Health Insurance Marketplace (also known as the Exchange) is a one-stop shop for low-cost health insurance.

- Depending on the consumer's income, the government covers part of the cost of Marketplace insurance.
- The Marketplace is an outcome of the Affordable Care Act
- On the Marketplace, consumers can look at the insurance options available to them all in one place.
- The Marketplace was created as a simple way for individuals to buy affordable health care coverage.
- Kentucky has transitioned to a fully State-based Marketplace (SBM) – kynect



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Marketplace Service Area for 2023

For 2023, Passport Marketplace is available to members residing within Bullitt, Jefferson and Oldham counties.

The provider network is open to any provider who wishes to participate, regardless of location within the Commonwealth.

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Marketplace Plans (1 of 2)

GOLD PLANS

- Confident Care Gold 1
- Confident Care Gold 1 + Vision

SILVER PLANS

- Constant Care Silver 1
- Constant Care Silver 1 + Vision

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Marketplace Plans (2 of 2)

Plans are standardized and cover the same benefits, but vary by level of copay, coinsurance, deductible and subsidy.

GOLD PLANS

- Ideal for mid-to-high earners
- Closely resembles employer-sponsored coverage

SILVER PLANS

- Ideal for low income as it is the closest to Medicaid
- Receives the most federal subsidy to cover the monthly premiums, copays, coinsurance, and deductible

For more details on plan year 2022 benefits and cost-sharing, check the "Marketplace Benefits-At-A-Glance"

Marketplace Required Benefits

All Qualified Health Plans (QHP) must include the following 10 categories of Essential Health Benefits (EHB) defined by ACA:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity & newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Laboratory services
- Pediatric services, including oral and vision care
- Prescription drugs
- Rehabilitative and habilitative services
- Preventive and wellness services, and chronic disease management

Marketplace Special Enrollment

The Marketplace must allow qualified individuals to enroll in a Marketplace plan or change from one Marketplace plan to another as a result of a qualifying event

- 31 days to report the qualifying event
- 60 days from the qualifying event to select a QHP

Examples of Special Enrollment Events	
Loss of Minimum Essential Coverage	Gaining or losing eligibility for premium tax credits or cost sharing reductions
Gaining or becoming a dependent	Relocation resulting in new or different QHP selection
Gaining lawful presence	American Indians and Alaska Natives (AI/AN) may enroll in a QHP or change from one QHP to another one time per month
Enrollment errors of the Marketplace	Exceptional circumstances
Material contract violations by QHP	

Premium Payments

- The first month's premium payment is referred to as the member's "binder payment"
- If a member does NOT make the binder payment, the coverage will not be effective
  - There will be a binder restriction placed on every Marketplace member record
  - Additional restrictions may also be added
- Premium payments can be made via the Marketplace website, www.passporthealthplan.com/Marketplace, through My Passport Health Plan member portal or by auto-pay from their checking account
- Status and eligibility of members can be obtained via our provider portal – Availity Essentials

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Premium Payments Grace Period – APTC Members

APTC Member: A member who receives Advanced Premium Tax Credits (“APTC”) (premium subsidies), which helps to offset the cost of monthly premiums for the member.

- The Affordable Care Act mandates all QHPs offering insurance through the Health Insurance Marketplace provide a grace period of three (3) consecutive months to APTC members who fail to pay their monthly premium by the due date.
- To qualify for a grace period, the member must have paid at least one full month’s premium within the benefit year.
- The grace period begins on the first day of the first month for which the member’s premium has not been paid.
- One the member enters the grace period, they have until the end of that period to resolve the entire outstanding premium period
- Partial payments will not extend the grace period

Premium Payments Grace Period – Non-APTC Members

Non-APTC Member: A member who is not receiving any Advanced Premium Tax Credits and is therefore solely responsible for the payment of the full monthly premium.

- Non-APTC members are granted a 30-day grace period.
- Members may still access services during their 30-day grace period.
- If the full past-due premium is not paid by the end of the grace period, the member will be terminated as of the last day of the grace period.
- To qualify for a grace period, the member must have paid at least one full month's premium within the benefit year.
- The grace period begins on the first day of the first month for which the member's premium has not been paid.
- Once the member enters the grace period, they have until the end of that period to resolve the entire outstanding premium period.
- Partial payments will not extend the grace period.

Grace Period Service Restrictions

Grace Period	APTC Member	Non-APTC Member
Month 1 (1st 30 days)	**No service restrictions**	**No service restrictions** If the full past-due premium amount has not been paid at the end of the initial 30 days, the member is terminated
Month 2	• Prior Authorization requests will be processed • Claims will be pended until the premium is paid in full	N/A
Month 3	• Prior Authorization requests will be processed • Claims will be pended until the premium is paid in full • If the premium has not been paid in full by the last day of the 3rd month (end of grace period) the member will be retroactively terminated to the last day of the first month of the grace period	N/A

Note! When a member is in a grace period, Passport will include a **service alert** on the provider portal, interactive voice response (IVR) and in the call centers

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Member Cost Sharing

Cost sharing is the deductible, copayment, or coinsurance that members must pay for covered services provided under their Passport Marketplace plan.

Cost sharing applies to all covered services, except preventive services, included in the Essential Health Benefits (as required by the Affordable Care Act).

It is the provider's responsibility to collect the copayment and cost share from the member to receive full reimbursement for a service.

The amount of the copayment and other cost sharing will be deducted from the Passport payment for all claims involving cost sharing.

Note! Balance billing a Passport Member for Covered Services is prohibited, other than for the Member's applicable copayment, coinsurance and deductible amounts.

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Member Information and Resources

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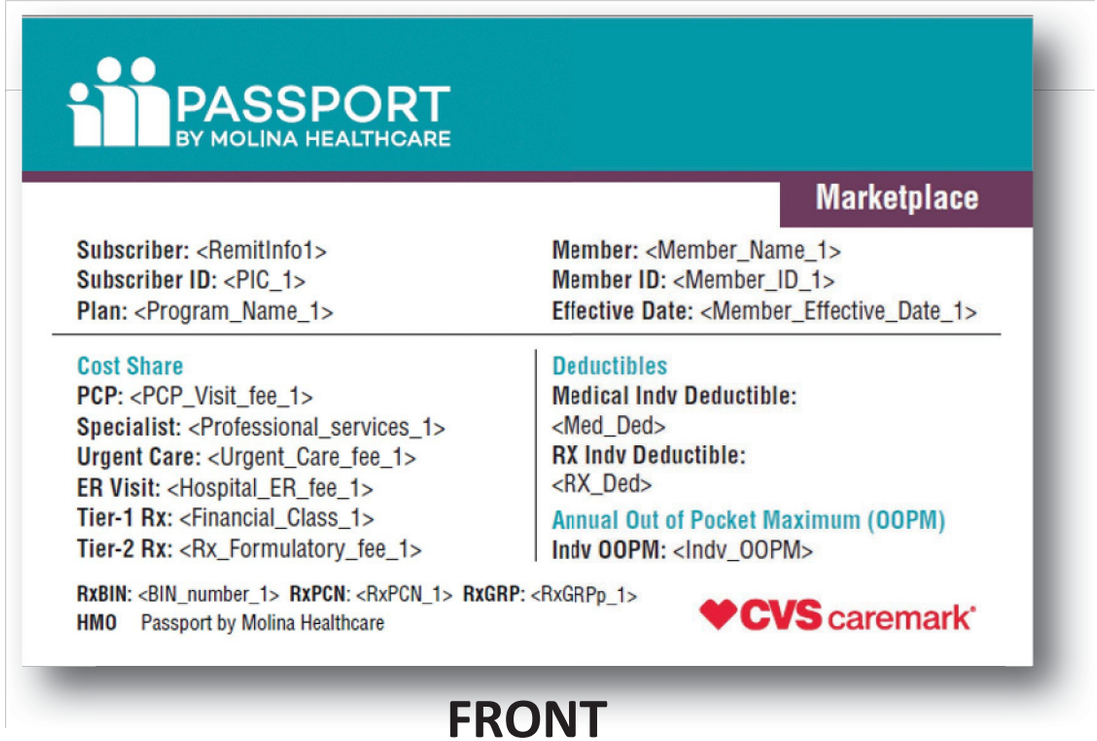
Member Identification Card



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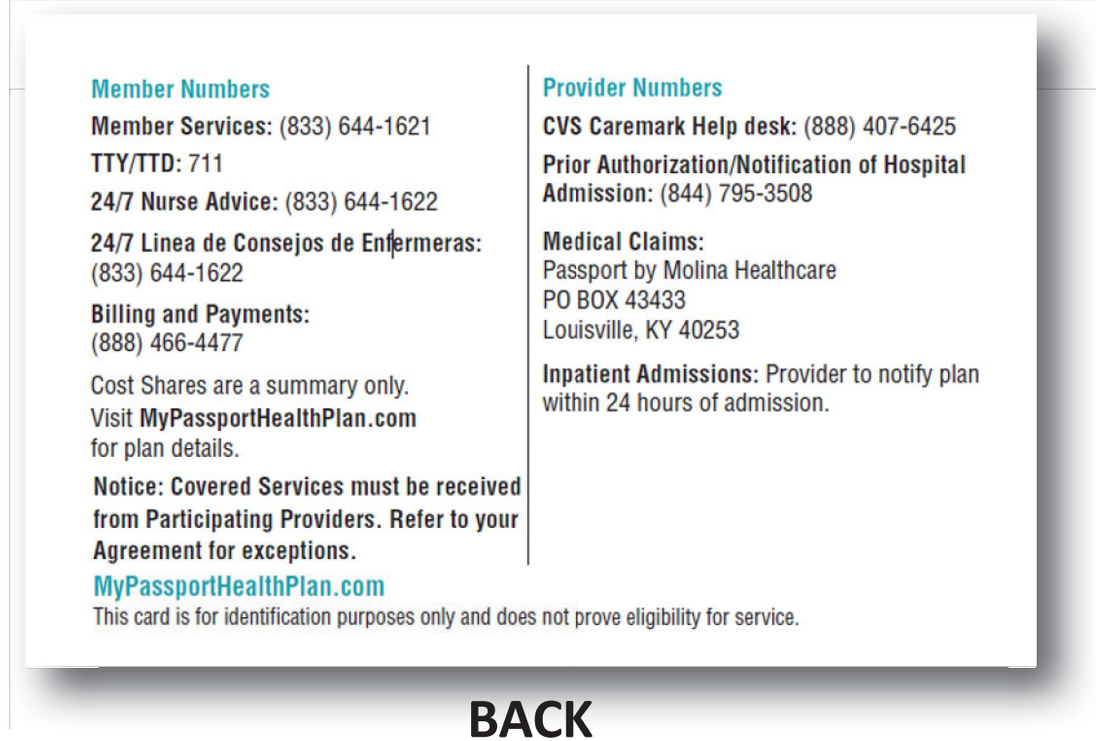

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Note! Possession of a member identification card is not a guarantee of eligibility. Always check eligibility prior to rendering services.

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Member Resources

Passport is committed to providing our member's with the best service possible. Members may reach out to us directly via our Member Services Team, find a provider in our online, searchable Provider Directory, review their information in the Member Portal, available 24/7 or visit our website for a copy of the Member Evidence of Coverage and much more.

Member Services:
1 (833) 644-1621 / TDD/TTY 711
Monday – Friday 8am-6pm EST

Provider Online Directory:
Passporthealthplan.com/Marketplace > Members > Find a Doctor

Member Portal:
My Passport
www.mypassporthealthplan.com

Member Evidence of Coverage:
Passporthealthplan.com/Marketplace > Members > Forms and Documents

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24/7 Nurse Advice Line and Behavioral Health Crisis Line

This telephone-based **Nurse Advice Line** is available to all Passport Marketplace members. Members may call anytime they are experiencing any type of symptoms or need health care information. Registered nurses are available **twenty-four (24) hours a day, seven (7) days a week** to assess symptoms and help make good health care decisions.

Nurse Advice Line
(833) 644-1622
TTY/TDD 711

The **Behavioral Health Crisis Line** is available for members who may be experiencing a behavioral health crisis or emergency **twenty- four (24) hours a day seven (7) days a week**.

Behavioral Health Crisis Line
(844) 800-5154

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Primary Care Provider (PCP) Assignment

Passport will offer each member a choice of Primary Care Provider (PCP). Passport will assign a PCP to those members who did not choose a PCP at the time of enrollment.

Providers are encouraged to ask members to update their PCP selection with Passport if they are transitioning their care.

Passport will pay a provider who sees a member who is not assigned to them. For example, if a provider is covering for another provider in their group.

Provider Roles and Responsibilities

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Provider Rights

Providers have the following rights:

- Providers have the right to expect 90% of Clean Claims to be paid within 30 days of receipt by Passport.
- Providers have the right to file a claims appeal regarding payment or contractual issues and expect timely processing and decision of that appeal by Passport.
- Providers have the right to expect Passport will ensure a Nurse Advice line is available to members 24 hours per day, 7 days per week.
- Providers have the right to expect Passport will ensure a Behavioral Health Crisis line available to members 24 hours per day, 7 days per week.
- Providers have the right to expect prompt and accurate member eligibility information from Passport via the Provider Portal and by phone.
- Providers have the right to receive a timely response to Prior Authorization requests; within 2 business days from receiving all required information for standard requests; and within 24 hours from receiving all needed information for expedited/urgent requests.

Primary Care Provider Responsibilities

PCP's have a responsibility to:

- Have screening and evaluation procedure for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders;
- Provide all needed initial, periodic and inter-periodic health assessments and immunizations for a member through the age of 21 years according to Bright Futures/AAP guidelines and intervals and at other times when Medically Necessary;
- Discuss Advance Medical Directives with all Passport members as appropriate;
- Submit an encounter for each visit where the Provider sees the member, or the member receives a HEDIS® service(s);
- Maintaining continuity of the member's health care and coordinate care with specialists as needed
- Maintaining a current medical record for the member, including documentation of all PCP and Specialty Care services;
- Provide primary and preventive care, recommend or arrange for all necessary preventive health care
- Arrange and refer members when clinically appropriate, to behavioral health Providers; make referrals for Specialty Care and other Medically Necessary services, both in and out of network, if such services are not available with Passport's network; and
- Ensure members use Network Providers. If assistance is needed in locating a participating Passport Provider, please contact Passport Health Plan at (800) 578-0775.

Behavioral Health Provider Responsibilities

Behavioral Health Providers have a responsibility to:

- Send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the PCP, with the member's or the member's legal guardian's consent.
- Follow Quality standards related to access.
- Ensure all members receiving inpatient psychiatric services are scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location, and name of the Provider. This appointment must occur within 7 days of the discharge date. If a member misses a behavioral health appointment, the Behavioral Health Provider shall contact the member within 24 hours of a missed appointment to reschedule.
- Assist members with accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.
- Participate in quarterly Continuity of Care meetings hosted by the commonwealth-operated or commonwealth- contracted psychiatric hospital and assist members for a successful transition to community supports.

Behavioral Health Discharge Planning

Behavioral Health Service Providers must assign a case manager prior to or on the date of discharge and provide basic, targeted or intensive Case Management services as Medically Necessary to Enrollees with SMI and co-occurring conditions who are discharged from an inpatient or residential stay for patients with SMI.

The Case Manager and other identified Behavioral Health Service providers shall also participate in Discharge Planning meetings to ensure compliance with federal Olmstead and other applicable laws. Appropriate Discharge Planning shall be focused on ensuring needed supports and services are available in the least restrictive environment to meet the Enrollee's behavioral, and physical health and identified SDoH needs, including psychosocial rehabilitation and health promotion.

Appropriate follow up by the Behavioral Health Service Provider shall occur to ensure the community supports are meeting the needs of the Enrollee discharged from a state operated or state contracted psychiatric hospital. Passport will assist Behavioral Health Service Providers to ensure patients can access free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.

Maintaining Provider Demographic Data

Passport strives to maintain the highest quality of provider data possible by enforcing policies that require notification prior to important provider demographic changes. All demographic changes must be submitted to Passport within **30 days**.

Providers are required to submit notification of changes including, but not limited to:

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

Provider Information Update forms are located at www.passporthealthplan.com/Marketplace > Providers > Forms and Documents

For questions regarding provider enrollment activities please contact:

Phone:
(800) 578-0775

In Writing:
Molina Healthcare, Inc
Attn: Credentialing Dept.
PO Box 2470
Spokane, WA 99210

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Provider Tools and Resources

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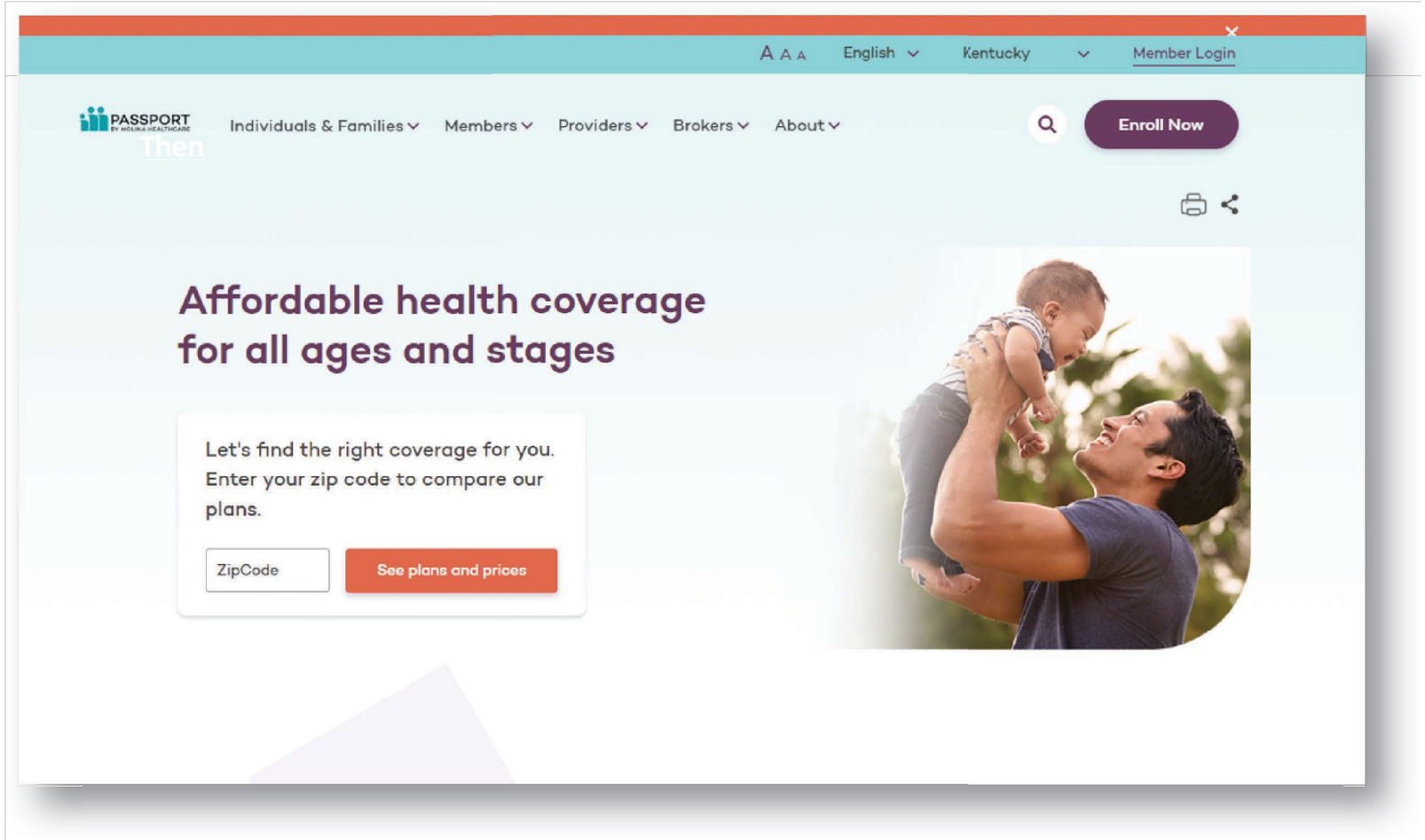
Passport Marketplace Website

www.Passporthealthplan.com/Marketplace

- Forms and Documents
- Provider Manual
- Provider Online Directory
- Payment Policies
- HIPAA
- EDI EFT/ERA
- Drug List
- Health Resources
- Communications
- FAQs



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Passport Provider Portal – Availity Essentials

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

The Provider Portal is a secure website that allows our providers to perform many self-service functions 24 hours a day, 7 days a week.

Services offered by Availity Essentials and Passport include:

- Claim submission/resubmission
- Claim status
- Viewing remittance advice
- Obtaining member eligibility and benefits information
- Submitting authorization requests
- Submit claim appeals Organization Registration Resource http://www.availity.com/registration-tips

Note! If you are currently using Availity for Passport's Medicaid line of business, you do not need to create a new Availity account!

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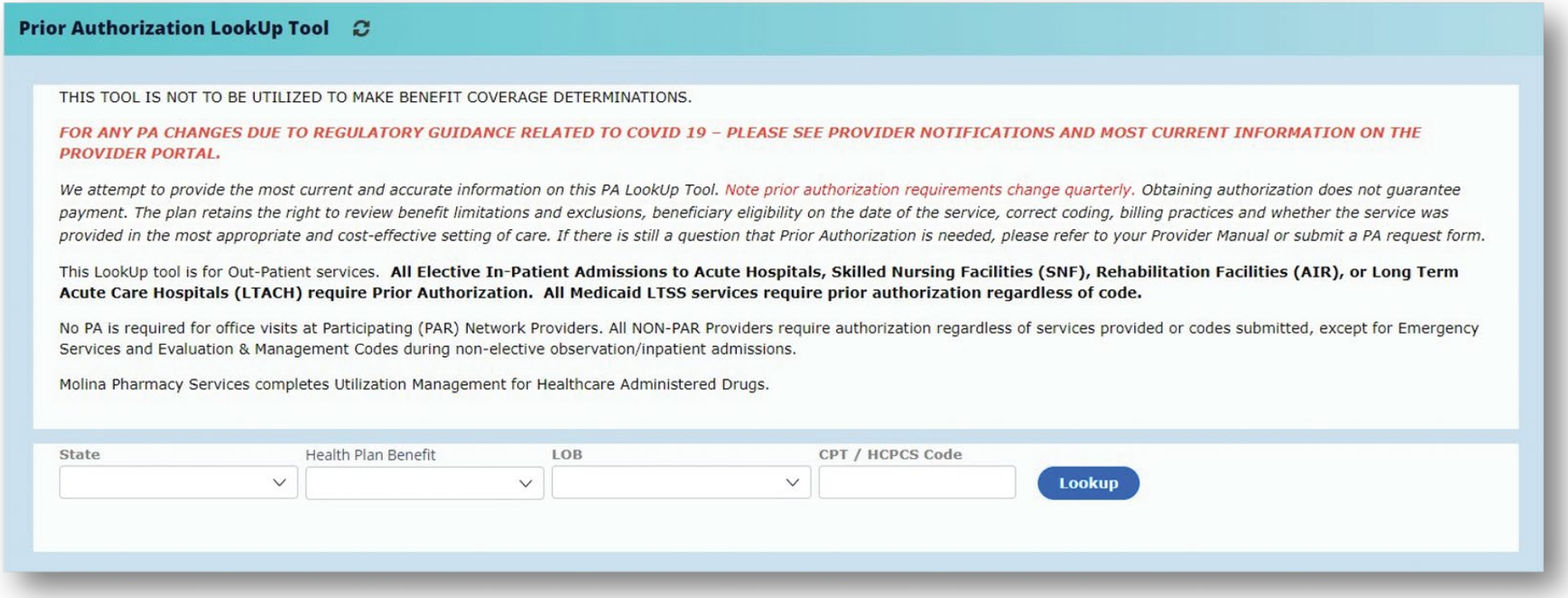
Prior Authorization Look-up Tool

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

To access the Prior Authorization Look-up Tool visit www.passporthealthplan.com/Marketplace > Providers.



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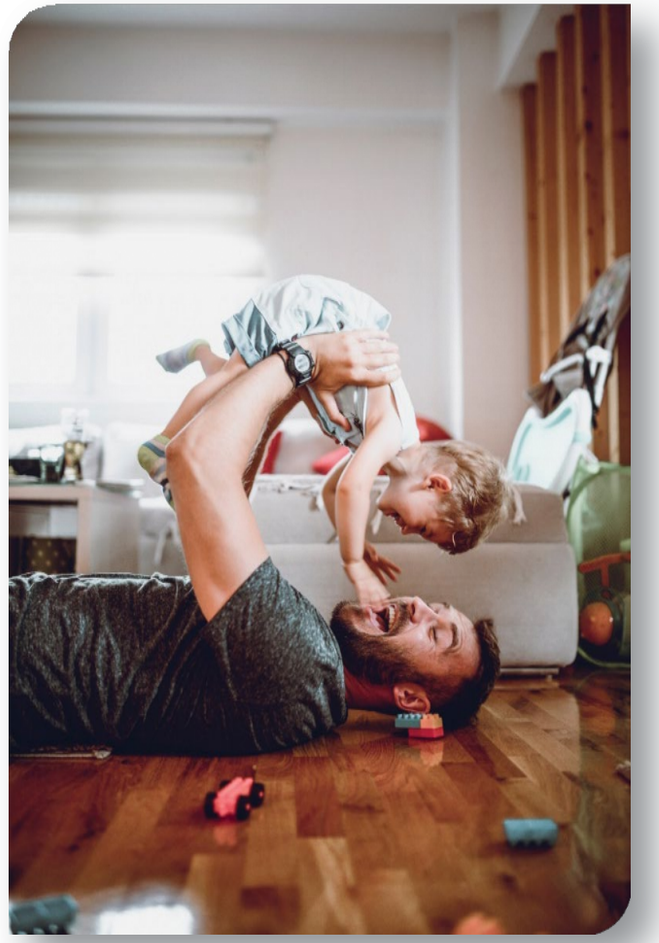
Verifying Member Eligibility

Passport encourages providers to check eligibility prior to visits to ensure the member is active on the date of service and to determine:

Online (preferred):
www.Availity.com

Phone:
(800) 578-0774



Note! At no time should a member be denied services because their name does not appear on the PCP's eligibility roster. If a member does not appear on the eligibility roster please utilize one of the other verification methods listed above.

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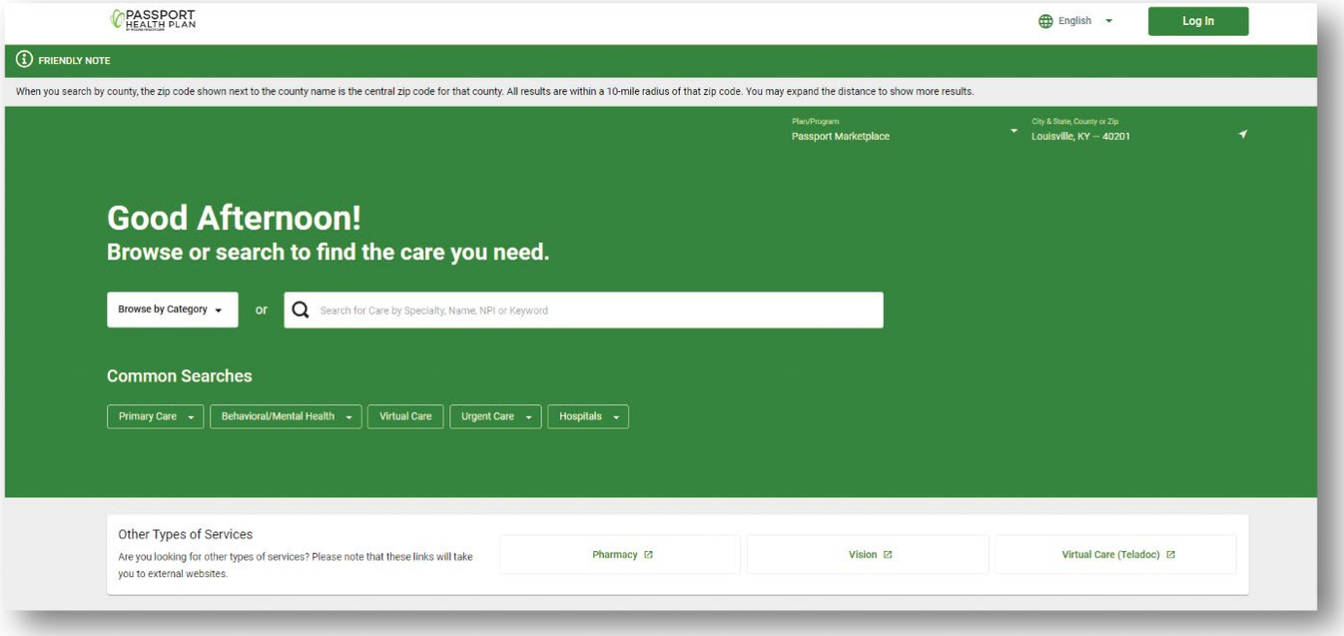
Provider Online Directory

To access our Provider Online Directory, visit us at www.passporthealthplan.com/Marketplace > Members and click on Find a Doctor or Pharmacy.

Providers are encouraged to validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. For questions or to report data issues within the Provider Directory please contact Passport's Provider Contact Center at 1 (800) 578-0775.



POD direct link:
https://passport.sapphirethreesixtyfive.com/?ci=ky-marketplace

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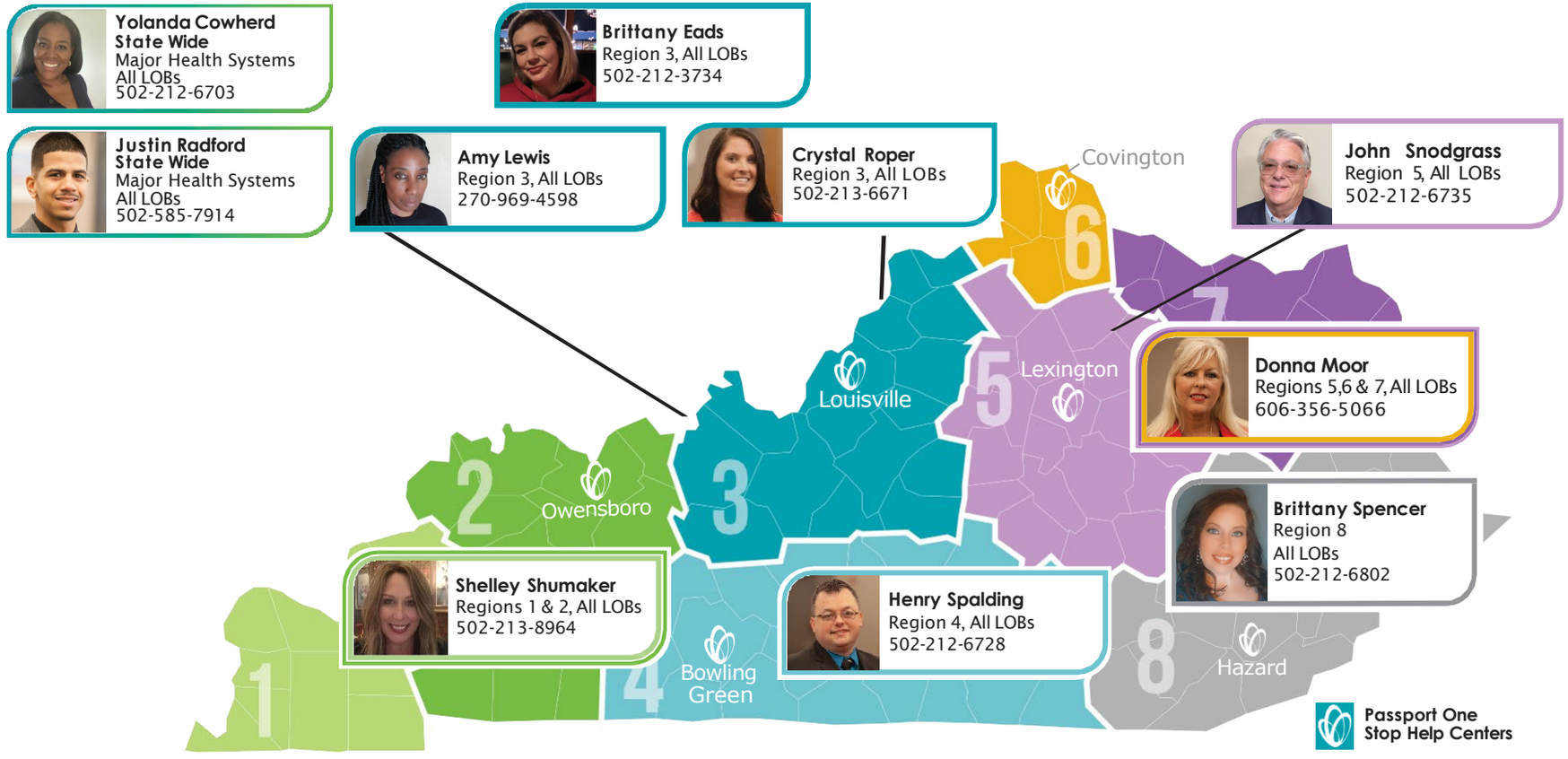
Provider Service Representatives

Click here to meet the Provider Services Team and obtain more information regarding your Provider Service Representative!



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Connect with Us!

What's New Updates on the Passport Website
www.passporthealthplan.com/Marketplace
Our website has the most up-to-date information available 24/7!

Provider Newsletter
Our quarterly Provider Newsletter addresses a multitude of topics impactful to Molina's overall organization.

eNews
Passport eNews provides real-time communications tailored to your provider type, delivered straight to your inbox. Register here!

News and Announcements in the Passport Provider Portal
www.availity.com
Check the News and Announcements in the Passport Payer Space of the Availity Portal!

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Billing and Claims Information

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Paper and Electronic Claim Submission

Passport accepts paper and electronic submissions of the CMS-1500 or UB04 claim forms. We highly encourage all in-network providers to submit claims electronically. Providers may submit initial and corrected claims via the methods listed below.

- **Online Via Passport's Provider Portal, Availity (preferred):** www.availity.com
- **Electronic Claim Submissions:**

Electronic Data Interchange (EDI):
Payer ID **61325**
Passport uses Change Healthcare as its gateway clearinghouse. Provider can also continue to submit claims to their usual clearinghouse. Passport accepts EDI transactions through Change Healthcare via the 837P for Professional and 837I for institutional. In order to ensure all data being 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.

For EDI claim submission issues please contact EDI Customer Service:

Email: EDI.claims@molinahealthcare.com

Paper Claim Submissions:

Passport Health Plan by Molina Healthcare
P.O. Box 43433
Louisville, KY 40253

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Timely Filing and Resubmissions

Timely Filing:

Providers are encouraged to submit claims for covered services rendered to members as soon as possible following the inpatient discharge date or date of service. All claims shall be submitted via the approved claim forms and shall include any and all medical records pertaining to the claim if requested by Passport or otherwise requested for claim processing per Passport's policies and procedures.

Initial Submission (clean claim)	Resubmissions/Corrections
365 calendar days after discharge or the date of service	**365 calendar days** from date of service

Corrected Claims:

Corrected claims are considered to be new claims and must be submitted with the correct coding to denote if it is a replacement of a prior claim or a corrected claim for the 837I or the correct resubmission code for an 837P. Please refer to billing guidelines in the Provider Manual for more information.

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

Passport utilizes **ECHO Health** for electronic payments. In-network providers are encouraged to register for Echo Health within **30 days** of receiving their first reimbursement check from Passport.

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/EFTERAInvitation.aspx?tp=MDAzMDg=

Questions? Contact ECHO Health at (800) 946-7758

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Claims

Passport employs a local, dedicated Provider Claims Service Unit to assist with claims questions and concerns.

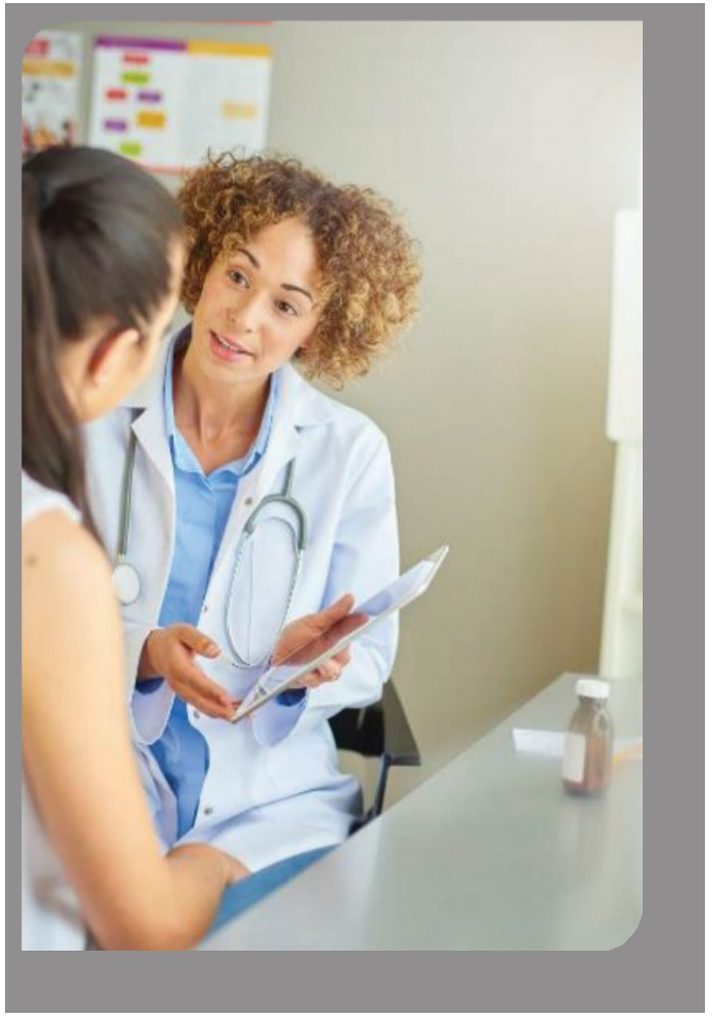
For all claims-related *inquiries* please contact the Provider Contact Center at:

Online via Provider Portal Availity Essentials (preferred):
www.Availity.com

Phone: (800) 578-0775
Monday – Friday
8am-6pm EST

In Writing:
Passport by Molina Healthcare
P.O. Box 43433
Louisville, KY 40253

Tip! When calling, please make sure to have your TIN/NPI, member ID, and DOS ready for the customer service representative.



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Claim Disputes/Reconsiderations

Providers disputing a claim previously adjudicated must request such an action **within sixty (60) days** of Passport's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all claim disputes must be submitted on the Provider Appeal Form found on Passport's website and provider portal.

All disputes/reconsiderations should be clearly marked as an appeal and must include the following documentation:

- Any documentation to support the adjustment and a copy of the authorization form (as applicable) must accompany the request
- The claim number must be clearly marked on all supporting documents

Disputes/reconsiderations should be sent via the following methods:

E-mail:

MHK_Provider_GnA@passporthealthplan.com

Mail:

Passport by Molina Healthcare Attn:
Provider Appeals
P.O. Box 43433
Louisville, KY 40253

Online via the Provider Portal – Availity Essentials (preferred):
www.availity.com

Fax:

(866) 315-2572

For help with any claims related process, call the Provider Contact Center at: (800) 578-0775

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Health Care Services

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Utilization Management (1 of 3)

Passport requires Prior Authorization for specified services as long as the requirement complies with federal and state regulations and the Passport Hospital or Provider Services Agreement.

- Services performed without authorization may not be eligible for payment
- Services provided emergently (as defined by Federal and state law) are excluded from the PA requirements
- Passport does not "retroactively" authorize services that require PA
  - The only possible exception for payment as a result of post-service review is in information is received indicating the Provider did not know nor reasonable could have known that the patient was a Passport member or there was a Passport error, a Medical Necessity review will be performed.

Prior Authorization requests should be sent via the following methods:

Online:
Available 24/7 Online via the Availity Essentials Portal at www.availity.com

Mail:
Passport by Molina Healthcare
Attn: Health Care Services
5100 Commerce Crossings Dr
Louisville, KY 40229

Phone:
(800) 578-0775
Advanced Imaging: (855) 714-2415
It may be necessary to submit additional documentation before the authorization can be processed.

Fax:
(833) 322-1061
Advanced Imaging: (877) 731-7218
Transplant: (877) 813-1206

Click here for PA forms and information

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Utilization Management (2 of 3)

The following services require a prior authorization:

Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:

- Inpatient, Residential Treatment, Partial Hospitalization, Day Treatment, Intensive Outpatient
- Electroconvulsive Therapy (ECT)
- Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)

Cardiology

Cosmetic, Plastic and Reconstructive Procedures (in any setting):

- Breast Reconstructive procedures do not require PA with Breast Cancer Diagnoses

Durable Medical Equipment

Elective Inpatient Admissions:

- Acute Hospital
- Skilled Nursing Facilities (SNF),
- Acute Inpatient Rehabilitation
- Long Term Acute Care (LTAC) Facilities

Experimental/Investigational Procedures

Genetic Counseling and Testing (except for prenatal diagnosis of congenital disorders of the unborn child through amniocentesis and genetic test screening of newborns mandates by state regulations)

Healthcare Administered Drugs

Home Healthcare Services (including home-based PT/OT/ST):

- PA not required for initial consultation

Utilization Management (3 of 3)

The following services require a prior authorization (cont.):

Hyperbaric/Wound Therapy
Advanced Imaging and Special Tests
Miscellaneous and Unlisted Codes:

- Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the prior authorization request

Neuropsychological and Psychological Testing
Non-Par Providers/Facilities:

- PA is required for office visits, procedures, labs, diagnostic studies, and inpatient stays

Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures
Pain Management Procedures (except Trigger Point Injections)
Physical Therapy, Occupational Therapy, Speech Therapy

- Limited to 20 visits per calendar year, per member, per type of therapy. If medical necessity requires additional visits, the provider must request additional visits via prior authorization

Prosthetics/Orthotics
Radiation Therapy and Radiosurgery
Sleep Studies (except home (POS 12) sleep studies)
Transplants/Gene Therapy, including Solid Organ and Bone Marrow

- Cornea transplant does not require authorization

Transportation Services

- Non-emergent air transportation

For a complete list of services that require PA, please use our **Prior Authorization LookUp Tool**.

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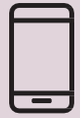
Health Management Programs

Passport offers programs to help our members and their families to manage a diagnoses health condition.

Our Health Management Programs include:

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



For more information about our programs, please call Health Management at: (800) 578-0775

Care Management

The Intensive Care Management (ICM) program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Passport case manager will assess the Member upon engagement in ICM; assist with arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services and identify; and address any barriers the Member experiences to accessing appropriate care. For more information about our Care Management program click here.

Members with the following conditions may qualify for Care Management and should be referred to the Passport ICM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- NICU stays lasting more than 5 days
- Catastrophic or end-stage medical conditions
- Comorbid chronic conditions (e.g. asthma, diabetes, COPD, CHF, Bipolar Disorder, etc.)
- High-technology home care requiring more than 2 weeks of treatment
- Member accessing Emergency Department services for ambulatory care sensitive conditions
- Children with special healthcare needs
- Members with high risk behavioral health conditions
- Members with barriers to accessing care or other needed services

Referral to Care Management

Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care provider to the ICM program.

Referrals to the ICM program may be made by contacting Passport at:

Phone:

(800) 578-0775

Fax:

(800) 983-9160

Health Education and Care Management Referral Form

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Quality

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Quality Improvement

Passport 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.

Passport requires contracted Providers and Medical Groups to comply with the following core elements and standards of care:

- Have a Quality Improvement Program in place
- Comply with and participate in Passport's Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential Quality of Care and/or Critical Incident investigations.
- Cooperate with Passport's quality improvement activities that are designed to improve quality of care and services and member experience.
- Allow Passport to collect, use and evaluate data related to practitioner 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 Passport Quality personnel for site and medical record review processes.

Contact Us!

Phone:
(800) 578-0775

Mail:
Passport by Molina Healthcare
Attn: Quality
5100 Commerce Crossings Dr
Louisville, KY 40229

PASSPORT BY MOLINA HEALTHCARE

Pharmacy

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Pharmacy Benefit Manager – CVS Caremark

CVS Caremark is the Pharmacy Benefit Manager (PBM) for Passport Marketplace.

Contact CVS Caremark:
Provider Services: (800) 578-0775
Member Services: (833) 644-1621

Prior Authorization Submission:
Fax: (833) 322-1061
www.Availity.com

- Passport will only process completed PA request forms, the following information must be included for the request form to be considered complete:
  - Member first/last name, date of birth and identification number
  - Prescriber first/last name, NPI, phone and fax number
  - Drug name, strength, quantity and direction of use
  - Diagnosis
- The Drug Formulary, Physician Administered Preferred Drug List, Specialty Medication Administration Site of Care policy and Medication Prior Authorization Criteria and Clinical Policies is available on the Passport website: www.passporthealthplan.com/Marketplace > Providers

Compliance

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BY MOLINA HEALTHCARE

Fraud, Waste & Abuse

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

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

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

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

Reporting Fraud, Waste & Abuse

Remember to include the following information when reporting:

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

Phone:
Passport's Compliance AlertLine
(866) 606-3889

Online:
https://Molinahealthcare.alertline.com

Mail:
Confidential
Compliance Official
Passport by Molina Healthcare
200 Oceangate, Suite 100
Long Beach, CA 90802

OR

Kentucky Department of Insurance
Division of Insurance Fraud Investigation
PO Box 4050
Frankfort, KY 40604
(800) 595-6053 / TDD (800) 648-6056

PASSPORT BY MOLINA HEALTHCARE

Diversity, Equity & Inclusion

National census data shows that the United States' population is becoming increasingly diverse. Passport is committed to providing appropriate and accessible care to all of our members regardless of race, ethnicity, language, ability, age, gender, sexual orientation, or religion. Passport has a demonstrated history of developing targeted healthcare programs for a 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 diverse 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; and
- Following the national CLAS Standards https://thinkculturalhealth.hhs.gov/clas/standards

Providers are required to participate in and cooperate with Passport's provider education and training efforts as well as member education and efforts. Providers are also to comply with all health education, CLAS Standards, and disability standards, policies, and procedures, as well as all federal mandates.

Additional resources are available to providers such as:

- Health plan and health education materials written at a 6th grade reading level
- Translated documents
- Accessible formats (i.e. braille, audio or large font)
- Cultural sensitivity trainings and cultural/linguistic consultation https://www.molinahealthcare.com/providers/ky/medicaid/resource/care_diverse.aspx

Providers may request interpreters for members whose primary language is other than English by calling Passport's Contact Center toll free at (800) 578-0775. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the member to a qualified language service provider.

Email us at

KYProviderRelations@MolinaHealthcare.com

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