PROVIDER MANUAL

(Provider Handbook)

Passport by Molina Healthcare, Inc.

(Passport)

Medicaid 2026

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in your Agreement with Passport by Molina Healthcare, Inc. “Passport” has the same meaning as “Health Plan” in your Agreement. The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at
PassportHealthPlan.com

Last Updated: 06/22/2026

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1. Contact Information

Passport by Molina Healthcare

2028 W. Broadway

Louisville, KY 40203

Provider Services Departments

The Provider Services department handles inquiries from Providers regarding address and Tax-ID changes, contracting and training. The department has Provider Services representatives who serve all of Passport's Provider network. Eligibility verifications and claims status can be conducted at your convenience via the Availity Essentials Portal.

The Provider Contact Center also has dedicated telephone representatives available to answer general inquiries from 8:00 a.m. to 6:00 p.m. EDT Monday through Friday.

Phone: (800) 578-0775
Fax:(502) 585-6060

Member Services Department

The Member Services department handles all telephone and written inquiries from Passport Members regarding benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services representatives are available from 7:00 a.m. to 7:00p.m. Monday through Friday.

Phone: (800) 578-0603
TTY/TDD: 711

Claims Department

Passport strongly encourages Participating Providers to submit Claims electronically (via a clearinghouse or Availity Essentials Portal) whenever possible.

- Access the Availity Essentials Portal (Availity.com)
- EDI Payer ID 61325.

To verify the status of your Claims, please use the Availity Essentials Portal. Claims questions can be submitted through the chat feature on the Availity Essentials Portal, or by contacting Provider Services.

Claims Recovery Department

The Claims Recovery department manages recovery for Overpayment and incorrect payment of Claims.

Provider Disputes	Passport by Molina Healthcare 2028 W. Broadway Louisville, KY 40203
RefundChecks Lockbox	Passport by Molina Healthcare P.O.Box2144

	Indianapolis,IN46206
Phone	(866) 642-8999
Fax	(866) 314-4613

Appeals and Grievances

The Appeals and Grievances department manages appeal and grievances inquiries.

Provider Appeals and Grievances, including post-service appeals:

Online:Availity.com(preferredsubmission)
Fax: (866) 315-2572
Email:MHK_Provider_GnA@MolinaHealthcare.com
Phone: (800)-578-0775 (Grievances only)

Mail:
Appeals and Grievances
Molina Healthcare
PO Box 36030
Louisville, KY 40233-6030

Member Appeals and Grievances, including pre-service appeals:

Fax: (833) 415-0673
Email: MHK_Enrollee_GnA@MolinaHealthcare.com

Mail:
Appeals and Grievances
Molina Healthcare
PO Box 36030
Louisville, KY 40233-6030
Phone:(800) 578-0603

Compliance and Fraud AlertLine

If you suspect cases of fraud, waste, or abuse, you must report it to Passport. You may do so by contacting our AlertLine or submitting an electronic complaint using the website listed below. For additional information on fraud, waste, and abuse, please refer to the Compliance section of this Provider Manual.
Confidential Compliance Official
Passport by Molina Healthcare
2028 W. Broadway
Louisville, KY 40203
Phone: (866) 606-3889
Website: MolinaHealthcare.alertline.com

Credentialing Department

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every 3 years, or sooner, depending on Passport's Credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Passport network. For additional information about Passport's Credentialing program, including Policies and Procedures, please refer to the Credentialing and Recredentialing section of this Provider Manual.

Molina Healthcare, Inc.

Attn: Credentialing Dept.

PO Box 2470

Spokane, WA 99210

Phone: (800) 578-0775

Nurse Advice Line

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

Phone: (800) 606-9880

TTY/TDD: 711 Relay

Healthcare Services Department

The Healthcare Services department conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. The Healthcare Services (HCS) department also performs Care Management (CM) for Members who will benefit from Care Management services. Participating Providers are required to interact with Passport's HCS Department electronically whenever possible. Prior Authorizations (PA)/Service Requests and status checks can be easily managed electronically.

Managing Prior Authorizations/Service Requests electronically provides many benefits to Providers, such as:

- Easy to access 24/7online submission and status checks.
- Ensures HIPAA compliance.
- Ability to receive real-time authorization status.
- Ability to upload medical records.
- Increased efficiencies through reduced telephonic interactions.
- Reduces costs associated with fax and telephonic interactions.

Passport offers the following electronic Prior Authorizations/Service Requests submission options:

- Submit requests directly to Passport via the Availity Essentials Portal.

Availity Essentials Portal Availity.com

Phone (800) 578-0775

Phone Numbers:

- Medical/Behavioral Health (800) 578-0775
- Transplant (855) 714-2415
- Advance Imaging (855) 714-2415
- NICU Management (Progeny) (888) 832-2006

Fax Numbers:

- Medical / Behavioral Health (833) 454-0641
- Transplant (877) 813-1206
- Advanced Imaging (877) 731-7218
- NICU Management (Progeny) (888) 821-4630

Evolent (formerly known as New Century Health)

Evolent (formerly known as New Century Health) administers select cardiology and select oncology prior authorizations for members age 18 and over

PA look up Tool: Provider Home Page
Phone: (888) 999-7713
Cardiology Fax: (714) 582-7547
Medical Oncology Fax: (213) 596-3783
Radiation Oncology Fax: (714) 494-8366

Behavioral Health

Passport manages all components of Covered Services for behavioral health. For Member behavioral health needs, please contact us directly at (800) 578-0775. Passport has a Behavioral Health Crisis Line that Members may access 24 hours per day, 365 days per year by calling the Member Services telephone number on the back of their Passport ID card.

Pharmacy Department

Prescription drugs are covered through MedImpact. A list of in-network pharmacies is available on the passporthealthplan.com website or by contacting Passport.

Phone:(800) 210-7628
Drug PA Fax: (858) 357-2612

Physician administered drugs(PAD) are covered through Passport. Providers should fax PAD requests to the fax number below. PAD related inquiries can be directed to Passport at the number below.

Phone: (800) 578-0775
PAD PA Fax: (844) 802-1406

Quality

Passport maintains a Quality department to work with Members and Providers in administering the Passport Quality Program.

Phone:(800) 578-0775
Fax: (502) 585-7915
Email: PassportQuality@molinahealthcare.com

Vision Services

VSP administers vision benefits for Passport members
Phone: (866) 615-1883
www.vspproviderhub.com

Molina Dental Services

Phone: (855) 994-2453
Hearing Impaired (TTY/TDD): 711

Passport by Molina Healthcare Service Areas

2. Provider Responsibilities

Non-discrimination in Healthcare Service Delivery

Providers must comply with the nondiscrimination of health care service delivery requirements as outlined in the Cultural Competency and Linguistic Services section of this Provider Manual.

Additionally, Passport requires Providers to deliver services to Passport Members without regard to source of payment. Specifically, Providers may not refuse to serve Passport Members because they receive assistance with cost sharing from a government-funded program.

Section 1557 Investigations

All Passport Providers shall disclose all investigations conducted pursuant to Section 1557 of the Patient Protection and Affordable Care Act to Passport's Civil Rights Coordinator.

Toll Free: (866) 606-3889
TTY/TDD: 711
Online: https://MolinaHealthcare.AlertLine.com
Email: civil.rights@passporthealth.com

Should you or a Passport Member need more information, you can refer to the Health and Human Services website: federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Providers Not Participating in Medicaid Fee-for-Service

All Passport Providers participating in the Passport network must be enrolled in the Kentucky Medicaid program. Authorization is required for non-participating Providers. If a Provider has not had a Medicaid number assigned, the Provider must apply for enrollment with the Department for Medicaid Services (DMS) and meet the Medicaid Provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service Providers of the appropriate provider type. To submit a Kentucky Medicaid enrollment application with DMS, go to the Medicaid Partner Portal Application (MPPA) at https://medicaidsystems.ky.gov/Partnerportal/home.aspx

Role and Responsibilities of Primary Care Provider (PCP)

The PCP is the manager of the patients' total health care needs. PCPs prescribe and provide routine and preventive medical services and coordinate all care that is given by Passport's participating specialists and facilities or any other medical facility where patients might seek care (e.g., Emergency Services). The coordination provided by PCPs may include direct provision of primary care; referrals for specialty care, including behavioral health and programs including disease management, educational programs, public health agencies, and community resources. In addition to fulfilling these roles, the PCP has 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 for a Member under the age of 21 years, and shall be responsible for providing or arranging for complete assessments at the intervals specified in the Kentucky approved periodicity schedule 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® services
- Maintaining continuity of the Member's health care
- Documenting all care rendered in a complete and accurate Medical Record that meets or exceeds the Department's specifications
- Provide primary and preventive care, recommend, or arrange for all necessary preventive health care, including EPSDT for Members under the age of 21 years
- Arranging and referring 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 at (800) 578-0775.
- Maintain formalized relationships with other PCPs to refer their Enrollees for after-hours care, during certain days, for certain services, or other reasons to extend the hours of service of their practice.
- The PCP remains solely responsible for the PCP functions listed above.

Specialty providers may serve as PCPs under certain circumstances, depending on the Enrollee's needs including an Enrollee who has a gynecological or obstetrical health care need, a disability, or chronic illness. The decision to utilize a specialist as the PCP shall be based on agreement among the Enrollee or family, the specialist, and the Contractor's medical director. The Enrollee has the right to Appeal such a decision in the formal Appeals process.

- Maintaining formalized relationships with other PCPs to refer their Enrollees for after-hours care, during certain days, for certain services, or other reasons to extend the hours of service of their practice. The PCP remains solely responsible for the PCP functions; Enrollee to PCPs ratios shall not exceed 1500:1 FTE Provider for children under twenty-one (21) and adults

Facilities, Equipment and Personnel

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

Provider Data Accuracy and Validation

It is important for Providers to ensure Passport has accurate practice and business information. Accurate information allows Passport to better support and serve our Member and Provider network.

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

Providers must validate their Provider information on file with Passport at least once every 90 days for

correctness and completeness.

Additionally, in accordance with the terms specified in your Provider Agreement, Providers must notify Passport of any changes as soon as possible, but at a minimum of 30 calendar days in advance of any changes in any Provider information on file with Passport. Changes include, but are not limited to:

- Change in office location(s)/address, 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 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 Passport in writing in accordance with the terms specified in your Provider Agreement.

Please visit our Provider Online Directory at passporthealthplan.com 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 data is submitted using the information submitted on the rosters but will be validated using CAQH to ensure accuracy. All Provider data submitted should match the information in CAQH to avoid Provider and service location information from being removed.

Note: Some changes may impact credentialing. Providers are required to notify Passport of changes to credentialing information in accordance with the requirements outlined in the Credentialing section of this Provider Manual.

Passport is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Network of Providers through various methods, such as letters, phone campaigns, face-to-face contact, fax, and fax-back verification, etc. Passport also may use a vendor to conduct routine outreach to validate data that impacts its Provider Directory or otherwise impacts its membership or ability to coordinate Member care. Providers are required to supply timely responses to such communications.

National Plan and Provider Enumeration System (NPPES) Data Verification

In addition to the above verification requirements, CMS recommends that Providers routinely verify and attest to the accuracy of their National Plan and Provider Enumeration System (NPPES) data.

NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider is able to attest and NPPES will reflect the attestation date. If the information is not correct, the Provider is able to request a change to the record and attest to the changed data, resulting in an updated certification date.

Passport 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 (FAQs) document published at the following link: cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Passport Electronic Solutions Requirements

Passport requires Providers to utilize electronic solutions and tools whenever possible.

Passport requires all contracted Providers to participate in and comply with Passport's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic Claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claims Appeal 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.

Any Provider entering the network as a Contracted Provider will be required to comply with Passport's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the Availity Essentials Portal within 30 days of entering the Passport network.

Passport 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 Passport. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including Claims submitted to Passport. Providers may obtain additional information by visiting Passport's HIPAA Resource Center located on Passport's website at passporthealthplan.com.

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Passport Providers include:

- Electronic Claims Submission Options
- Electronic Payment: Electronic Funds Transfer (EFT) with Electronic Remittance Advice (ERA)
- Availity Essentials Portal

Kentucky Health Information Exchange (KHIE)

To establish and maintain a strong provider network, Passport has developed and adheres to a Network Development and Management Plan that aligns with the Kentucky Department for Medicaid Services' (DMS) goals and supports the needs of its Medicaid Program Membership.

As we move forward in our contracting efforts it is imperative that we call attention to the section in Passport's Managed Care Contract with DMS that states all providers must register with and adhere to the Kentucky Health Information Exchange (KHIE) guidelines. The contract agreement mandates the following:

- Providers who contract with Passport will sign a Participation Agreement with the Kentucky Health Information Exchange (KHIE) within one (1) month of contract signing.
- Hospitals that contract with Passport will be required to submit ADTs (Admission, Discharge, Transfer messages) to KHIE.
- If the provider does not have an electronic health record, they must still sign a Participation Agreement with KHIE and sign up for Direct Secure Messaging services so that clinical information can be shared securely with other providers in their community of care.
- Molina is required to submit a monthly report to the Kentucky Office of Health Data and Analytics regarding the above items.

Electronic Claims Submission Requirement

Passport strongly encourages participating Providers to submit Claims electronically whenever possible. Electronic Claims submission provides significant benefits to the Provider including:

- Promoting HIPAA compliance.
- Helping to reduce operational costs associated with paper Claims (printing, postage, etc.).
- Increasing accuracy of data and efficient information delivery.
- Reducing Claim processing delays as errors can be corrected and resubmitted electronically.
- Eliminating mailing time and enabling Claims to reach Passport faster. Passport offers the following electronic Claims submission options:
- Submit Claims directly to Passport via the Availity Essentials Portal. Availity.com.
- Submit Claims to Passport through your EDI clearinghouse using Payer ID 61325, refer to Passport's website passporthealthplan.com for additional information.

While both options are embraced by Passport, submitting Claims via the Availity Essentials Portal (available to all Providers at no cost) offers several additional Claims processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper Claims.
Availity Essentials Portal Claims submission benefits:

- Add attachments to Claims
- Submit corrected Claims
- Easily and quickly void Claims
- Check Claims status
- Receive timely notification of a change in status for a particular Claim
- Ability to Save incomplete/un-submitted Claims
- Create/Manage Claim Templates

For additional information on EDI Claims submission, please refer to the Claims and Compensation section of this Provider Manual.

Electronic Payment (EFT/ERA) Requirement

Participating Providers are required to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and receive payment and ERA access faster than the paper check and remittance advice (RA) processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Passport uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery processes. Additional instructions on how to register are available under the EDI/ERA/EFT tab on Passport's website at passporthealthplan.com.

Availity Essentials Portal

Providers and third-party billers can use the no cost Availity Essentials Portal to perform many functions online without the need to call or fax Passport. Registration can be performed online and once completed the easy-to-use tool offers the following features:

- Verify Member eligibility, covered services and view HEDIS needed services (gaps).
- Claims
    - Submit Professional (CMS1500) and Institutional CMS-1450 (UB04) Claims with attached files.
    - Correct/Void Claims.

    - Add attachments to previously submitted Claims.
    - Check Claims status.
    - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
    - Create and manage Claim Templates.
    - Submit and manage Claim disputes, including formal appeals or reconsideration requests, for finalized Claims
    - View, dispute, and resolve Claim overpayments.
- Prior Authorizations/Service Requests
    - Create and submit Prior Authorization/Service Requests.
    - Check status of Authorization/Service Requests.
    - Access prior authorization letters directly through the new DC Hub functionality in the Availity Essentials portal. Please note: letters will only be available for prior authorization requests submitted via the Availity Essentials portal.
- View HEDIS® Scores and compare to national benchmarks.
- View a roster of assigned Passport Members for PCP(s).
- Download forms and documents.
- Send/receive secure messages to/from Passport.
- Manage Overpayment invoices (Inquire, Dispute, and Resolve).

Provider network management portal: enrollment tool

- The **Provider Network Management Portal** is a secure, free tool used to manage Provider enrollment and credentialing requests. All credentialing requests for a Provider to join the network must be submitted electronically through the portal.
- Available functions include:
    - Adding practitioners to an existing group
    - Submitting credentialing requests
    - Tracking credentialing and participation status
    - Providing additional or missing information for enrollment or credentialing
    - Uploading provider rosters
    - Adding new facility locations

Access

- Office managers, administrative personnel, or Providers who need access to the portal for the first time must submit a registration request directly through the Provider Network Management Portal at Molina/Provider Management.

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Passport to the Provider. Balance billing for a Passport Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance, and deductible amounts. However, if a Member agrees in advance in writing to pay for a Non-Medicaid covered services, then Passport, Passport's

Provider, or Passport's Subcontractor may bill the Member. The standard release form signed by the Member at the time of services does not relieve Passport, Providers and Subcontractors from the prohibition against billing a Medicaid Member in the absence of a knowing assumption of liability for a Non-Medicaid Covered Services. The form or other type of acknowledgement relevant to the Medicaid Member liability must specifically state the services or procedures that are not covered by Medicaid. Any Provider who knowingly and willfully bills a Member for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if Passport becomes insolvent.

Non-Medicaid Covered Services

The following list is representative of non-covered services and procedures, and is not meant to be exhaustive:

- Any laboratory service performed by a Provider without current certification in accordance with the CLIA. This requirement applies to all facilities and individual Providers of any laboratory service
- Cosmetic procedures or services performed solely to improve appearance.
- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only.
- Medical or surgical treatment of infertility (for example, the reversal of sterilization, in vitro fertilization, etc.).
- Induced abortion and miscarriage performed out of compliance with federal and Kentucky laws and judicial opinions.
- Paternity testing.
- Personal service or comfort items.
- Postmortem services.
- Services that are investigational, mainly for research purposes, or experimental in nature. This includes, but is not limited to, drugs.
- Gender reassignment services.
- Sterilization of a mentally incompetent or institutionalized Enrollee.
- Services provided in countries other than the United States, unless approved by the
- Secretary of the Kentucky Cabinet for Health and Family Services.
- Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid Program regulations referenced herein.
- Services for which the Enrollee has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage.

Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Passport's Member materials (such as Member Handbooks).

For additional information, please refer to the Member Rights and Responsibilities section of this Provider Manual.

Member Information and Marketing

Any written informational or marketing materials directed to Passport Members must be developed and distributed in a manner compliant with all Commonwealth and Federal Laws and regulations and approved

by Passport prior to use.

Please contact your Provider Services representative for information and a review of proposed materials.

Member Eligibility Verification

Possession of a Passport ID card does not guarantee Member eligibility or coverage. Providers should verify eligibility of Passport Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Passport places the responsibility for eligibility verification on the Provider of services.

Providers who contract with Passport may verify a Member's eligibility by checking the following:

- Availity Essentials portal at availity.com
- Passport Provider Services automated IVR system at (800) 578-0775

For additional information please refer to the Eligibility, Enrollment, and Disenrollment section of this Provider Manual.

Healthcare Services (Utilization Management and Care Management)

Providers are required to participate in and comply with Passport's Utilization Management and Care Management programs, including all policies and procedures regarding Passport's facility admission, prior authorization, and Medical Necessity review determination procedures. Providers will also cooperate with Passport in audits to identify, confirm, and/or assess utilization levels of covered services. For additional information, please refer to the Healthcare Services section of this Provider Manual.

In Office Laboratory Tests

Passport's policies allow only certain lab tests to be performed in a Provider's office regardless of the line of business. All other lab testing must be referred to an In-Network Laboratory Provider that is a certified, full-service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing, and pathology. A list of those lab services that are allowed to be performed in the Provider's office is found on the Passport website at passporthealthplan.com.

Additional information regarding In-Network Laboratory Providers and In-Network Laboratory Provider patient service centers is found on the laboratory Providers' respective websites at appointment.questdiagnostics.com/patient/confirmation and labcorp.com/labs-and-appointments.

Specimen collection is allowed in a Provider's office and shall be compensated in accordance with your agreement with Passport and applicable Commonwealth and Federal billing and payment rules and regulations.

Claims for tests performed in the Provider's office, but not on Passport's list of allowed in-office laboratory tests will be denied.

Treatment Alternatives and Communication with Members

Passport endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow up care. Passport promotes open discussion between Provider and Members, following HIPAA compliant communication practices, regarding Medically Necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and facilitate training in self-care and other measures Members may take to promote their own health.

Pharmacy Program

Providers are required to adhere the Kentucky Preferred Drug List and prescription policies, including the Pharmacy Coordinated Services Program (CSP) policies. For additional information, please refer to the Pharmacy section of this Provider Manual.

Participation in Quality Programs

Providers are expected to participate in Passport's Quality Programs and collaborate with Passport in conducting peer review and audits of care rendered by Providers. Such participation includes, but is not limited to:

- Access to Care Standards
- Site and Medical Record-Keeping Practice Reviews as applicable
- Delivery of Patient Care Information

For additional information, please refer to the Quality section of this Provider Manual.

Compliance

Providers must comply with all Commonwealth and Federal Laws and regulations related to the care and management of Passport Members.

Confidentiality of Member Health Information and HIPAA Transactions

Passport requires that Providers respect the privacy of Passport Members (including Passport Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member protected health information, including maintaining confidentiality for Family Planning Services in accordance with applicable Federal and Commonwealth laws and judicial opinions for Passport Members less than 18 years of age pursuant to federal and commonwealth regulations. For additional information please refer to the Compliance section of this Provider Manual

Participation in Grievance and Appeals Programs

Providers are required to participate in Passport's Grievance Program and cooperate with Passport in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of Member records for a period of not less than 10 years and retained further if the records are under review or audit until such time that the review or audit is complete. For additional information, please refer to the Complaints, Grievance and Appeals Process section of this Provider Manual.

Participation in Credentialing

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

For additional information on Passport's Credentialing program, including Policies and Procedures, please refer to the Credentialing section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in Passport's Delegated Services Addendum. For additional information on Passport's delegation requirements and delegation oversight, please refer to the Delegation section of this Provider Manual.

Primary Care Provider Responsibilities

PCPs are responsible to:

- Serve as the ongoing source of primary and preventive care for Members
- Assist with coordination of care as appropriate for the Member's health care needs
- Recommend referrals to specialists participating with Passport
- Triage appropriately
- Notify Passport of Members who may benefit from Care Management
- Participate in the development of Care Management treatment plans

3. Culturally Linguistically Appropriate Services

Background

Passports works to ensure all Members receive culturally linguistically appropriate care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), seek to improve the appropriateness and accessibility of health care services by meeting the cultural, linguistic, and accessibility related needs of individuals served. Passport complies with Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination in health programs and activities receiving federal financial assistance on the basis of race, color, and national origin, sex, age, and disability per title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1975 (29 U.S.C. § 794). Molina complies with applicable portions of the Americans with Disabilities act of 1990. Molina also complies with all implementing regulations for the foregoing. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, ages, and religions as well as those with disabilities in a manner that recognizes, values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on culturally and linguistically appropriate services is available at passporthealthplan.com, from your local Provider Services representative and by calling Passport Provider Services at (800) 578-0775.

Nondiscrimination in Health Care Service Delivery

Passport complies with Section 1557of the ACA. As a Provider participating in Passport's Provider Network, you and your staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR); State law; and Federal program rules, including Section 1557of the ACA.

You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.
2. You **MUST** post in a conspicuous location in your office, a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found in the Member Handbook located at molinahealthcare.com/members/ky/en-US/mem/medicaid/overvw/handbook
3. You **MUST** post in a conspicuous location in your office, a Tagline Document, that explains how to access non-English language services. A sample of the Tagline Document that you will post can be found in the Member Handbook located atmolinahealthcare.com/members/ ky/enUS/mem/medicaid/overvw/handbook
4. If a Passport Member is in need of accessibility-related services, you MUST provide reasonable accommodations for individuals with disabilities and appropriate auxiliary aids and services
5. If a Passport Member is in need of language assistance services while at your office, and you are a recipient of Federal Financial Assistance, you **MUST** take reasonable steps to make your services accessible to persons with limited English proficiency ("LEP").You can find resources on meeting your LEP obligations at hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html; See also, hhs.gov/civil-rights/for-providers/ clearance-medicare-providers/technical-assistance/limited-english-proficiency/index.html.
6. If a Passport Member complains of discrimination, you **MUST** provide them with the following

information so that they may file a complaint with Passport's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802 Phone (866) 606-3889 TTY/TDD, 711 civil.rights@MolinaHealthcare.com	Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 Website:ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Form: hhs.gov/ocr/complaints/index.html

If you or a Passport Member needs additional help or more information, call (800) 368-1019 or TTY/TDD (800) 537-7697.

Culturally and Linguistically Appropriate Process

Passport is committed to reducing health care disparities and improving health outcomes for all Members. Training employees, Providers and their staff, and quality monitoring improving appropriateness and accessibility are the cornerstones of assessing, respecting, and responding to a wide variety of cultural, linguistic, and accessibility needs when providing health care services. Passport integrates culturally and linguistically appropriate training into the overall Provider training and quality monitoring programs. An integrated quality approach enhances the way people think about our Members, service delivery and program development so that culturally and linguistically appropriate practice become a part of everyday thinking.

Provider and Community Training

Passport offers educational opportunities in culturally and linguistically appropriate practices for Providers, and Passport conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Services and/or online/ web-based training modules. View training and resource here: https://www.molinahealthcare.com/providers/ky/medicaid/comm/training.aspx

Training modules, delivered through a variety of methods, include:

1. Provider written communications and resource materials
2. On-site culturally and linguistically appropriate practices training
3. Online culturally and linguistically appropriate practices Provider training; and,
4. Integration of Culturally and linguistically appropriate practices and concepts and nondiscrimination of service delivery into Provider communications.

Integrated Quality Improvement – Ensuring Access

Passport ensures Member access to language services such as oral interpretation, American Sign Language (ASL) and written materials in alternate formats Passport must also ensure access to programs, aids, and services that are congruent with cultural norms. Passport supports Members with disabilities and assists Members with LEP.

Passport develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats (i.e., braille, audio, large print), leading to better communication, understanding and Member satisfaction. Online materials found on passporthealthplan.com and information delivered in digital form meet Section 508 accessibility requirements

to support Members with visual impairments.

Key Member information, including Appeal and Grievance forms, are also available in threshold languages on the Passport Member website.

Access to Language Services

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.

Passport Providers must support Member access to telephonic language services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Passport Members language services if the Members do not request them on their own. Please remember it is never permissible to ask a family member, friend, or minor to interpret.

All eligible Members who are Limited English Proficient (LEP) are entitled to receive language services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, limited reading proficiency(LRP), or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are Passport Members responsible for the cost of such services. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services.

Passport is available to assist providers with locating these services if needed.

An LEP is an individual whose primary language for communication is not English and who individual hasa limited ability to read, write, speak, or understand English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations). It is possible that an individual with LEP may be able to speak or understand English but still be limited to read or write in English. It is also important to not assume that an individual who speaks some English is proficient in the technical vocabulary of the health care services required.

Passport Members are entitled to:

- Be provided with effective communications with medical Providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964.
- Be given access to Care Managers trained to work with individuals with cognitive impairments.
- Be notified by the medical Provider that interpreter services, including ASL, are available at no cost
- Be given reasonable accommodation, appropriate auxiliary aids and services.
- Decide, with the medical Provider, to use an interpreter and receive unbiased interpretation.
- Be assured of confidentiality, as follows:
    - Interpreters must adhere to the Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of Member records.
    - Interpreters may, with Member's with written consent, share information from the Member's records only with appropriate medical professionals and agencies working on the Member's behalf.

    - Interpreters must ensure that this shared information is similarly safeguarded
- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan.

Interpreters include people who can speak the Member's primary language, assist with a disability or help the Member understand the information.

When Passport Members need an interpreter, and limited hearing and/or limited reading services for health care services, the Provider should:

- Verify the Member's eligibility and medical benefits.
- Inform the Member that an interpreter, limited hearing, and/or limited reading services are available.
- Passport is available to assist Providers with locating these services if needed:
    - Providers needing assistance finding on-site video remote, or telephonic interpreter services.
    - Providers needing assistance finding translation services. obtaining written materials in preferred languages.
    - Providers with Members who cannot hear or have limited hearing ability may use TTY/TDD at 711.
    - Providers with Members with limited vision may contact Passport for documents in large print, braille or audio version.
    - Providers with Members with limited reading proficiency (LRP).The Passport Member Services representative will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version.

Phone: (800) 578-0600

Claims Denied for Missing/Additional Documentation:

Claims denied for missing or additional documentation requirements such as consent forms, invoices, explanation of benefits from other carriers, or itemized bills are not considered claim appeals. To process your claim, these documents, along with a claim, must be received by the claims department within timely filing requirements. Do not include a provider appeal form with a claim submission. Please mail claims denied for missing or additional documentation to:

KY Medicaid Claims
Passport by Molina Healthcare
PO Box 36090
Louisville, KY 40233

KY Marketplace Claims
Passport by Molina Healthcare
PO Box 43433
Louisville, KY 40253

Documentation

As a contracted Passport Provider, your responsibilities for documenting Member language services/needs in

the Member's medical record are as follows:

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic Member lists that are sent to you each month by Passport.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of Passport's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code, and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if a Member insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after notification of his or her right to have a qualified interpreter at no cost.

Members Who Are Deaf or Hard of Hearing

TTY/TDD connection is accessible by dialing 711.This connection provides access to Member & Provider Contact Center, Quality, Healthcare Services, and all other health plan functions.

Passport strongly recommends that Provider offices make assistive listening devices available for Members who are deaf and hard of hearing. Assistive listening devices enhance the sound of the Provider's voice to facilitate a better interaction with the Member.

Passport will provide face-to-face service delivery for ASL to support Members who are deaf or hard of hearing. Requests should be made 3 business days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via Passport Member Services.

Passport will provide on-site or video service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made at least three (3) business days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via Passport Member Services.

Nurse Advice Line

PassportprovidesNurseAdviceservicesforMembers24hours per day, 7daysperweek, The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Passport's Nurse Adviceline directly, (800) 606-9880 (English and Spanish) or TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

Program and Policy Review Guidelines

Passport conducts assessments at regular intervals of the following information to ensure its programs are most effectively meeting the needs of its Members and Providers:

- Annual collection and analysis of race, ethnicity, and language data from:
  - Eligibleindividualstoidentifysignificantculturallyandlinguisticallydiversepopulations within a plan's membership.
  - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually.

- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider Network and cultural responsiveness.
- Collection of data and reporting for the Diversity Race/Ethnicity Description of Membership HEDIS® measure.
- Collection of data and reporting for the Language Description of Membership HEDIS® measure
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found across the plan's subpopulations.
- Analysis of HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Qualified Health Plan (QHP) Enrollee Experience Survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services

4. Member Rights and Responsibilities

Providers must comply with the rights and responsibilities of Passport Members as outlined in the Passport Member Handbook and on the Passport website. The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be accessed via the Member pages on passporthealthplan.com.

Member Handbooks are available on Passport's Member Website. Member Rights and Responsibilities are outlined under the heading "Your Rights and Responsibilities" within the Member Handbook document and copied below for easy reference.

Kentucky and Federal Law requires that health care Providers and healthcare facilities recognize Member rights while the Members are receiving medical care, and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of the Members.

For additional information, please contact Passport Provider Services at (800) 578-0775, 8 a.m.- 6 p.m. EDT Monday through Friday. TY users, please call 711.

Member Rights and Responsibilities:

Passport Members have the right to:

- Respect,dignity,privacy,confidentiality,accessibility,andnondiscrimination.
- Get information on the structure and operation of the health plan, its services, its practitioners and providers and member rights and responsibilities.
- To receive notice of any significant changes in the Benefits Package at least thirty
- (30) days before the intended effective date of the change.
- Prepare Advance Medical Directives.
- Timely referral and access to medically indicated specialty care.
- Be furnished health care services in accordance with federal and state regulations.
- Choose your Primary Care Provider and to change your PCP in a reasonable manner.
- Consent for or refusal of treatment and active participation in decision choices.
- Voice Grievances and receive access to the Grievance process, receive assistance in filing an appeal, and request a State Fair Hearing from the Contractor and/or the Department.
- Know if a co-payment or contribution is required. Know the names, education, and experience of your health care providers.
- Be treated with respect with recognition of your dignity and your right to privacy.
- Timely access to care that does not have any communication or physical access barriers.
- Timely referral and access to medically indicated specialty care ask questions and receive complete information relating to the Enrollee's medical condition and treatment options, including Specialty Care.
- Assistance with Medical Records in accordance with applicable federal and state laws.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Receive information in accordance with 42 C.F.R. 438.10.
- Any American Indian enrolled with the Contractor eligible to receive services from a participating I/T/U provider or an I/T/U PCP shall be allowed to receive services from that

provider if part of Contractor's Network.

- Receive Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services.
- Take part in decision making with your doctor about your health care, including the right to refuse treatment and openly discuss appropriate or medically necessary treatment choices of your health problems, regardless of cost or coverage. Get a fair and timely reply to requests for service. Voice complaints or appeals about the organization and the care it provides.
- Know that your member information will be kept private. It is only used in reports to the state to show that the Plan is following state rules and laws.
- Ask how your doctor is paid.
- To be able to file an appeal, a grievance (complaint) or request a State Fair Hearing (after Passport has made a decision and you aren't happy with that decision).
- To get help with filing an appeal, grievance (complaint) or request a State Fair Hearing (after Passport has made a decision and you aren't happy with that decision).
- To receive information and timeframes for filing an appeal, a grievance, or a State Fair Hearing.
- To make recommendations regarding the Plan's member rights and responsibility policy.
- To use any hospital or other setting for emergency care.
- To receive detailed information on emergency and after-hours coverage.
- To receive all information, including but not limited to, enrollment notices, informational materials, instructional materials, available treatment options, and alternatives in a manner and format that may be easily understood.
- Be free From any form of restraint or seclusion used as means of pressure, discipline, convenience, or retaliation.
- Include assistance with requesting and receiving a copy of your medical records at no cost to you, and request that they be corrected.
- Be provided culturally and linguistically appropriate healthcare services (CLAS) Be provided covered healthcare services.
- Be free to exercise your rights without negatively affecting the way Passport, our providers or the State treat you.
- Be free from other discrimination prohibited by State and Federal regulations.
- Request clinical practice guidelines upon request.
- Get a second medical opinion.
- Get help with any special language needs.
- To receive interpretation by phone services free of charge for all non-English languages, not just those identified as prevalent.
- Prepare Advance Medical Directives.
- Be furnished health care services in accordance with federal and state regulations.

Passport Members have the responsibility to:

- Work with their PCP to protect and improve your health. You can report other insurance benefits, when you are eligible, to your Department for Medicaid Services Specialist by calling Beneficiary Help Line at (800) 642-3195, TTY (866) 501-5656.
- Show your Passport ID card, Medicaid card and valid ID to all providers before receiving services.
- Never let anyone use your Passport ID card or Medicaid card.
- Make appointments for routine checkups and immunizations (shots).

- Keep your scheduled appointments and be on time calling as soon as you can if you must cancel.
- Provide complete information about your past medical history.
- Provide complete information about current medical problems.
- Listen to your PCP's advice and ask questions about your care when you are in doubt.
- Call or go back to your PCP if you do not get better or ask to see another provider.
- Follow your provider's medical advice.
- Respect the rights of other patients and healthcare workers.
- Use emergency room services only when you believe an injury or illness could result in death or lasting injury.
- Notify your PCP if emergency treatment was necessary and follow-up care is needed.
- Report changes that may affect your coverage to your Department for Medicaid Services specialist. This could be an address change, birth of a child, death, marriage, or divorce, or change in income.
- Promptly apply for Medicare or other insurance when you are eligible.
- Find out how your health coverage works.
- Call your PCP when you need medical care, even if it is after-hours.
- Tell us if you have problems with any health care staff by calling Member Services at (800) 578-0603, 7a.m.- 7p.m. EDT, Monday through Friday.
- Report suspected Fraud and Abuse

Second Opinions

If Members do not agree with their Provider's plan of care, they have the right to a second opinion from another Provider. Members should call Member Services to find out how to get a second opinion. Second opinions may require Prior Authorization.

5. Eligibility, Enrollment, Disenrollment

Enrollment

Enrollment in Medicaid Programs

The Kentucky Department for Medicaid Services has the exclusive right to determine an individual's eligibility for the Medicaid Program and eligibility to become a Passport Member.

Noneligible Member shall be refused enrollment or re-enrollment, have their enrollment terminated, or be discriminated against in any way because of their health status, need for health services race, ethnicity, national origin, religion, gender, age, mental or physical disability, or sexual orientation.

Effective Date of Enrollment

Eligibility begins on the first day of the month for Members joining Passport with the following exceptions:

- Newborns, born to an eligible mother, are eligible at birth
- Members who meet the requirements for presumptive eligibility, in accordance with commonwealth and federal guidelines, are effective on the of eligibility determination
- Unemployed parent program Members are enrolled beginning the date that the definition of unemployment or underemployment, in accordance with 45 D.F.R. 233.100, is met.

Newborn Enrollment

Passport begins coverage of newborns on the date of birth when the newborn's mother is a Passport Member. The delivery hospital is required to enter the birth record into the birth record system, KY CHILD (Kentucky's Certificate of Live Birth, Hearing, Immunization, and Lab Data). That information is used to auto enroll the deemed eligible newborn within 24 hours of birth. All claims for newborns must be submitted using the newborn's name and Kentucky Medicaid ID number. Providers can verify newborn eligibility in the Availity Essentials portal at Availity.com.

Eligibility Verification

Medicaid Programs

The Commonwealth of Kentucky, through the Department for Medicaid Services, determines eligibility for the Medicaid Programs. Payment for services rendered is based on eligibility and benefit entitlement. The Contractual Agreement between Providers and Passport places the responsibility for eligibility verification on the Provider of services. Additionally, a Provider is required to verify if a Member has been enrolled in a Lock-In Program which directs Members to certain Providers. Failure to verify a Member's enrollment in the Lock-in Program will result in Claims denials for Providers who are not on the Member's restricted Provider list.

Eligibility Listing for Medicaid Programs

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

- Passport Provider Services at (800) 578-0775

- Eligibility can also be verified through the KyHealthNet System. kymmis.com
- Availity Essentials Portal Availity.com

Possession of a Medicaid ID Card does not mean a recipient is eligible for Medicaid services. A Provider should verify a recipient's eligibility each time the recipient receives services. The verification sources can be used to verify a recipient's enrollment in a managed care plan. The name and telephone number of the managed care plan are given along with other eligibility information.

Identification Cards

Passport Sample Member ID

Card Front

PASSPORT
BY MOLINA HEALTHCARE
MedImpact
Medicaid

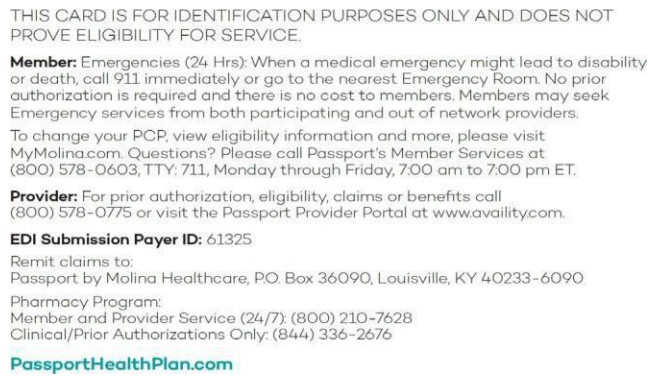
Member:
ID #:
DOB:
Provider:
PCP phone:

RxBIN:
RxPCN:
RxGRP:

Member Service: (800) 578-0603; TTY: 711
Eligibility Info: (800) 578-0603; TTY: 711
24-Hour Nurse Advice Line: (800) 606-9880; TTY: 711
24-Hour Behavioral Health Crisis Line: (844) 800-5154
RX Questions: MedImpact (800) 210-7628
Dental Questions: Molina Dental Services (855) 994-2356
Vision Questions: March Vision (844) 516-2724

MyMolina.com

Card Back


THIS CARD IS FOR IDENTIFICATION PURPOSES ONLY AND DOES NOT PROVE ELIGIBILITY FOR SERVICE.

Member: Emergencies (24 Hrs): When a medical emergency might lead to disability or death, call 911 immediately or go to the nearest Emergency Room. No prior authorization is required and there is no cost to members. Members may seek Emergency services from both participating and out of network providers.

To change your PCP, view eligibility information and more, please visit MyMolina.com. Questions? Please call Passport's Member Services at (800) 578-0603, TTY: 711, Monday through Friday, 7:00 am to 7:00 pm ET.

Provider: For prior authorization, eligibility, claims or benefits call (800) 578-0775 or visit the Passport Provider Portal at www.availity.com.

EDI Submission Payer ID: 61325

Remit claims to:
Passport by Molina Healthcare, P.O. Box 36090, Louisville, KY 40233-6090

Pharmacy Program:
Member and Provider Service (24/7): (800) 210-7628
Clinical/Prior Authorizations Only: (844) 336-2676

PassportHealthPlan.com

Members are reminded in their Member Handbooks to carry ID cards with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Passport Members are eligible for benefits and to verify PCP assignment, prior to rendering services. Unless an Emergency Medical Condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

Disenrollment

Voluntary Disenrollment

Passport Members may change to another health plan during their first 90 days after initial enrollment, and annually thereafter.

Involuntary Disenrollment

The Department for Medicaid Services has the sole authority to disenroll Members. Disenrollment may be initiated for the following reasons:

- Member commits fraud related to the Medicaid program.
- Member is abusive or threatening to Passport, Passport's agents, or Providers.
- Member is admitted to a nursing facility for more than 31 days.
- Member is incarcerated in a correctional facility.
- Member no longer qualifies for Medicaid Assistance.
- Member cannot be located.

PCP Dismissal

A PCP may dismiss a Member from their practice under following circumstances:

- Incompatibility of the PCP/patient relationship.
- Member has not utilized a service within one year of enrollment in the PCP's practice and the PCP has documented unsuccessful contact attempts by mail and phone on at least six separate occasions during the year.
- Inability to meet the medical needs of the Member.

A PCP may not dismiss a Member from their practice under following circumstances:

- Change in Member's health status or need for treatment.
- Member's utilization of medical services.
- Member's diminished mental capacity.
- Disruptive behavior that results from the Member's special health care needs unless the behavior impairs the ability of the PCP to furnish services to the Member or others.
- Transfer requests shall not be based on race, color, national origin, handicap, age, or gender.
- The initial PCP must serve until the new PCP begins serving the Enrollee, barring ethical or legal issues. The Enrollee has the right to a grievance regarding such a transfer. The PCP shall make the request for change to the Contract or in writing. The Enrollee may request PCP change in writing, face to face or via telephone.

All dismissal requests must be sent in writing via this Primary Care Provider Member Dismissal Form located at passporthealthplan.com with reason for dismissal and approved by Passport. The PCP must continue providing services to the Member until the new PCP begins providing services to the Member, barring ethical or legal issues. Passport Members have the right to file a grievance regarding such a transfer.

Missed Appointments

Participating Providers are responsible for establishing a process for documenting missed appointments. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record, and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. Providers are strongly encouraged to report missed or cancelled appointments within the Missed or Cancelled Appointments Panel in KY HealthNet (kymmis.com).

PCP Assignment

Passport Members are encouraged to choose their own PCPs upon enrollment. If the Member or their designated representative does not choose a PCP, one will be assigned to the Member. Passport will take into consideration known factors such as:

- Previous member PCP information.
- PCP information of family members(e.g., siblings).
- Member's geographic location(within 30 miles or 30 minutes).
- Provider relationships.
- Age and Gender of the member.
- Primary Language (to extent known).
- Dual Eligible Enrollees and Enrollees who are presumptively eligible are not required to have a Primary Care Provider (PCP).

PCP Changes

If for any reason a Member wants to change PCPs, he or she may conveniently do so by logging on to mypassporthealthplan.com or by calling Member Services and asking for the change. If Passport assigned the Member to the PCP and the Member calls within the first month of membership with Passport, the change will be backdated to the first (1st) day of the current month. All other PCP changes are effective immediately upon request. A new ID card is sent to the Member when a PCP change is made with new PCP information.

PCPs have the right to request an Enrollee's disenrollment from his/her practice and to be reassigned to a new PCP in the following circumstances:

- Incompatibility of the PCP/patient relationship;
- Enrollee has not utilized a service within one (1) year of enrollment in the PCP's practice and;
- The PCP has documented unsuccessful contact attempts by mail and phone on at least six (6) separate occasions during the year; or
- Inability to meet the medical needs of the Enrollee.

If the requirements have been met, the PCP or group must submit the Primary Care Provider Member Dismissal Form to kyproviderrelations@MolinaHealthcare.com.

6. Benefits and Covered Services

This section provides an overview of the medical benefits and Covered Services for Passport Medicaid Members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires Prior Authorization, please contact Passport at (800) 578-0775 Monday through Friday, 8:00 a.m. to 6:00 p.m. EDT.

Member Cost Sharing

Cost Sharing is the Deductible, Copayment, or Coinsurance that Members must pay for Covered Services provided under their Passport plan. There are no copayments for Passport Members.

Services Covered by Passport

Passport covers the services described in the Summary of Benefits documentation and below.
If there are questions as to whether a service is covered or requires prior authorization, please reference the Prior Authorization tools located on the Passport website and the Availity Essentials Portal. You may also contact Passport at (800) 578-0775; Monday through Friday, 8:00 a.m. to 6:00 p.m. EDT.

Passport, through its contracted Providers, is required to arrange for the following Medically Necessary services for each patient:

- Alternative birthing center services.
- Ambulatory surgical center services.
- Behavioral health services – mental health and substance use disorders, including services related to the Mobile Crisis Intervention Continuum.
- Chiropractic services.
- Community mental health center services.
- Dental services, including oral surgery, orthodontics, and prosthodontics.
- Durable medical equipment, including prosthetic, orthotic devices, and disposable medical supplies.
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening and special services.
- End-stage renal dialysis services.
- Family planning services in accordance with federal and state law and judicial opinion.
- Hearing services, including hearing aids for Members younger than 21.
- Home health services.
- Hospice services (non-institutional only).
- Independent laboratory services.
- Inpatient hospital services.
- Inpatient mental health services.
- Meals and lodging for appropriate escort of Members.
- Medical detoxification, i.e., management of symptoms during the acute withdrawal phrase from a substance to which the Member is addicted.
- Medical services, including but not limited to, those provided by physicians, advanced practice registered nurses, physicians assistants and federally qualified health centers (FQHCs), primary care centers and rural health clinics (RHCs).
- Organ transplant services not considered investigational by Federal Drug Administration (FDA).

- Other laboratory and X-ray services.
- Outpatient hospital services.
- Outpatient mental health services.
- Pharmacy and limited over-the-counter drugs, including mental/behavioral health drugs
- Podiatry services.
- Preventive health services, including those currently provided in public health departments,
- FQHCs/primary care centers, and RHCs.
- Psychiatric residential treatment facilities (Level I and Level II).
- Care management services for Members with complex chronic illnesses (includes adult and child targeted care management).
- Specialized children's services clinics.
- Targeted case management.
- Therapeutic evaluation and treatment, including physical therapy, speech therapy and occupational therapy.
- Behavioral health services - mental health and substance use disorders, including services related to the Mobile Crisis Intervention Continuum.
- Transportation to covered services, including emergency and ambulance stretcher services.
- Urgent and emergency care services.
- Vision care, including vision examinations, services of opticians, optometrists, and ophthalmologists, including eyeglasses for Members younger than 21.

The contractor shall not prohibit or restrict a Provider from advising a Member about his or her health Status, medical care, or treatment, regardless of whether benefits for such care are provided under the Contract if the Provider is acting within the lawful scope of practice.

Extra Benefits and Rewards

Passport offers additional benefits to our Members beyond the benefits outlined above. Information regarding the most current extra benefits and rewards available to Passport Members is available at the following link: molinahealthcare.com/members/ky/en-us/mem/medicaid/overvw/coverd/benefits.aspx

Obtaining Access to Certain Covered Services

Non-Preferred Drug Exception Request Process

The Provider may request a prior authorization for clinically appropriate drugs that are not preferred under the Member's Medicaid Plan. Using the FDA label, community standards, and high levels of published clinical evidence, clinical criteria are applied to requests for medications requiring prior authorization.

- For a Standard Exception Request, the Member and/or Member's Representative and the prescribing Provider will be notified of Molina's decision within 24 hours of receiving the complete request.
- If the initial request is denied, a notice of denial will be sent in writing to the Member and prescriber within 24 hours of receiving the complete request.
- Members will also have the right to appeal a denial decision, per any requirements set forth by the Kentucky Department for Medicaid Services.
- Passport will allow a 72-hour emergency supply of prescribed medication for dispensing at any time

that a prior authorization is not available. Pharmacists will use their professional judgment regarding whether or not there is an immediate need every time the 72-hour option is utilized. This procedure will not be allowed for routine and continuous overrides. Providers may use the Kentucky Medicaid pharmacy universal Prior Authorization form, which is found on Passport's website. The most current Prior Authorization guide is also available on the Authorization Review Guide website. Pharmacy Prior authorization forms can be faxed to Passport at (858) 357-2612. More details about the Pharmacy prior authorization process are found in the Pharmacy chapter of this Manual.

Specialty Drug Services

Many self-administered and office-administered injectable products require prior authorization. In some cases, they will be made available through a vendor, designated by Passport. More information about the prior authorization process, including a link to the Prior Authorization Request Form, is available in the Healthcare Services section of this Manual. Physician administered drugs require the appropriate National Drug Code (NDC) with the exception of vaccinations or other drugs as specified by CMS.

Injectable and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases, they will be made available through a vendor designated by Passport. More information about the Prior Authorization process is available in the Healthcare Services and Pharmacy Chapters of this Provider Manual.

Access to Behavioral Health Services

Behavioral Health services are a direct access benefit and are available with no referral required. PCPs may assist members in finding a Behavioral Health provider or members may contact Passport's Member Contact Center at (800) 578-0775.

Passport's Nurse Advice Line is available 24 hours a day, 7days a week, 365 days per year for mental health or substance abuse needs. The services Members receive will be confidential.

Additional details regarding Covered Services and any limitations can be obtained in the benefit information linked above, or by contacting Passport. If inpatient services are needed, prior authorization must be obtained, unless the admission is due to an emergency situation.

Emergency Mental Health or Substance Abuse Services

Passport's Behavioral Health Crisis Line, staffed by trained personnel, is available 24 hours a day, 7 days a week 365 days per year to assist with Member emergency and crisis behavioral health needs at (844) 800-5154. Members are directed to call 988, 911, or go to the nearest emergency room if they need Emergency Services for mental health or substance abuse. Examples of emergency mental health or substance abuse problems are:

- Danger to self or others.
- Not being able to carry out daily activities.
- Things that will likely cause death or serious bodily harm.

Out of Area Emergencies

Members having a health emergency who cannot get to a Passport approved Providers are directed to do the following:

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

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

Emergency Transportation

When aMember's condition is life-threatening and requires use of special equipment, life-support systems, and close monitoring by trained attendants while enroute to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes, but is not limited to, ambulance, air, or ground transport.

Non-Emergency Medical Transportation

The Kentucky Department for Medicaid Services contracts with the Kentucky Transportation Cabinet, Office of Transportation Delivery's HSTD program to provide non-emergency medical transportation (NEMT). Through the HSTD program, certain eligible Members receive safe and reliable transportation to Medicaid Covered Services. More information about the HSTD program is available at: chfs.ky.gov/agencies/dms/dpo/bpb/Pages/transportation.aspx.

Passport covers non-emergency transport by stretcher and by ambulance for Members. Only non-emergency Air Ambulance requires prior authorization. Additional information regarding the availability of this benefit is available by contacting Provider Services at (800) 578-0775.

Preventive Care

Preventive Care and Clinical Practice Guidelines are located under the "health resources" tab on the Provider pages of the passporthealthplan.com website.

We need your help conducting these regular exams in order to meet the targeted Commonwealth and Federal standards. Passport provides and coordinates Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), and EPSDT Special Services, through the PCP, for any Member under the age of 21 years. If you have questions or suggestions related to well-childcare, please call Passport's Healthcare Services Department at (800) 578-0775.

Immunizations

Adult Members may receive immunizations as recommended by the Centers for Disease Control and Prevention (CDC) and prescribed by the Member's PCP. Child Members may receive immunizations in accordance with the recommendations of the American Academy of Pediatrics (AAP) and prescribed by the child's PCP. Immunization schedule recommendations from the American Academy of Pediatrics and/or the CDC are available at the following website: cdc.gov/vaccines/schedules/hcp/index.html.

Passport covers immunizations not covered through Vaccines for Children(VFC).

Well Child Visits and EPSDT Screening Guidelines

The Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit requires the provision of early and periodic screening services and well-care examinations to individuals from birth until 21 years of age, with diagnosis and treatment of any health or mental health problems identified during these exams. The standards and

periodicity schedule generally follow the recommendations from the AAP and Bright Futures. To view information on AAP and Bright future please visit:
aap.org/en-us/professional-resources/practice Transformation/managing- patients/Pages/Periodicity-Schedule.aspx or to view the most current PDF visit: periodicity_schedule.pdf

The screening services include but are not limited to:

- Comprehensive health and developmental history (including assessment of both physical and mental health development).
- Immunizations in accordance with the most current Kentucky Recommended (or American Academy of Pediatrics, Centers for Disease Control and Prevention Advisory Committee on Immunization Practices) Childhood Immunization Schedule, as appropriate.
- Comprehensive unclothed physical exam.
- Laboratory tests as specified by the AAP, including screening for lead poisoning.
- Health education.
- Vision services.
- Hearing services.
- Dental services.

When screening examination indicates the need for further evaluation, Providers must provide diagnostic services or refer Members when appropriate without delay. Providers must provide treatment or other measures (or refer when appropriate) to correct or ameliorate defects and physical and mental illness or conditions discovered by the screening services.

We need your help conducting these regular exams in order to meet the Kentucky Department for Medicaid Services standards. Providers must use correct coding guidelines to ensure accurate reporting for EPSDT services. If you have questions or suggestions related to EPSDT or well childcare, please call Molina Healthcare Inc.'s Health Education line at (866) 472-9483.

EPSDT Special Services

EPSDT provides any Medically Necessary diagnosis and treatment for Members under the age of 21 indicate as the result of an EPSDT health assessment or any other encounter with a licensed or certified health care professional, even if the service is not otherwise covered by the Medicaid Program. These services which are not otherwise covered by the Medicaid Program are called EPSDT Special Services. EPSDT Special Services shall be available for eligible Member, including Provider who can deliver the Medically Necessary services described in federal Medicaid law. EPSDT Special Services require authorization.

Passport provides EPSDT Special Services as required by 42 USC Section 1396 and by 907KAR 11:034, Section 7and Section 8.

Passport provides the Medically Necessary health care, diagnostic services, rehabilitative services, treatment, and other measures described in 42USC Section 1396d(a) to all Members under the age of 21. Medical Necessity is determined without regard to whether the screen and/or service was performed by a contracted or a non-contracted Provider if there are no participating Providers who can provide the service. Some EPSDT services require prior authorization.

EPSDT Primary Care Provider Responsibilities

Passport ensures compliance with Kentucky law and/or regulation (907KAR 11:034) that delineates the requirements of all EPSDT Providers participating in the Medicaid program.

- The members' Primary Care Provider (PCP) shall provide EPSDT services to all eligible members in accordance with EPSDT guidelines issued by the Commonwealth and Federal government and in conformance with the DMS approved periodicity schedule.
- The PCP shall provide all needed initial, periodic, and inter-periodic health assessments in accordance with 907KAR 11:034.
- The PCP assigned to each eligible member shall be responsible for providing or arranging for complete assessments at the intervals specified by the commonwealth department's approved periodicity schedule and at other times when Medically Necessary.
- The PCP shall provide all needed diagnosis and referrals to treatment/treating Providers/ specialists for eligible members in accordance with Kentucky Lawand/or regulations.
- The PCP and other Providers in Passport's network shall provide diagnosis and treatment or provide a referral to out-of- network Providers who shall provide treatment if the service is not available within Passport's network.
- The PCP shall maintain a consolidated record for each eligible member, including reports of informing the member and/ or their family about EPSDT, information received from other Providers and dates of contact regarding appointments and rescheduling when necessary for EPSDT screening, recommended diagnostic or treatment services and follow-up with referral compliance and send Passport reports from referral physicians or Providers.
- PCPs providing EPSDT services shall submit an encounter record for each EPSDT service provided according to requirements provided by DMS, including use of specified EPSDT procedure codes, referral codes and the member and/or their families acceptance or refusal for EPSDT services.

EPSDT Provider Training and Education

Passport trains Providers offering EPDT services concerning the components of an EPSDT assessment, EPSDT Special Services, and emerging health status issues among Members. In addition, training is provided concerning physical assessment procedures for nurse practitioners, registered nurses and physician assistants who provide EPSDT screening services and who are supported by adequately equipped offices to perform EPSDT services.

Prenatal Care

Stage of	How often to see the
1 month- 6 months	1 visit a month
7 months- 8months	2 visits a month
9 months	1 visit a week

Emergency Services

Emergency Services or Emergency Care means: covered inpatient and outpatient services that are as follows:

- Furnished by a Provider that is qualified to furnish these services; and
- Needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Medical Condition or Emergency means:

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
  - Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
  - Serious impairment of bodily functions, or
  - Serious dysfunction of any bodily organ or port; or
- With respect to a pregnant woman having contractions:
  - That there is an inadequate time to affect a safe transfer to another hospital before deliver, or
  - That transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergent and Urgent Care Services are covered by Passport without an authorization. This includes non-contracted Providers inside or outside of Passport's service area.

Immediate treatment for any Emergency Medical or Behavioral Health Services by a health provider that is most suitable for the type of injury, illness, or condition, regardless of whether the facility is in Contractor's Network.

Nurse Advice Line

Members may call the Nurse Advise Line anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours day, 7 days a week, to assess symptoms and help make good health care decisions.

English/Spanish Phone: (800) 606-9880
TTY/TDD: 711 Relay

Passport is committed to helping our Members:

- Prudently use the services of your office.
- Understand how to handle routine health problems at home.
- Avoid making non-emergent visits to the emergency room (ER).

These registered nurses do not diagnose. They assess symptoms and guide the patient to the most appropriate level of care following specially designed algorithms unique to the Nurse Advice Line. The Nurse Advice Line may refer back to the PCP, a specialist, 911 or the ER. By educating patients, it reduces costs and over utilization on the health care system.

Services Not Covered

Certain services, including but not limited to the following are services currently not covered by the Kentucky Medicaid Program:

- Any laboratory service performed by a Provider without current certification in accordance with the Clinical Laboratory Improvement Amendment (CLIA).This requirement applies to all facilities and individual Providers of any laboratory service;
- Cosmetic procedures or services performed solely to improve appearance

- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only
- Medical or surgical treatment of infertility(e.g., the reversal of sterilization, invitro fertilization, etc.)
- Induced abortion and miscarriage performed out-of-compliance with federal and Kentucky laws and judicial opinions
- Paternity testing
- Personal service or comfort items
- Postmortem services
- Services, including but not limited to drugs, that are investigational, mainly for research purposes or experimental in nature
- Sex transformation services
- Sterilization of a mentally incompetent or institutionalized Member
- Services provided in countries other than the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services
- Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid program regulations referenced herein; and
- Services for which the Member has no obligation to pay, and for which no other person has a legal obligation to pay are excluded from coverage.

Additional information is available by calling Passport at (800) 578-0775.

Health Management Programs

For additional information, please refer to the Health Care Services section of this Provider Manual.

Telehealth and Telemedicine Services

Passport Members may obtain physical and behavioral health Covered Services by Participating Providers, through the use of Telehealth and Telemedicine services. Not all participating Providers offer these services. The following additional provisions apply to the use of Telehealth and Telemedicine services:

- Services must be obtained from a participating Provider.
- Members have the option of receiving PCP services through telehealth. If they choose to use this option, the Member must use a Network Provider who offers telehealth.
- Services are meant to be used when care is needed now for non-emergency medical issues.
- Services are a method of accessing Covered Services, and not a separate benefit.
- Services are not permitted when the Member and Participating Provider are in the same physical location.
- Services must be coded in accordance with applicable reimbursement policies and billing guidelines
- Rendering Provider must comply with applicable federal and state guidelines for telehealth service delivery

Asynchronous services maybe offered however providers must provide in-person or synchronous accommodations upon Member request. Providers who do not comply with a request for synchronous services may be subject to corrective action or suspension of asynchronous services.

For additional information on Telehealth and Telemedicine claims and billing, please refer to the Claims and

Compensation section of this Provider Manual or refer to 907KAR 3:170.

Upon at least ten (10) days prior notice to Provider, Passport shall further have the right to a demonstration and testing of Provider telehealth service platform and operations. This demonstration may be conducted either virtually or face-to-face, as appropriate for telehealth capabilities and according to the preference of Passport. Provider shall make its personnel reasonably available to answer questions from Passport regarding telehealth operations.

7. Healthcare Services (HCS)

Introduction

Healthcare Services is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Passport provides CM services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the Passport UM program include pre-service authorization review, inpatient authorization management that includes admission and concurrent medical necessity review, and restrictions on the use of out-of-network or non-participating Providers.

Utilization Management (UM)

Passport ensures that the service delivered is Medically Necessary and demonstrates an appropriate use of resources based on the level of care needed for a Member. This program promotes the provision of quality, cost-effective, and medically appropriate services that are offered across a continuum of care as well as integrating a range of services appropriate to meet individual needs. Passport's UM program maintains flexibility to adapt to changes in the Member's condition and is designed to influence a Member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care.
- Evaluating the Medical Necessity and efficiency of health care services across the continuum of care.
- Defining the review criteria, information sources, and processes that are used to review and approve the provision of items and services, including prescription drugs.
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization.
- Implementing comprehensive processes to monitor and control the utilization of health care resources.
- Ensuring services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness.
- Reviewing processes to ensure care is safe and accessible.
- Ensuring qualified healthcare professionals perform all components of the UM and CM processes.
- Ensuring UM decision making tools are appropriately applied in determining Medical Necessity decision.

Key Functions of the UM Program

All prior authorizations are based on a specific standardized list of services. The key functions of the UM program are listed below:

Eligibility and Oversight

- Eligibility verification
- Benefit administration and interpretation
- Verification that authorized care correlates to Member's medical necessity need(s) & benefit plan

- Verifying of current Physician/hospital contract status

Resource Management

- Prior Authorization management
- Admission, and Inpatient Review
- Referrals for Discharge Planning and Care Transitions
- Staff education on consistent application of UM functions

Quality Management

- Evaluate Satisfaction of the UM program using Member and Provider input
- Utilization data analysis
- Monitor for possible over- or under-utilization of clinical resources
- Quality oversight
- Monitor for adherence to CMS, NCQA, State and health plan UM standards

For more information about Passport's UM program, or to obtain a copy of the HCS Program description, clinical criteria used for decision making and how to contact a UM reviewer, access the Passport website or contact the UM Department.

UM Decisions

An organizational determination is any decision made by Passport or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination).
- Determination to delay, modify, or deny authorization or payment of request(adverse determination).

Passport follows a hierarchy of Medical Necessity decision making with Federal and State/ Commonwealth regulations taking precedence. Passport covers all services and items required by State and Federal regulations.

Board certified licensed reviewers from appropriate specialty areas are utilized to assist in making determinations of Medical Necessity, as appropriate. All utilization determinations are made in a timely manner to accommodate the clinical urgency of the situation, in accordance with Federal and State regulatory requirements and NCQA standards.

Requests for authorization not meeting medical necessity criteria are reviewed by a designated Passport Medical Director or other appropriate clinical professional. Only a licensed physician or pharmacist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate may determine to delay, modify or deny authorization of services to a Member for reasons of Medical Necessity.

Providers can contact Passport's Healthcare Services department at (800) 578-0775 to obtain Passport's UM Criteria.

Where applicable, Molina Clinical Policies can be found on the public website at MolinaClinicalPolicy.com. Please note that Passport follows state-specific criteria, if available, before applying Molina-specific criteria.

Medical Necessity

"Medically Necessary" or **"Medical Necessity"**: To be Medically Necessary or a Medical Necessity, a Covered Benefit shall be:

- Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy
- Appropriate in terms of the service, amount, scope, and duration based on generally accepted standards of good medial practice
- Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care Provider, or for cosmetic reasons
- Provided in the most appropriate location, with regard to generally accepted standards of good medical practice, where the service may, for practical purposed, be safely and effectively provided
- Needed, if used in reference to an Emergency Medical Service, to exist using the prudent layperson standard
- Provided in accordance with EPSDT requirements established in 42 U.S.C. 1396d(r) and 42 C.F.R. Part 441 Subpart B for individuals under 21 years of age and medical necessity at defined by 907KAR 11:034 Section 9; and
- Provider in accordance with 45 C.F.R 440.230

This is for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms. Those services must be deemed by Passport to be:

1. In accordance with generally accepted standards of medical practice
2. Clinically appropriate and clinically significant, in terms of type, frequency, extent, site, and duration. They are considered effective for the patient's illness, injury, or disease; and
3. Not primarily for the convenience of the patient, physician, or other health care Provider. The services must not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. This literature is generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

The fact that a Provider has prescribed, recommended, or approved medical or allied goods or services does not, by itself, make such care, goods, or services Medically Necessary, a Medical Necessity or a Covered Service/benefit.

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

Passport has partnered with MCG Health to implement Cite for Guideline Transparency. Providers can access this feature through the Availity Essentials Portal. With MCG Cite for Guideline Transparency; Passport can share clinical indications with Providers. The tool operates as a secure extension of Passport's existing MCG investment and helps meet regulations around transparency for delivery of care:

- Transparency—Delivers medical determination transparency.
- Access—Clinical evidence that payers use to support member care decisions.
- Security—Ensures easy and flexible access via secure web access.

MCG Cite for Guideline Transparency does not affect the process for notifying Passport of admissions or

for seeking Prior Authorization approval. To learn more about MCG or Cite for Guideline Transparency, visit MCG'swebsite or call (888) 464-4746.

Passport has partnered with MCG Health to extend our Cite AutoAuth self-service method for all lines of business to submit advanced imaging prior authorization (PA) requests.

Cite AutoAuth can be accessed via the Availity Essentials Portal and is available 24 hours per day/7days per week. This method of submission is strongly encouraged as your primary submission route, existing fax/phone/email processes will also be available. Clinical information submitted with the PA will be reviewed by Passport. This system will provide quicker and more efficient processing of your authorization request, and the status of the authorization will be available immediately upon completion of your submission.

What is Cite AutoAuth and how does it work?

By attaching the relevant care guideline content to each PA request and sending it directly to Passport, health care providers receive an expedited, often immediate, response. Through a customized rules engine, Cite AutoAuth compares Passport's specific criteria to the clinical information and attached guideline content to the procedure to determine potential for auto authorization. Self-services available in the Cite AutoAuth tool include, but are not limited to, MRIs, CTs, PET scans. To see the full list of imaging codes that require PA, refer to the PA code Look-Up Tool at Passporthealthplan.com.

Medical Necessity Review

Passport only reimburses for services that are Medically Necessary. Medical Necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively. To determine Medical Necessity, in conjunction with independent professional medical judgment, Passport uses nationally recognized evidence-based guidelines, third-
party guidelines, CMS guidelines, State/Commonwealth guidelines, Molina clinical policies, and guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

Levels of Administrative and Clinical Review

The Passport review process begins with administrative review followed by clinical review if appropriate. Administrative review includes verifying eligibility, appropriate vendor or Participating Provider, and benefit coverage. The Clinical review includes medical necessity and level of care. All UM requests that may lead to a medical necessity adverse determination are reviewed by a health care professional at Passport (medical director, pharmacist director, or appropriately licensed health professional).

Passport's Provider training includes information on the UM processes and Authorization requirements.

Clinical Information

Passport requires copies of clinical information be submitted for documentation. Clinical information includes but is not limited to; physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Passport does not accept clinical summaries, telephone summaries, or inpatient case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations allow such documentation to be acceptable.

Referrals

A referral may become necessary when a Provider determines medically necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals unless the situation is one involving the delivery of Emergency Services. Information is to be exchanged between the PCP and specialist to coordinate care of the patient to ensure continuity of care. Providers need to document referrals that are made in the patient's medical record. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Passport Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted with Passport. In the case of Emergency Services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care, and Emergency Services. There may be circumstances in which referrals may require an out-of-network Provider. Prior authorization will be required from Passport except in the case of Emergency Services.

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a referral request to Passport.

While referrals are not required for the specialist's claims to be paid, Providers need to document referrals that are made in the patient's medical record and on the claim submission in Box 17.

For additional information, please refer to the Health Care Services section of this Provider Manual.

Direct Access Services: Members have direct access, and do not require a referral for the following types of service:

- Primary care vision services,
- Primary care dental and oral surgery services and evaluation by orthodontists and prosthodontist
- Voluntary family planning (in accordance with state laws and judicial opinion)
- Maternity care for Members under 18 years of age
- Immunizations to Members under 21 years of age
- Sexually transmitted disease screening, evaluation, and treatment
- Tuberculosis screening, evaluation, and treatment
- Testing for HIV, HIV-related conditions and other communicable diseases as defined by 902 KAR 2:020
- Chiropractic services
- For Members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, Members may directly access a specialist as appropriate for the Member's condition and identified needs; and
- Women's health specialists.

Prior Authorization

Passport requires prior authorization for specified services as long as the requirement complies with Federal or Commonwealth regulations and the Passport Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Passport prior authorization documents are customarily updated quarterly, but

may be updated more frequently as appropriate, and are posted on the Passport website at passporthealthplan.com.

Providers are encouraged to use the Passport prior authorization forms or the Kentucky Universal prior authorization form, both of which are provided on the Passport web site. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Passport ID number).
- Provider demographic information (refer to Provider and referred to Provider/facility including address and NPI number).
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information sufficient to document the Medical Necessity of the requested service is required including:
    - Pertinent medical history (including treatment, diagnostic tests, and examination data).
    - Requested length of stay (for inpatient requests).
    - Rationale for expedited processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and Commonwealth Law) are excluded from the prior authorization requirements. Obtaining authorization does not guarantee payment. Passport retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding, billing practices, and whether the service was provided in the most appropriate and cost-effective setting of care. Passport does not retroactively authorize services that require PA.

Passport follows all prior authorization requirements related to care for newborns and their mothers in alignment with the Newborns' and Mothers' Health Protection Act (NMPHA).

Passport makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation. The definition of expedited/urgent is when the standard time frame or decision making process could seriously jeopardize the life or health of the Member, the health or safety of the Member or others, due to the Member's psychological state, or in the opinion of the Provider with knowledge of the Member's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request, or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

Passport will make an organizational determination as promptly as the Member's health requires and no later than contractual and regulatory requirements. Expedited timeframes are followed when the Provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health. Requests for authorization or preauthorization for treatment of a Member with a diagnosis of a substance use disorder will be reviewed under the expedited timeframe.

Providers who request prior authorization determination for patient services and/or procedures may request to review the criteria used to make the final decision. A Passport Medical Director is available to discuss Medical Necessity decisions with the requesting Provider at (800) 578-0775 during business hours.

Upon approval, the requester will receive an authorization number. The number may be provided by telephone, fax, or via Availity Essentials portal. If a request is denied, the requester and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the Provider via fax. Providers may receive notifications or denials via fax or the Availity Essentials portal.

Peer-to-Peer Review

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion within five (5) business days from the notification.

A "peer" is considered a the Member's or Provider's clinical representative (licensed medical professional) Contracted external parties, administrators, or facility UM staff can only request that a peer-to-peer telephone communication be arranged and performed but the discussion should be performed by a peer.

When requesting a peer-to-peer discussion, please be prepared with the following information:

- Member name and ID#
- Auth ID#
- Requesting Provider Name and contact number and best times to call

Once a Peer to Peer is requested, a telephone call will be scheduled with the Medical Director who rendered the adverse benefit determination. Every effort will be made to schedule the call as expeditiously as possible. During the Peer-to-Peer review, the provider should have available any new clinical information that would support a medical necessity determination.

Requesting Prior Authorization

Notwithstanding any provision in the Provider Agreement that requires Provider to obtain a prior authorization directly from Passport, Passport may choose to contract with external vendors to help manage prior authorization requests.
For additional information regarding the prior authorization of specialized clinical services, please refer to the Prior Authorization tools located on the passporthealthplan.com website:

- Prior Authorization Code Look-up Tool
- Prior Authorization Code Matrix Prior Authorization Guide

The most current Prior Authorization Guidelines and the Prior Authorization Request Form can be found on the Passport website at Utilization Management (MolinaHealthcare.com).

- **Availity Essentials portal:** Passport is transitioning to a portal-only submission model, and phone or fax-based submissions may be phased out in certain markets. Participating Providers should use the Availity Essentials portal for prior authorization submissions All prior authorization submissions must include supporting clinical documentation to ensure timely and accurate review. Instructions for how to submit a prior authorization request are available on the Availity Essentials portal. The benefits of submitting your prior authorization request through the Availity Essentials portal are: Create and submit Prior Authorization Requests
- Check status of Authorization Requests
- Receive notification of change in status of Authorization Requests
- Attach medical documentation required for timely medical review and decision making
- Receive notification of authorization decisions

- Access prior authorization letters directly through the new DC Hub functionality in the Availity Essentials portal.

Please note: letters will only be available for prior authorization requests submitted via the Availity Essentials portal.

Fax: The Prior Authorization Request Form can be faxed to Passport at: (833) 454-0641.
Phone: Prior authorizations can be initiated by contacting Passport's Healthcare Services department at (800) 578-0775. It may be necessary to submit additional documentation before the authorization can be processed.

Evolent (Formerly known as New Century Health)

Passport collaborates with Evolent (formerly known as New Century Health) to conduct medical necessity review on certain prior authorization (PA) requests.

PA requests for Participating Servicing Providers are to be submitted to Evolent for professional service review and decisions for Passport adult Members ages 21 and over.

All out-of-network Servicing Provider PA requests and PA requests for Passport Members under the age of 21 will be reviewed by Passport.

Evolent conducts reviews for the following professional services:

Cardiology

- Non-Invasive Cardiology
- Non-Invasive Vascular
- Cardiac Cath and Interventional Cardiology
- Vascular Radiology and Intervention
- Vascular Surgery
- Thoracic Surgery
- Cardiac Surgery
- Electrophysiology

Please consult the PA Lookup Tool for further guidance on where to submit professional services PA requests.

For inpatient service requests, once approved by Evolent, the inpatient status will be reviewed by Passport upon notification of the admission. The inpatient admission and length of stay will be determined by Inpatient Utilization Management (Concurrent Review) at the time of hospitalization. Providers are to follow Passport's inpatient notification process as you do today, and the continued stay will be reviewed for medical necessity and a decision made at that time.

Medical Oncology

Cancer Related Diagnoses: C00-D09.0, D37.01-D49.9, D61.810, D61.82, D63.0, D64.0-D64.81, D70.1, D72.822, D75.81, E34.0

Infused, injectable and oral* chemotherapy, hormonal therapeutic treatment, supportive agents, and symptom management medications.

**Pharmacy benefits single oral agent requests are out of scope for Evolent, and pre-authorization must be obtained from Passport or applicable Pharmacy Benefits Manager (PBM). For Marketplace Members, Pharmacy benefits oral agents submitted in a request combined with infused/injectable cancer agents will be reviewed by Evolent for preauthorization.*

Radiation Oncology

Cancer Related Diagnoses: C00-D09.0, D37.01-D49.9, D61.810, D61.82, D63.0, D64.0-D64.81, D70.1, D72.822, D75.81, E34.0

- Brachytherapy
- Conformal
- IMRT (Intensity-modulated radiation therapy)
- SBRT (Stereotactic Body Radiation Therapy)
- IGRT (Image-guided radiation therapy)
- 2D, 3D (2 or 3 dimensional)
- SRS (Stereotactic radiosurgery)
- Radiopharmaceuticals
- Proton and Neutron Beam Therapy

CAR-T

For inpatient CAR-T service requests, the inpatient status will be approved when medical necessity criteria is met, simultaneously with the approval of the CAR-T professional service(s) being reviewed.

The inpatient admission length of stay (where CAR-T is in scope) will be determined by Inpatient Utilization Management (Concurrent Review) at the time of any needed hospitalization. Providers are to follow Passport's inpatient notification process as you do today, and the continued stay will be reviewed for medical necessity and a decision made at that time. If other services are being performed during the inpatient stay that are unrelated to the CAR-T procedures, a separate authorization will need to be completed through Passport's standard prior authorization process for medical necessity determination.

PA request submission

The requesting in-network Provider must complete a PA request using one of the following methods:

- For Providers' convenience, logging into the Evolent Provider Web Portal is the preferred submission method: my.newcenturyhealth.com
    - Evolent's Provider Web Portal functionality offers instant approvals for PA requests
- PA look up Tool: Provider Home Page
- Phone: (888) 999-7713
- Cardiology Fax: (714) 582-7547
- Medical Oncology Fax: (213) 596-3783
- Radiation Oncology Fax: (714) 494-8366

Providers should call the Evolent Network Operations department at (888) 999-7713, Option 6, with questions or for assistance with access/training on the Evolent Provider Web Portal.

Evolent: peer-to-peer review

Peer-to-peer review will be conducted by Evolent via physician discussions with expanded collaboration to better discuss treatment plans.

Providers are strongly encouraged to take advantage of Evolent's streamlined peer-to-peer process to hold timely conversations related to requested services.

TurningPoint Comprehensive Condition Management: Musculoskeletal Surgical Quality and Safety Program

Passport has contracted with TurningPoint to provide an innovative solution to work collaboratively with providers, facilities, and physicians to reduce treatment variability, promote safety, quality of care improvements, and support for Passport members. As part of this program, Passport has delegated its utilization management function to TurningPoint for a limited scope of procedures outlined below:

Orthopedic Surgical Procedures
 	
Including all associated partial, total, and revision surgeries:
• Knee Arthroplasty
• Unicompartmental/Bicompartmental Knee Replacement Hip Arthroplasty
• Shoulder Arthroplasty
• Elbow Arthroplasty
• Ankle Arthroplasty
• Wrist Arthroplasty
• Acromioplasty and Rotator Cuff Repair
• Anterior Cruciate Ligament Repair
• Knee Arthroscopy
• Hip Resurfacing
• Meniscal Repair
• Hip Arthroscopy
• Femoroacetabular Arthroscopy
• Ankle Fusion
• Shoulder Fusion
• Wrist Fusion
• Osteochondral Defect Repair
	Spinal Surgical Procedures
	Including all associated partial, total, and revision surgeries:
	• Spinal Fusion Surgeries
	  ○ Cervical
	  ○ Lumbar
	  ○ Thoracic
	  ○ Sacral
	  ○ Scoliosis
	• Disc Replacement
	• Laminectomy/Discectomy Kyphoplasty/Vertebroplasy
	• Sacroiliac Joint Fusion
	• Implantable Pain Pumps
	• Spinal Cord Neurostimulator
	• Spinal Decompression

Prior Authorization is required for inpatient, outpatient, and doctor's office settings for these procedures. Clinical coding specific to the procedures included in the program may be accessed using the PA Lookup Tool. Please note the coding is subject to regular updates/changes as CPT/HCPCS coding is added or deleted.

Turningpoint: utilization management and precertification contact information

TurningPoint requests a digital-first approach, with case submissions expected to be submitted through the provider portal whenever feasible. TurningPoint's provider portal can be accessed at https://myturningpoint-healthcare.com.

TurningPoint is available at (866) 422-0800, 5 am – 5 pm of each normal business day in each time zone where

TurningPoint conducts its review activities. In the event a provider needs to contact TurningPoint for prior authorization after hours or on weekends, TurningPoint has medical professionals on-call 24 hours a day, 7 days a week.

Turningpoint: peer-to-peer review

Peer to peer reviews are unique in that they are conducted by specialized physicians in accordance with the procedure.

· Medicare: peer to peer reviews are offered, but are for educational purposes only per CMS guidelines.

· Medicaid; Marketplace (commercial): peer to peer reviews are offered for reconsideration of final determinations to allow for review of supporting clinical documentation

Providers can initiate a peer-to-peer conversation with a TurningPoint Medical Reviewer by contacting TurningPoint's Peer to Peer Department at (800) 581-3920.

Progeny Health: NICU Admission and Concurrent Review

Passport collaborates with Progeny Health for neonatal care management services provided to premature and medically complex newborns in the Neonatal Intensive Care Unit (NICU).

All NICU utilization management functions including initial admissions, continued stay requests, discharge planning, and all readmissions up to 60 days post-discharge of the initial NICU discharge will be managed by Progeny Health.

Providers must submit NICU authorization requests and clinical documentation supporting the NICU stay to Progeny Health directly.

- Phone: (888) 832-2006
- UM Email: MolinaMarketplaceUM@progenyhealth.com
- CM Email: MolinaMarketplaceCM@progenyhealth.com
- Website: ProgenyHealth.com

For all infants born and/or admitted to the NICU, NICU Notification of Admission must be faxed directly to Progeny Health at (877) 847-1708. The following information must be included:

- Mother's Name, Date of Birth, Member ID number
- Infant Name (if known) and Member ID number (if known)
- Attending Physician NPI number
- Facility NPI number

Progeny Health: Peer-to-peer review

- Peer-to-peer may be requested with a Progeny Health Medical Director by calling (888) 832-2006 and following the Physician Advisor's prompt and directions.
- If peer-to-peer is declined or if the denial determination is upheld, providers would follow Passport's appeal process if not in agreement with the determination.

Progeny Health: Transfers and readmissions

- Progeny Health will manage infants transferred from the NICU to another acute care facility under the guidance of <Molina>'s current rules for higher, lateral, and lower-level care transfers.
- Progeny Health will manage emergent readmissions for all infants managed by Progeny Health for their initial NICU admission if readmitted within the first 60 days after the **initial** NICU discharge date.

Progeny Health: Utilization Management Cases

- All concurrent stay reviews and discharge summaries should be faxed directly to Progeny Health.

Progeny Health: Care Management Program Review

- Families will have a dedicated Case Manager who will provide support and education.
- Following notification of NICU admission, Progeny Health outreaches caregivers for early inpatient engagement to evaluate Social Determinants of Health and barriers to safe discharge home.
- Progeny Health Case Managers will continue to follow <Molina> Members for 60 days from the **initial** NICU discharge date.
- Progeny Health Case Managers, Social Workers, and Care Coordinators assist Passport Members with identifying support and utilizing national and local community resources.
    - Identifying PCP
    - Behavioral health support
    - Lactation services/obtaining a breast pump
    - Transportation resources

Progeny Health will collaborate with facility CM for infants with anticipated discharge needs, complex medical care, or considerable social situations.

Open Communication about Treatment

Passport prohibits contracted Providers from limiting Provider or Member communication regarding a Member's health care. Providers may freely communicate with, and act as an advocate for their patients. Passport requires provisions within Provider contracts that prohibit solicitation of Members for alternative coverage arrangements for the primary purpose of securing financial gain. Noncommunication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

Passport and its contracted Providers may not enter into contracts that interfere with any ethical responsibility or legal right of Providers to discuss information with a Member about the Member's health care. This includes, but is not limited to, treatment options, alternative plans, or other coverage arrangements.

Delegated Utilization Management Functions

Passport may delegate UM functions to delegated entities. They must have the ability to meet, perform the delegated activities and maintain specific delegation criteria in compliance with all current Passport policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the Delegation section of this Provider Manual.

Communication and Availability to Members and Providers

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling 8:00 a.m. to 6:00 p.m. Monday and Friday 8:00 a.m. to 5:30 p.m. Tuesday, Wednesday, and Thursday(except for holidays). All staff Members identify themselves by providing their first name, job title, and organization.

Passport offers TTY/TDD services for Members who are deaf, hard of hearing, or speech impaired. Language assistance is also always available for Members.

After business hours, Providers should use the Availity Essentials Portal for UM access.

Passport's Nurse Advice Line is available to Members 24 hours a day, seven days a week at (800) 606-9880. Passport's Nurse Advice Line may handle after-hours UM calls.

Passport's Behavioral Health Crisis Line is available twenty-four (24) hours a day, seven (7) days a week for mental health or substance abuse needs by calling (844) 800-5154.

Emergency Services

Emergency Services or Emergency Care means: covered inpatient and outpatient services that are as follows:

- Furnished by a Provider that is qualified to furnish these services; and
- Needed to evaluate or stabilize an Emergency Medical Condition. Emergency Medical Condition or Emergency means:
    - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
        - Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
        - Serious impairment of bodily functions, or
        - Serious dysfunction of any bodily organ or port; or
- With respect to a pregnant woman having contractions:
    - That there is an inadequate time to affect a safe transfer to another hospital before deliver, or
    - That transfer may pose a threat to the health or safety of the woman or the unborn child.

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent Emergency Services rendered to the Member do not require prior authorization from Passport.

Emergency Services are covered on a 24-hour basis without the need for prior authorization for all Members experiencing an Emergency Medical Condition.

Passport also provides Members 24-hour Nurse Advice Line for medical advice.911 information is given to all Members at the onset of any call to the plan.

For Members within our service area: Passport contracts with vendors that provide 24-hour Emergency Services for ambulances and hospitals. An out of network emergency hospital stay may only be covered until the Member has stabilized sufficiently to transfer to an available participating facility. Services provided after stabilization in a non-participating facility are not covered, and the Member may be responsible for payment.

Members over-utilizing the emergency department will be contacted by Passport Care Managers to provide

assistance whenever possible and determine the reason for using Emergency Services.
Passport Care 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.

Inpatient Management

Planned Admissions

Passport requires prior authorization for all elective inpatient procedures to any facility. Facilities are required to notify Passport within 24 hours or by the following business day once an admission has occurred for concurrent review. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent Inpatient Admissions

Passport requires notification of all emergent inpatient admissions within 48 hours of admission. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Passport requires that notification includes Member demographic information, facility information, date of admission and clinical information sufficient to document the Medical Necessity of the admission. Emergent inpatient admission services performed without meeting admission notification, Medical Necessity requirements or failure to include all the needed clinical documentation to support the need for an inpatient admission result in a denial of authorization for the inpatient stay.

Inpatient at Time of Termination of Coverage

When a Member's coverage with Passport terminates during a hospital stay, Passport will continue to cover services through discharge unless Law or Government Program requirements mandate otherwise.

Inpatient/Concurrent Review

Passport performs concurrent inpatient review to ensure Medical Necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Passport will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Passport requires that request clinical information updates be received by Passport from the inpatient facility within 24 hours of the request.

Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

Passport will authorize hospital care as an inpatient, when the clinical record supports the Medical Necessity for the need for continued hospital stay. It is the expectation that observation has been tried in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed. Upon discharge, the Provider must provide Passport with a copy of Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient Status Determinations

Passport's UM staff follow Federal and State guidelines along with evidence-based criteria to determine if the collected clinical information for requested services are "reasonable and necessary forth diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding, and Medical Necessity requirements (refer to the Medical Necessity Review subsection of this Provider Manual).

Discharge Planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission.

UM staff work closely with the hospital discharge planners to determine the most appropriate discharge setting for our Members. The clinical staff review Medical Necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

Readmission review is an important part of Passport's Quality Improvement Program to ensure that Passport Members are receiving hospital care that is compliant with nationally recognized guidelines as well as Federal and State regulations.

Passport will conduct readmission reviews when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates.

When a subsequent admission to the same facility with the same or similar diagnosis occurs within 24 hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within fourteen (14) calendar days of discharge, and it is determined that the readmission is related to the first admission and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

- A Readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:
  - Premature or inadequate discharge from the same hospital.
  - Issues with transition or coordination of care from the initial admission.
  - For an acute medical complication plausibly related to care that occurred during the initial admission.
- Readmissions that are excluded from consideration as preventable readmissions include:
  - Planned readmissions associated with major or metastatic malignancies, multiple traumas, and burns.
  - Neonatal and obstetrical Readmissions.
  - Behavioral Health readmissions.
  - Transplant related readmissions.

Same or Affiliated hospital: If a hospital belongs to a hospital system governed by a single hospital agreement, or if it shares the same tax identification number with one or more other hospitals, any readmission within a 14-calendar day period to another hospital within the same system or under the same tax identification number will be considered a readmission to the original hospital.

Post-Service Review

Failure to obtain authorization when required may result in denial of payment for those services. The only possible exception for payment as a result of post-service review is if information is received indicating the Provider did not know nor reasonably could have known that patient was a Passport Member or there was a Passport error, a Medical Necessity review will be performed. A post service review may be conducted when a member receives retrospective eligibility. Decisions, in this circumstance, will be based on medical necessity. Specific Federal or Commonwealth requirements or Provider contracts that prohibit administrative denials supersede this policy.

Retrospective (Retro) Eligibility

Retrospective Eligibility is coverage of Medicaid benefits for an applicant that may be backdated for a full three months prior to the month in which the application for Medicaid is filed.

UM requests for services which occurred during the retrospective eligible time period maybe received in writing from the provider, either by ax, mail, secure mail or the Availity Essentials Portal.

Providers may submit a request utilizing the available forms including the Universal Fax Form for either pre or post-pay; medical records may be attached for UM to determine medical necessity. For Outpatient Services conducted during the Retro Eligible period, authorization is not required; providers should submit the claim. UM will only conduct review for Inpatient Services that occurred during the retro eligible period.

UM determination of a retrospective review request will be completed within five (5) calendar days.

If a request for a retrospective review is received and the member was eligible at the time the service was rendered, the provider shall be instructed to submit a claim appeal. The Utilization Management Department does not conduct review requests where the provider failed to obtain authorization for an eligible member.

Affirmative Statement about Incentives

All medical decisions are coordinated and rendered by qualified practitioners and licensed staff unhindered by fiscal or administrative concerns. Passport and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

Passport requires that all utilization-related decisions regarding Member coverage and/or services are based solely on appropriateness of care and existence of coverage. Passport does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Passport does not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.

Out of Network Providers and Services

Passport maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care to Passport Members.
Passport requires Members to receive medical care within the participating, contracted network of Providers unless it is for Emergency Services or EPSDT Special Services that cannot be provided by any participating Provider as defined by Federal Law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be prior authorized by Passport. Non-network Providers may provide Emergency Services for a Member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or Commonwealth Laws or regulations.

If the Contractor is unable to provide within its network necessary Covered Services, it shall timely and adequately cover these services out of network for the Enrollee for as long as Contractor is unable to provide the services in accordance with 42 C.F.R. 438.206.

Avoiding Conflict of Interest

The HCS department affirms its decision-making is based on appropriateness of care and service and the existence of benefit coverage.

Passport does not reward Providers or other individuals for issuing denials of coverage or care.

Furthermore, Passport never provides financial incentives to encourage authorization decision makers to make determinations that result in under-utilization. Passports also requires our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Coordination of Care and Services

Passport HCS staff work with Providers to assist with coordinating referrals, services and benefits for Members who have been identified for Passport's Integrated Care Management (ICM) program via assessment or referral such as, self-referral, Provider referral, etc. In addition, the coordination of care process assists Passport Members, as necessary, in transitioning to other care when benefits end.

Passport staff provide an integrated approach to care needs by assisting Members with identification of resources available to the Member, such as community programs, national support groups, appropriate specialists, and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Passport staff is done in partnership with Providers, Members and/or their legally authorized representative(s) to ensure efforts are efficient and non-duplicative.

Continuity of Care and Transition of Members

It is Passport's policy to provide Members with advance notice when a Provider they are seeing during the course of active treatment will no longer be in-network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out of network Provider for a given period of time and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member up to ninety (90) days or longer, if necessary, for a safe transfer to another Provider as determined by Passport or its delegated Medical Group/IPA.
- Passport will not disrupt or interrupt active care of new Members and will ensure continuity of care for new Members receiving health care under fee for service prior to enrollment in the plan even if the current treating Provider is not contracted with Passport.
- When a woman has entered prenatal care before enrolling with Passport, Passport will allow the Member to continue with the same prenatal care Provider throughout the entire pregnancy whether or not the Provider is contracted with Passport to perform such services. Passport shall ensure prompt initiation of prenatal care or continuation of care without interruption for women who are pregnant at the time they enroll.
- High risk of second or third trimester pregnancy – The terminated Provider will continue

to provide services following termination until postpartum services related to delivery are completed or longer, if necessary, for a safe transfer.

For additional information regarding continuity of care and transition of Members, please contact Passport at (800) 578-0775.

Continuity and Coordination of Provider Communication

Passport stresses the importance of timely communication between Providers involved in a Member's care. This is especially critical between specialists, including behavioral health Providers, and the Member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

Reporting of Suspected Abuse and/or Neglect

A vulnerable adult is a person who is receiving or may be in need of receiving community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of themselves, or unable to protect themselves against significant harm or exploitation. When working with children, one may encounter situations suggesting abuse, neglect, and/or unsafe living environments. Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are:

- Physicians, dentists, interns, residents, or nurses
- Public or private school employees or childcare givers
- Psychologists, social workers, family protection workers, or family protection specialists
- Attorneys, ministers, or law enforcement officers Suspected abuse and/or neglect should be reported as follows:

Child Abuse

Suspected child abuse should be reported to the Child Protection Branch of the Kentucky Cabinet for Health and Family Services (CHFS).

To report suspected child abuse and neglect call toll-free to:
877-KYSAFE1 (877-597-2331)
(800) 752-6200

Non-emergency reports can be made online: prd.webapps.chfs.ky.gov/reportabuse/OutofHours.aspx

If the child's life is in danger, call 911.

Adult Abuse

Suspected abuse or neglect of an adult should be reported to the Adult Protection branch of CHFS using the phone numbers listed above for child abuse reporting.

Non-emergency reports should be made online using the Kentucky Child/Adult Protective Services Reporting System at: prd.webapps.chfs.ky.gov/reportabuse/OutofHours.aspx.

If the situation is a life-threatening emergency, call 911.

Passport's HCS teams will work with PCPs and Medical Groups/IPA, and other delegated entities who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the PCP/Medical Group/IPA, other delegated entities, or other clinical personnel. Under State and Federal Law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

Passport will follow up with Members that are reported to have been abused, exploited, or neglected to ensure appropriate measures were taken, and follow up on safety issues. Passport will track, analyze, and report aggregate information regarding abuse reporting to the Healthcare Services Committee and the proper State agency.

PCP Responsibilities in Care Management Referrals

The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The care manager provides the PCP with the Members' completed Health Risk Assessment (HRA) and or Enrollee Needs Assessment (ENA) as applicable, individualized care plan (ICP), multidisciplinary care team (MCT) updates, and information regarding the Member's progress through the ICP. The PCP is responsible for the provision of preventive services, for the primary medical care of Members and referrals to appropriate treating Providers/specialists. The PCP is responsible for educating the Member about the benefits of care management and referring the Member to Passport's Care Management program if the Member's needs to warrant additional care management support.

Care Manager Responsibilities

The care manager collaborates with the Member and any additional participants as directed by the Member to develop an ICP that includes recommended interventions from Member's MCT, as applicable. ICP interventions include the appropriate information to address medical and psychosocial needs and/or barriers to accessing care, care coordination to address Member's health care goals, health education to support self-management goals, and a statement of expected outcomes. Jointly, the case manager and the Member/authorized representative(s) are responsible for implementing the plan of care. Additionally, the care manager:

- Assesses the Member, at set intervals or after a significant change in condition, to determine if the Member's needs warrant care management and shares the completed assessments (HRA and/or ENA) with each Member and/or legally authorized representative.
- Monitors and communicates the progress of the implemented ICP to the Member's MCT, as Member needs warrant.
- Serves as a coordinator and resource to the Member, their representative and MCT participants throughout the implementation of the ICP and revises the plan as suggested and needed. Coordinates appropriate education and encourages the Member's role in self-management.
- Monitors progress toward the Member's achievement of ICP goals in order to determine an appropriate time for the Member's graduation from the ICM program.

Health Management

The tools and services described here are educational support for Passport Members and may be changed

at any time as necessary to meet the needs of Passport Members. Level 1 Members can be engaged in the program for up to sixty (60) days depending on Member preference and the clinical judgement of the Health Management Team.

Level 1 Health Management

Passport offers programs to help our Members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators that includes condition specific triage assessment, care plan development and access to tailored educational materials. Members are identified via Health Risk assessments and Identification and Stratification. You as a Provider also help us identify Members who may benefit from these programs. Members can request to be enrolled or disenrolled in these programs at any time. Our programs include:

The chronic conditions programs include:

- Asthma
- Depression
- Diabetes
- COPD
- Heart Failure
- Hypertension

Passport's healthy lifestyle programs include:

- Weight Management
- Tobacco Cessation
- Nutrition consult

For more information about these programs, please call (833) 269-7830 (main line) or (866) 472-9483 (healthy lifestyle programs), TTY/TDD: 711 or fax at (800) 642-3691.

Maternity Screening and High-Risk Obstetrics

Passport offers to all pregnant members prenatal health education with resource information as appropriate and screening services to identify high risk pregnancy conditions. Care managers with specialized OB training provide additional care coordination and health education for members with identified high risk pregnancies to assure best outcomes for members and their newborns during pregnancy, delivery and through their sixth week post-delivery. Pregnant member outreach, screening, education, and care management are initiated by Provider notification to Passport, member self-referral and internal Passport notification processes. Providers can notify Passport of pregnant/high risk pregnant members via faxed Pregnancy Notification Report Forms.

Pregnancy Notification Process

The PCP shall submit to Passport the Pregnancy Notification Report Form available at passporthealthplan.com within one (1) working day of the first prenatal visit and/or positive pregnancy test. The form should be faxed to Passport at (800) 983-9160.

Passport care management is available for Members with a high-risk pregnancy, including Members with a history of a previous preterm delivery. For more information about our maternity programs, please call Passport's Maternity Department at (866) 891-2320 Option 1.

Member Newsletters

Member Newsletters are posted on the passporthealthplan.com website at least once a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

Member Health Education Materials

Members can access our easy-to-read evidenced-based educational materials about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes, depression, and other relevant health topics identified during our engagement with Members. Materials are available through the Member Portal, direct mail as requested, email, and the My Passport mobile app.

Program Eligibility Criteria and Referral Source

Health Management Programs are designed for Passport Members with a confirmed diagnosis. Identified Members will receive targeted outreach such as educational materials, telephonic outreach, or other materials to access information on their condition. Members can contact Passport Member Services or assigned Health Manager at any time and request to be removed from the program.
Members may be identified for or referred to HM programs from multiple pathways which may include the following:

- Pharmacy Claims data for all classifications of medications.
- Encounter Data or paid Claims with a relevant CMS-accepted diagnosis or procedure code.
- Member Services welcome calls made by staff to new Member households, and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry.
- Member Assessment calls made by staff for the initial or annual Health Risk Assessments (HRA) for enrolled Members.
- External referrals from Provider(s), caregivers, or community-based organizations.
- Internal referrals from Nurse Advice Line, Medication Management, or Utilization Management.
- Member self-referral due to general plan promotion of program through Member newsletter or other Member communications.

Provider Participation

Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease
- Clinical resources such as patient assessment forms and diagnostic tools'
- Patient education resources
- Provider Newsletters promoting the health management programs, including how to enroll patients and outcomes of the programs
- Clinical Practice Guidelines; and,
- Preventive Health Guidelines.
- Case Management collaboration with the Member's Provider
- Faxing a Provider Collaboration Form to the Member's Provider when indicated

Additional information on health management programs is available from your local Passport Healthcare Services Department.

Primary Care Providers

Passport provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine and Obstetrics and Gynecology are eligible to serve as PCPs.

Members may choose a PCP or have one selected for them by Passport. Passport's Members are required to see a PCP who is part of the Passport Network.

Passport's Members may select or change their PCP by contacting Passport's Member & Provider Contact Center.

Specialty Providers

Passport maintains a network of specialty Providers to care for its Members. Some specialty care Providers may require a referral for a Member to receive specialty services; however, no prior authorization is required for in-network providers. Members are allowed to directly access women health specialists for routine and preventive health without a referral for services.

Passport will help to arrange specialty care outside the network when Providers are unavailable, or the network is inadequate to meet a Member's medical needs. To obtain such assistance, contact the Passport UM department. Referrals to specialty care outside the network require prior authorization from Passport.

Care Management (CM)

Passport provides a comprehensive ICM program to all Members who meet the criteria for services. The CM program focuses on coordinating the care, services, and resources needed by Members throughout the continuum of care. Passport adheres to Care Management Society of America Standards of Practice Guidelines in its execution of the program.

The Passport care managers may be licensed professionals and are educated, trained, and experienced in Passport's ICM program. The ICM program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes. The ICM program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Passport care manager will assess the Member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, preventive services and to identify and address any barriers the Member experiences to accessing appropriate care. The Passport care manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of ICM program enrollment, as well as facilitating and assisting with the development of the Members' ICP.

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. The care manager works collaboratively with the Member and all participants of the MCT when warranted, including the PCP and specialty Providers, ancillary Providers, the local Health Department, or other community-based resources when identified. The referral source should be prepared to provide the care manager with demographic, health care, and social data about the Member being referred.

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.
- Catastrophic or end-stage medical conditions (e.g., neoplasm, organ/tissue transplants, End Stage Renal Disease).
- Comorbid chronic illnesses (e.g., asthma, diabetes, COPD, CHF, etc.).
- Preterm births.
- High-technology home care requiring more than two (2) weeks of treatment.
- Members accessing Emergency Department services inappropriately.
- Individuals with Special Health Care Needs Members under guardianship with Department for Aging and Independent Living (DAIL).
- Members over utilizing prescription drugs.

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

Phone: (800) 578-0775
Fax: (800) 983-9160
Email: KYCareManagement@MolinaHealthcare.com

Transitions of Care

Passport's Transitions of Care (ToC) Program is designed to improve the quality of care while ensuring appropriate utilization for Members admitted to the hospital. During an episode of illness, Members may receive care in multiple settings, which can result in fragmented and poorly executed transitions. ToC provides targeted interventions for Members most likely to be negatively impacted. The program closely follows the Members most at risk for hospital readmissions by identifying specific diagnoses and other case determinants most correlated with readmissions.

ToC provides a high level of support and intervention for Members upon notification of admission up to 30 days following discharge from a ToC setting back to the community. Settings that are supported in the ToC program include home, hospital/acute care, Skilled Nursing Facility, rehabilitation facility, inpatient psychiatric facility/center and licensed personal care home.

The Passport ToC program confirms and reestablishes the Member's connection to his/her medical home. It provides services to support continuity and coordination of care from one care setting to another, as the Member's health status changes. The purpose of the ToC program is to improve clinical outcomes, identify and address transition of care needs, and promote Member self-determination and satisfaction, while reducing hospital readmissions and emergency department visits by:

- Ensuring the Member is fully prepared to continue the plan of care throughout the entire transition.
- Engaging the Member directly so they have an active voice in the implementation of their individualized plan of care.
- Facilitating the fundamental elements of the program designed to produce positive outcomes: medication review, practitioner and/or specialist follow-up appointments, assessment of health status, dietary and nutritional needs, and home health and DME needs.
- Supporting the Member through the transition and coordinating needed services with

appropriate Providers and other payor sources.
- Promoting Member self-management and encouraging empowerment.

ToC Coaches aid the Member through the transition process to ensure a safe and successful transition. Upon notification of a transition need, the assigned ToC Coach/CM reaches out to the Member/designee to engage them in transitions of care activities, interventions and addressing the program elements. The Passport ToC Coach/CM attempts to reach out to the Member while still inpatient and continues to support the Member as they transition from an inpatient level of care back to the community for up to thirty (30) days after the transition. The first post discharge call is aimed no later than five (5) calendar days of discharge notification or transition to perform a comprehensive physical and behavioral health assessment designed to support the successful transition to community-based care and/or housing. To perform such assessment, the Member's Person-Centered Recovery/Care Plan will review the level of care determination developed by the Provider / Provider agency, as applicable, in tandem with Passport's routine UM/ ToC procedures. Interventions conducted by the ToC Coach include inpatient and facility contacts, at a minimum one post discharge assessment, administration of an HRA for any changes in health status, assurance all ToC elements are appropriately assessed and addressed, assurance the ICP is appropriately completed/updated/reviewed to reflect Member's identified transition and individualized needs and preferences and Provider coordination to address the Member's transitional needs at each milestone. Intervals in which the Member receives follow-up contacts are based on the Member's identified needs and preferences.

The ToC Coach/CM serves as the main point of contact during the transition period, but other Passport staff may be engaged in the process as needed, including but not limited to the Member's PCP as well as participants of the Member's multidisciplinary care team. The Member's PCP is notified of the admission to ensure that the Member's main Provider is aware of the transition and can assist with coordinating timely follow up care and post discharge services.

The Passport HCS team will work with the Member and/or designee to ensure PCP and/or other treating Providers are aware of health status changes, address risk(s) associated with transition needs, and assist with planning, preparation and follow up care post-transition and may recommend a formal MCT meeting with inpatient, acute care, skilled nursing facility or post-discharge care team (home health, PT/OT/ST, specialty) participation, as needed. Passport ensures HIPAA compliance when sharing relevant information with Providers as Members move between settings.

ToC Coaches and CMs, focus on an empowerment model to teach Members and/or their designees to self-manage their conditions, communicate with their Providers, and identify changes in health status to report to their physician and address at the right level of care. Passport's ToC program allows for identifying the Member's ability to self-manage and develop a plan to address their transition needs that includes, but is not limited to assessment, goal setting, problem solving, care planning, engaging caregiver/designees, communicating with Providers, and empowering Members throughout the entire care continuum and transition needs.

Coordinated Services Program

Members may be assigned to receive care from a certain set of Providers, Pharmacy, and/ or emergent/urgent care settings based on the Members misuse or overuse of pharmacy or emergency department care. Members potentially eligible for the Coordinated Services Program (CSP) have their utilization reviewed to determine clinical composition, risk and possible misuse or overuse of

healthcare services. Members may be referred to care management prior to enrollment to educate and support behavioral changes and positive health outcomes. If Member's behaviors do not change, regardless of care management engagement, the Care Manager will initiate Member enrollment into the CSP. The Member's Care Manager will contact their assigned PCP to make the PCP aware of the Member being enrolled with certain Providers and settings of care as a part of the CSP. Members should be referred to CM for potential non-emergent care setting lock-in if the PCP is aware of the Member using 3 different emergent care settings 3 or more times in a 6-month period. See the Pharmacy section for pharmacy CSP criteria.

The Member will receive a list of CSP Providers/pharmacy and/or settings of care. All CSP decisions are made by a team of professional clinical Passport staff, and Members are reevaluated for CSP based on Member performance 60 days prior to the end of the 24-month lock-in term. If Member misutilization is still present, CSP enrollment may remain in place for an additional 24 months. If Member misutilization is no longer present, the Member may be disenrolled from the CSP. Overrides will be made at the discretion of Passport and may be made available to Members and CSP Providers if:

- The Member is out of town,
- The CSP Pharmacy is out of the Member's medicine,
- The Member moved and has not changed their pharmacy,
- A Member's medication is stolen, or
- The CSP setting cannot provide the urgent/emergent services a Member needs.

In certain circumstances, the Member may request a change in Provider during their CSP period. Passport may consider a change in CSP Provider if the:

- Provider does not want to serve the Member,
- Provider has closed and moved to another site, not convenient to the Member,
- Provider has been suspended/excluded/terminated/disqualified from the Medicaid program, or
- Member have moved beyond 30 min/miles from the Provider.

Additionally, enrollment in the CSP should be verified by checking the Member eligibility status in the Availity Essentials Portal. Failure to verify a Member's enrollment in the CSP may result in Claims denials. for Providers who are not on the Member's restricted Provider list.

8. Behavioral Health

Overview

Passport provides a Behavioral Health benefit for Members. Passports take an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health, and other specialty Providers to ensure whole person care. Passport complies with the most current Mental Health Parity and Addiction Equity requirements. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Utilization Management and Prior Authorization

For additional information please refer to the **Prior Authorization** subsection found in the **Health Care Services** section of this Provider Manual.

Some behavioral health services may require prior authorization.

Behavioral Health inpatient and substance use disorder residential services psychiatric residential treatment and select outpatient treatment(s) can be requested by submitting a Prior Authorization form or contacting Passport's Prior Authorization team at (800) 578-0775. Passport strongly recommends the use of the Availity Essentials portal to submit ALL prior authorization requests. Emergency psychiatric services do not require Prior Authorization. All requests for Behavioral Health services should include the most current version of Diagnostic Statistical Manual of Mental Disorders (DSM) classification. Passport utilizes standard, generally accepted Medical Necessity criteria for Prior Authorization reviews. American Society of Addiction Medicine (ASAM) criteria is utilized to determine Medical Necessity for SUD services.

Please see the Prior Authorization Section in the Healthcare Services chapter of this Manual for additional information.

Access to Behavioral Health Providers and PCPs

Members may be referred to an in-network Behavioral Health Provider via referral from a PCP or by Member self-referral. PCPs are able to screen and assess Members for the detection and treatment of, or referral for, any known or suspected Behavioral Health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health service within the scope of their practice and in compliance with all state and regulatory requirements for the service provision. A formal referral form or Prior Authorization is not needed for a Member to self-refer or be referred to a PCP or Behavioral Health Provider.

Behavioral Health Providers may refer a Member to an in-network PCP, or a Member may self-refer. Members may be referred to a PCP and specialty care Providers to manage their health care needs. Behavioral Health Providers may refer the member to a PCP if they identify other health concerns, including physical health concerns, that should be addressed.

Care Coordination and Continuity of Care

Discharge Planning

Discharge planning begins upon admission to an inpatient or residential behavioral health facility. Members who were admitted to an inpatient or residential behavioral health setting must have an adequate outpatient follow-up

appointment scheduled with a behavioral health Provider prior to discharge and to occur within seven (7) days of discharge.

Interdisciplinary Care Coordination

In order to provide care for the whole person, Passport emphasizes the importance of collaboration amongst all Providers on the Member's treatment team. Behavioral Health, Primary Care, and other specialty Providers shall collaborate and coordinate care amongst each other for the benefit of the Member. Collaboration of the treatment team will increase communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunities for optimal health outcomes. Passport's ICM program may assist in coordinating care and communication amongst all Providers of a Member's treatment team.

Care Management

Passport's Care Management team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and/or substance use disorder (SUD) needs.
Members with high-risk psychiatric, medical, or psychosocial needs may be referred by a Behavioral Health or Primary Care Provider to the CM program.
Referrals to the ICM program may be made by contacting Passport at:
Phone: (800) 578-0775
Fax: (800) 983-9160
Additional information on the ICM program can be found in the Care Management chapter of this manual.

Behavioral Health Care Management

Access to Records and Information to Support Member Care Coordination and Care Management Activities

Passport is committed to working with its Providers to address the care coordination and care management needs of its members. To facilitate such activities, all Providers (including substance use disorder providers and behavioral health providers) are required to cooperate with and provide to Passport any and all relevant patient/member records and information requested by Passport to support such activities. To the extent a consent and/or authorization from the patient/member is required by law to disclose the requested records/information to Passport, the Provider shall make best efforts to obtain the necessary consent(s) and/or authorization(s) from the patient/member.

Both Passport and the Provider agree to comply with HIPAA and other applicable federal and state privacy laws and regulations including, but not limited to, the HIPAA privacy regulations set forth in 45 C.F.R. Part 164 Subpart E, the HIPAA security regulations set forth in 45 C.F.R. Part 164 Subpart C, 42 C.F.R. Part 2 Regulations governing the Confidentiality of Substance Use Disorder Patient Records and state-specific medical privacy laws.

Responsibilities of Behavioral Health Providers

Passport promotes collaboration with Providers and integration of both physical and behavioral health services in effort to provide quality care coordination to Members. Behavioral Health Providers are expected to provide in-scope, evidence-based mental health, and substance use disorder services to Passport Members. Behavioral Health Providers may only provide physical health care services if they are licensed to do so.

To support the overall well-being of the Members, behavioral health Providers will 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.

Providers shall follow Quality standards related to access. Passport provides oversight of Providers to ensure Members are able to obtain needed health services within the acceptable appointment timeframes. Please see the Quality chapter for specific access to appointment details.

All Members receiving inpatient psychiatric services must be 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 Seven (7) days of the discharge date. If a Member misses a behavioral health appointment, the Behavioral Health Provider shall contact the Member within twenty-four (24) hours of a missed appointment to reschedule.

If either the Contractor or a Provider (including Behavioral Health) requires a referral before making an appointment for Specialty Care, any such appointment shall be made within thirty (30) Days for routine care or forty-eight (48) hours for Urgent Care. Behavioral Health Providers must assist Members with accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.

Behavioral Health Providers shall 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 support.

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 patient’s behavioral, and physical health and identified HRSN 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 by Molina Healthcare 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.

Behavioral Health Crisis Lines

Passport has a Behavioral Health Crisis Line that may be accessed by Members 24/7year-round. The Passport Behavioral Health Crisis Line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals and/or triage to appropriate support, resources, and emergency response teams.

Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling (844) 800-5154.

National Suicide Lifeline

988 is the National Suicide Lifeline. Anyone in need of suicide or mental health crisis support (or anyone worried about someone else), can receive free and confidential support 24 hours a day, 7days a week, 365 days per year, by dialing 988 from any phone.

Behavioral Health Toolkit for Providers

Passport has developed an online Behavioral Health Tool Kit to provide support with screening, assessment, and diagnosis of common behavioral health conditions, plus access to Behavioral Health HEDIS® Tip Sheets, and other evidence-based guidance, training opportunities for Providers, and recommendations for coordinating care. The material within this tool kit is applicable to Providers in both primary care and behavioral health settings. The Behavioral Health Tool Kit for Providers can be found under the "Health Resources" tab at PassportHealthPlan.com

9. Quality

Maintaining Quality Improvement Processes and Programs

Passport works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Passport Quality department **toll free at** (800) 578-0775.

The address for mail requests is:
Passport by Molina Healthcare Inc.
Attn: Quality Department
2028 W. Broadway
Louisville, KY 40203

This Provider Manual contains excerpts from the Passport Quality Improvement Program. For a complete copy of Passport's Quality Improvement Program, you can contact your Provider Services Representative or call the telephone number above to receive a written copy.

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 does not delegate Quality Improvement activities to Medical Groups/IPAs. However, Passport requires contracted Medical Groups/IPAs to comply with the following core elements and standards of care. Passport Medical Groups/IPAs must:

- 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 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 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 Passport Quality personnel for site and medical record review processes.

Patient Safety Program

Passport's Patient Safety Program identifies appropriate safety projects and error avoidance for Passport Members in collaboration with their PCPs. Passport continues to support safe personal health practices for our Members through our safety program, pharmaceutical management and care management/health management programs and education. Passport monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

Passport has established a systematic process to identify, investigate, review, and report any Quality of Care, Adverse Event/Never Event, Critical Incident (as applicable), and/or service issues affecting Member care. Passport will research, resolve, track, and trend issues. Confirmed Adverse Events/Never Events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

- Surgery on the wrong body part
- Surgery on the wrong patient
- Wrong surgery on a patient

Passport is not required to pay for inpatient care related to "never events."

Medical Records

Passport requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. PCPs should maintain the following medical record components, that include but are not limited to:

- Medical record confidentiality and release of medical records within medical and behavioral health care records.
- Medical record content and documentation standards, including preventive health care.
- Storage maintenance and disposal processes.
- Process for archiving medical records and implementing improvement activities.
- Passport has a process to systematically review provider Medical Records to ensure compliance with the Medical Records standards.
- Passport shall institute improvement and actions when standards are not met.
- Passport will assess performance/compliance to for Medical Record standards of PCP's/ PCP sites, high risk/high volume specialist, dental providers, providers of ancillaries' services no less than every three (3) years.

Medical Record Keeping Practices

Below is a list of the minimum items that are necessary in the maintenance of the Member's Medical records:

- Each patient has a separate record.
- Medical records are stored away from patient areas and preferably locked.
- Medical records are available during each visit and archived records are available within twenty-four (24) hours.
- If hard copy, pages are securely attached in the medical record and records are organized by dividers or color-coded when thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record keeping is monitored for Quality and HIPAA compliance, including privacy of confidential information, such as race, ethnicity, language, sexual orientation and gender identity.
- Storage maintenance for the determined timeline and disposal per record management

processes.
- Process is in place for archiving medical records and implementing improvement activities.
- Medical records are kept confidential, and there is a process for release of medical records including behavioral health care records.
- Immunizations and tuberculosis records are required to be kept for a person's lifetime

Content

Providers must remain consistent in their practices with Passport's medical record documentation guidelines. Medical records are maintained for each Passport Member and should include, but not be limited to the following information:

- The patient's name or ID number on each page in the record
- The patient's name, date of birth, sex, marital status, address, employer name, school, home and work address and telephone numbers, emergency contact, consent forms, preferred language spoken and guardianship information
- Legible signatures and credentials of the Provider and other staff members within a paper chart
- A list of all Providers who participate in the Member's care
- Information about services that are delivered by these Providers
- A problem list that describes the Member's medical and behavioral health conditions
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Medication reconciliation within thirty (30) days of an inpatient discharge with evidence of current and discharge medication reconciliation and the date performed
- Allergies and adverse reactions (or notation that none are known)
- Documentation that shows Advance Directives, Power of Attorney and Living Will have been discussed with Member, and a copy of Advance Directives when in place;
- Past medical and surgical history, including physical examinations, treatments, preventive services, serious accidents, illnesses, and risk factors (for children, past medical history includes prenatal care and birth information, operations, and childhood illnesses, such as chickenpox)
- Treatment plans that are consistent with diagnosis
- A working diagnosis that is recorded with the clinical findings
- Pertinent history for the presenting problem
- Pertinent physical exam for the presenting problem
- Lab and other diagnostic tests that are ordered as appropriate by the Provider
- Clear and thorough progress notes that state the intent for all ordered services and treatments
- Notations regarding follow-up care, calls, or visits that include the specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate
- Notes from consultants as applicable
- Up-to-date immunization records and documentation of appropriate history (pursuant to 902 KAR 2:060)
- Identification and history of nicotine, alcohol use or substance abuse
- Documentation of reportable diseases and conditions to the local health department

serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020 • All staff and Provider notes are signed physically or electronically with either name or initials
- All entries are dated
- Dates of encounter(s)
- All abnormal lab/imaging results show explicit follow up plan(s)
- All ancillary services reports
- Documentation of all emergency care provided in any setting
- Documentation of all hospital admissions and follow-up care, inpatient, and outpatient care, including hospital discharge summaries, hospital history and physicals and operative report
- Follow-up visits provided secondary to reports of emergency room care
- Labor and Delivery Record for any child seen since birth
- All written Denials of service and the reason for the Denial
- A signed document stating with whom protected health information may be shared; and
- Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer.

A Member's Medical Record shall include the following minimal detail for individual clinical encounters:

- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status
- Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits
- Plan of treatment including:
    - Medication history, medications prescribed, including the strength, amount, directions for use and refills
    - Therapies and other prescribed regimen; and
    - Follow-up plans including consultation, referrals, and directions, including time to return.

A Member's Medical Record shall include at a minimum for hospitals and mental hospitals:

- Identification of the Member
- Physician name
- Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care (as required under 42 C.F.R. 456.172 (mental hospitals) or 42 C.F.R. 456.70 (hospitals)
- Initial and subsequent continued stay review dates (described under 42 C.F.R. 456.233 and 42
- C.F.R. 465.234 (for mental hospitals) and 42 C.F.R. 456.128 and 42 C.F.R. 456.133 (for hospitals)
- Reasons and plan for continued stay if applicable
- Other supporting material appropriate to include
- For non-mental hospitals only:
    - Date of operating room reservation; and
    - Justification of emergency admission if applicable.

Organization

- The medical record is legible to someone other than the writer.
- Each patient has an individual record.
- Chart pages are bound, clipped, or attached to the file.
- Chart sections are easily recognized for retrieval of information.
- A release document for each Member authorizing Passport to release medical information for facilitation of medical care.

Retrieval

- The medical record is available to the Provider at each encounter
- The medical record is available to Passport's for purposes of quality improvement
- The medical record is available to the applicable state and/or federal agency and the external quality review organization upon request
- The medical record is available to the Member upon their request
- A storage system for inactive Member medical records which allows retrieval within 24 hours, is consistent with state and federal requirements and the record is maintained for not less than 10 years from the last date of treatment or for a minor, one (1) year past their 20th birthday but, never less than 10 years
- An established and functional data recovery procedure in the event of data loss
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

Passport Providers shall develop and implement confidentiality procedures to guard Member protected health information, in accordance with HIPAA privacy standards and all other applicable Federal and Commonwealth regulations. This should include, and is not limited to, the following:

- Ensure that medical information is released only in accordance with applicable Federal or Commonwealth Law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure timely access by Members to the records and information that pertain to them.
- Abide by all Federal and Commonwealth Laws regarding confidentiality and disclosure of medical records or other health and enrollment information.
- Medical Records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training for all staff on handling and maintaining protected health care information.
- Ensure that confidential information, such as patient race, ethnicity, preferred language, sexual orientation, gender identity, and Health-Related Social Need are protected

Additional information on medical records is available from your local Passport Quality department. See also the Compliance Section of this Provider Manual for additional information regarding HIPAA.

Advance Directives (Patient Self-Determination Act)

Passport complies with the advance directive requirements of Kentucky as well as any federal requirements. Passport requires PCPs to ensure Members receive information regarding advance directives and that contracted Providers and facilities uphold executed documents.

Advance Directives are a written choice for health care. There are two (2) types of Advance Directives:

- **Durable Power of Attorney for Health Care:** allows an agent to be appointed to carry out health care decisions.
- **Living Will:** allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.

When There Is No Advance Directive: The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

Providers must inform adult Passport Members, eighteen (18) years old and up, of their right to make health care decisions and execute Advance Directives. It is important that Members are informed about Advance Directives.

New adult Members or their identified personal representative will receive educational information and instructions on how to access advance directives forms in their Member Handbook, Evidence of Coverage (EOC) and other Member communications such as newsletters and the Passport website. If a Member is incapacitated at the time of enrollment, Passport will provide advance directive information to the Member's family or representative and will follow up with information to the Member at the appropriate time. All current Members will receive annual notice explaining this information, in addition to newsletter information.

Members who would like more information are instructed to contact Member Services or are directed to the Caring Info website at https://www.caringinfo.org/planning/advance-directives/by-state/kentucky/ for forms available to download. Additionally, the Passport website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

PCPs must discuss Advance Directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance.

Passport network Providers and facilities are expected to communicate any objections they may have to a Member directive prior to service when possible. Members may select a new PCP, if the assigned Provider has an objection to the Member's desired decision. Passport will facilitate finding a new PCP or specialist as needed.

In no event may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an Advance Directive. CMS Law gives Members the right to file a complaint with Passport or the State survey and certification agency if the Member is dissatisfied with Passport's handling of Advance Directives and/or if a Provider fails to comply with Advance Directives instructions.

Passport will notify the Provider of an individual Member's Advance Directives identified through Care Management or Care Coordination. Providers are instructed to document the presence of an Advance Directive in a prominent location of the Medical Record. Advance Directives forms are State specific to meet State regulations.

Passport expects that there will be documented evidence of the discussion between the Provider and the Member during routine Medical Record reviews.

Access to Care

Passport maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and participating specialists, Providers surveyed include OB/GYN (high-volume specialists), Oncologists (high impact specialists), and behavioral health providers. Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The PCP or their designee must be available 24 hours a day, 7 days a week to Members.
Consistent with KRS 304.17A-515, the Contractor shall have a Provider Network that meets the following accessibility requirements:

- For urban areas, a Provider Network that is available to all Members within thirty (30) miles or thirty (30) minutes of each Member's place of residence or work, to the extent that services are available
- For areas other than urban areas, a Provider Network that makes available PCP and hospital services within thirty (30) minutes or thirty (30) miles of each Member's place of residence or work, to the extent those services are available.
- All other Providers shall be available to all Members within fifty (50) minutes or fifty (50) miles of each Member's place of residence or work, to the extent those services are available

Appointment Access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Passport Members in the timeframes noted.

Medical Appointment

Appointment Types	Standard
Preventive Care, non-urgent	Within 30 calendar days
Family Planning (Counseling & Medical Services	**Age 18 years and up:** As Soon As Possible, and within 30 calendar days **Less than 18 years**: As immediately as possible and within 10 calendar days
PCP	Urgent: within 48 hours **Non-Urgent**: within 30 calendar days
Specialists	Urgent: within 48 hours **Non-Urgent**: within 30 calendar days
General and Pediatric Dental Services	Urgent: within 48 hours **Non-Urgent**: within 30 calendar days
General Vision Services	Urgent: within 48 hours **Non-Urgent:** within 30 calendar days
Labs & Radiology	Urgent: within 48 hours **Non-Urgent:** within 30 calendar days
Emergency Care	24 hours per day/7 days per week and in accordance with Commonwealth standards

Behavioral Health Appointment

Appointment Type	Standard
Life Threatening Emergency	Immediately
Non-life-Threatening Emergency	Within 6 hours
Urgent Care	Within 48 hours
Routine Care	**Initial Visit:** Within 10 business days of request **Follow-up visit**: within 30 calendar days of request
Post-Discharge Outpatient Aftercare	Within 7 days of discharge
Referrals	Within 30 Calendar days

Note: Behavioral Health Providers must contact Members who have missed an appointment within 24 hours to re-schedule. Additional information on appointment access standards is available from your local Passport Quality department

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed 30 minutes. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours

All providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Passport requires Providers to maintain a 24-hour telephone service, 7 days a week. Acceptable arrangements include:

- Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner, and the PCP or designee is available to return the call within a maximum of thirty (30) minutes
- Office phone is answered after hours by a recording directing the Member to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes; and
- Office phones are transferred after office hours to another location where someone shall answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.

Unacceptable:

- Office phone is only answered during office hours
- Office phone is answered after hours by a recording that tells Enrollees to leave a message
- Office phone is answered after hours by a recording that directs Enrollees to go to the emergency room for any services needed; and
- Returning after-hours calls outside of thirty (30) minutes.

Appointment Scheduling

Each Provider must implement an appointment scheduling system. The following are the minimum standards:

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided

and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments.

2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record, and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider is to notify the Passport Provider Services department toll free at (800) 578-0775 or TTY/ TDD 711. Providers are strongly encouraged to report missed or cancelled appointments within the Missed or Cancelled Appointments Panel in KY HealthNet (https://kymmis.com).
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time.
4. Special needs of Members must be accommodated when scheduling appointments. This includes but is not limited to wheelchair-using Members and Members requiring language interpretation.
5. A process for Member notification of preventive care appointments must be established. This includes but is not limited to immunizations and mammograms.
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, participating Providers have agreed that they will not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status or status as a recipient of Medicaid benefits. Additionally, a participating Provider or contracted medical group/IPA may not limit their practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care. If a PCP chooses to close their panel to new Members, Passport must receive 30 calendar days advance written notice from the Provider.

Women's Health Access

Passport allows Members the option to seek obstetric and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Passport as providing obstetric and gynecological services. Member access to obstetric and gynecological services is monitored to ensure Members have direct access to participating Providers for obstetric and gynecological services. Gynecological services must be provided when requested regardless of the gender status of the Member.

Additional information on access to care is available from your local Passport Quality department.

Monitoring Access for Compliance with Standards

Access to care standards are reviewed, revised as necessary, and approved by the Quality Improvement and Health Equity Transformation Committee on an annual basis.
Provider network adherence to access standards is monitored via the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability, after- hours access, Provider ratios and geographic access.
2. Member complaint data – assessment of Member complaints related to access and availability of care.

3. Member satisfaction survey – evaluation of Members' self-reported satisfaction with appointment and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement and Health Equity Transformation Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified Provider-specific and/or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement and Health Equity Transformation Committee.

Quality of Provider Office Sites

Passport Providers are to maintain office-site and medical record keeping practices standards. Passport continually monitors Member appeals and complaints/grievances for all office sites to determine the need of an office site visit and will conduct office site visits as needed. Passport assesses the quality, safety, and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical Accessibility.
- Physical Appearance.
- Adequacy of Waiting and Examining Room Space.

Physical Accessibility

Passport evaluates office sites as applicable, to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site, and ease of access for patients with physical disabilities.

Physical Appearance

The site visits include, but are not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety as needed.

Adequacy of Waiting and Examining Room Space

During the site visit as required, Passport assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Administration & Confidentiality of Facilities

Facilities contracted with Passport must demonstrate an overall compliance with the guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis; the waiting room is well-lit, office hours are posted, and parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available; the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour, and there is a minimum of two (2) office exam rooms per Provider.

- Basic emergency equipment is located in an easily accessible area. Fire extinguishers are readily available. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one (1) CPR certified employee is available.
- Yearly OSHA training (Fire, Safety, Blood-borne Pathogens, etc.) is documented for offices with ten (10) or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, contracts, and evidence of a hazardous waste management system in place.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers, or labels are possible alternative methods. Exam rooms ensure patient privacy.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed, and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

EPSDT Services to Enrollees Under 21 Years of Age

Passport maintains systematic and robust monitoring mechanisms to ensure all required Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services to Enrollees under 21 years of age are timely according to required preventive guidelines. All Enrollees under 21 years of age should receive preventive, diagnostic and treatment services at intervals as set forth in Section 1905(R) of the Social Security Act. Passport's Quality or the Provider Services department is also available to perform Provider training to ensure that best practice guidelines are followed in relation to well child services and care for acute and chronic health care needs.

Well Child/Adolescent Visits

Visits consist of age-appropriate components, that include but are not limited to:

- Comprehensive health and developmental history.
- Nutritional assessment.
- Height and weight and growth charting.
- Comprehensive unclothed physical examination.
- Appropriate immunizations according to the Advisory Committee on Immunization Practices.
- Laboratory procedures, including lead blood level assessment, appropriate for age and risk factors.
- Periodic developmental and behavioral screening.
- Vision and hearing tests.
- Dental assessment and services.
- Health education, including anticipatory guidance such as child development, healthy

lifestyles, accident, and disease prevention.

- Periodic objective screening for social emotional development using a recognized, standardized tool.
- Perinatal mood disorder screening for parent(s) of infants in the most appropriate clinical setting, e.g., at the pediatric, behavioral health or OB/GYN visit.

Diagnostic services, treatment, or services Medically Necessary to correct or ameliorate defects, physical or mental illnesses, and conditions discovered during a screening or testing must be provided or arranged for either directly or through referrals. Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided within the Member's Covered Benefit Services. Members should be referred to an appropriate source of care for any required services that are not Covered Services.
Passport shall have no obligation to pay for services that are not Covered Services. For more information on the EPSDT covered benefits and services, see the Benefits and Covered Services chapter of this Manual.

Monitoring for Compliance with Standards

Passport monitors compliance with the established performance standards as outlined above at least annually. Performance below Passport's standards may result in a Corrective Action Plan (CAP) with a request the Provider submit a written corrective action plan to Passport within 30 calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Provider's permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs

Passport maintains an active Quality Improvement Program. The Quality Improvement Program provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health Management

The Passport Health Management Program provides for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases. For additional information, please refer to the Health Management subsections in the Healthcare Services section of this Provider Manual.

Clinical Practice Guidelines

Passport adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature, and/or appropriately established authority.
Passport CPGs include but are not limited to the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)

- Autism
- Bipolar Disorder
- Cancer Treatment and Prevention
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Dementia
- Depression
- Diabetes
- Elder Abuse
- Heart Failure in Adults
- Hepatitis C
- HIV/AIDS
- Homelessness-Special Health Care Needs
- Hypertension
- Incontinence
- Ong-term Services and Supports (LTSS)
- Osteoporosis
- Parkinson's Disease
- Perinatal & Postpartum Care
- Pregnancy Management
- Pressure Ulcers
- Schizophrenia
- Sickle Cell Disease
- Substance Use Disorder
- Suicide Prevention
- Trauma-Informed Primary Care
- Weight Management

All clinical practice guidelines are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement and Health Equity Transformation Committee. In fact, a review is conducted at least monthly to identify new additions or modifications. On an annual basis, clinical practice guidelines are distributed to Providers at Clinical Practice Guidelines (passporthealthplan.com) (or when changes are made during the year), and the Provider Manual. Notification of the availability of the clinical practice guidelines is published in the Passport Provider Newsletter.

Preventive Health Guidelines

Passport provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American Academy of Pediatrics and Centers for Disease Control and Prevention (CDC), in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include, but are not limited to:

- Adult Preventive Services Recommendations (U.S. Preventive Services Task Force). Links to current recommendations are included on Passport's website.
- Recommendations for Preventive Pediatric Health Care (Bright Futures/American Academy of

Pediatrics). Links to current recommendations are included on Passport's website.

- Recommended Adult Immunization Schedule for ages 19 Years or Older, United States. These recommendations are revised every year by the Centers for Disease Control and Prevention. Links to current recommendations are included on Passport's website.
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States. These recommendations are revised every year by the Centers for Disease Control and Prevention. Links to current recommendations are included on Passport's website.
- All preventive health guidelines are updated monthly, as needed, and are approved by the Quality Improvement and Health Equity Transformation Committee. In fact, a review is conducted at least monthly to identify new additions or modifications. On an annual basis, Preventive Health Guidelines are distributed to Providers at passporthealthplan.com/Guide clinical (or when changes are made during the year) and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Passport Provider Newsletter.

Cultural and Linguistic Appropriate Services

Passport works to ensure all Members receive culturally linguistically appropriate care across the service continuum to reduce health disparities and improve health outcomes. For additional information about Passport's program and services, please refer to the Culturally Linguistically Appropriate Services section of this Provider Manual.

Measurement of Clinical and Service Quality

Passport 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
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

Passport evaluates continuous performance according to, or in comparison with objectives, measurable performance standards and benchmarks at the national, regional and/or at the local/ health plan level.

Contracted Providers and Facilities must allow Passport to use its performance data collected in accordance with the Provider's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of Quality Improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced Member cost sharing.

Passport's most recent results can be obtained from your local Passport Quality department or by visiting our website at www.passporthealthplan.com.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Passport utilizes the NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the

spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use, and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are used to evaluate the effectiveness of multiple quality improvement activities and clinical programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the effectiveness of these programs. Selected HEDIS® results are provided to federal and state regulatory agencies and accreditation organizations as part of our contracts with these agencies. The data are also used to compare against established health plan performance benchmarks. On an annual basis, HEDIS® rates are reported at https://www.molinahealthcare.com/members/ky/en-us/mem/medicaid/overvw/quality/HEDIS-Results.aspx

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS® is the tool used by Passport to summarize Member satisfaction with Providers, health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Customer Service, Rating of Health Care, and Getting Needed Prescription Drugs (for Medicare). The CAHPS® survey is administered annually in the spring to randomly selected Members by an NCQA-certified vendor. CAHPS® results are used in much the same way as HEDIS® results; only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Passport's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered. On an annual basis, CAHPS® rates are reported at https://www.molinahealthcare.com/members/ky/en-us/mem/medicaid/overvw/quality/CAHPS-Results.aspx

Behavioral Health Satisfaction Assessment

Passport obtains feedback from Members about their experience, needs, and perceptions of accessing behavioral health care. This feedback is collected at least annually to understand how our Members rate their experiences in getting treatment, communicating with their clinicians, receiving treatment and information from the plan among other areas.

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey both focus on Member experience with health care Providers and health plans, Passport conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Passport, as this is one of the primary methods used to identify improvement areas pertaining to the Passport Provider Network. The survey results have helped establish improvement activities relating to Passport's specialty network, inter-Provider communications, and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

Passport monitors the effectiveness of clinical and service activities through metrics selected to

demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating "best practices". The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods.

In addition to the methods described above, Passport also compiles complaints and appeals data as well as requests for out-of-network services to determine opportunities for service improvements.

What Can Providers Do?

- Ensure patients are up to date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed
- Check that staff is properly coding all services provided; and
- Be sure patients understand what *they* need to do.

Passport has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the Availity Essentials Portal. There are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey Star Ratings measures, contact your local Passport Quality department.

HEDIS® and CAHPS® are registered trademarks of the National Committee for Quality Assurance (NCQA).

Value Based Payment Continuum (VBC)

Passport recognized the need to "meet providers where they are at." Our VBC payment methodologies support that objective with an accountable care continuum of value-based models, including pay-for-performance, quality payment bundles, gain share, partial shared-risk models, and full-risk capitation—all of which reward quality improvements, and some that also incentivize improved cost of care. Passport may partner with Providers in the following ways:

Pay for Performance:

- Initial engagement with fee-for-service providers
- Financial incentives are tied to key access, quality, and outcomes indicators
- Identify Providers with at-risk patients and HEDIS score improvement opportunities

Pay for Quality:

- Enhanced reimbursement opportunities tied to HEDIS and STAR measures
- Focuses on providers investing in processes to drive better outcomes and lower costs
- Additional financial incentives for improved performance on utilization metrics with assigned members

Patient Centered Medical Homes:

- Focuses on Providers engaging in team-based and integrated care coordination
- Rewards Providers who achieve NCQA Patient Centered Medical Home accreditation status
- Increases the level of care coordination and information sharing between different care settings

Shared Risk and Accountable Care:

- Offers Providers additional compensation from sharing in savings or risk resulting from improved care quality and outcomes with potential to move to accountable care contract including upside/downside risk based on benchmark data and quality measures

Full Risk Arrangements:

- Progresses into partial/full risk arrangements with more experienced Providers demonstrating a track record or positive administrative experience and capability in successfully managing government sponsored healthcare populations

10. Compliance

Fraud, Waste, and Abuse

Introduction

Passport is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Passport's Compliance department maintains a comprehensive plan, which addresses how Passport will uphold and follow State and Federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud, waste, and abuse prevention, detection, and correction along with the education of appropriate employees, vendors, Providers, and associates doing business with Passport.

Passport's Special Investigation Unit (SIU) supports compliance in its efforts to prevent, detect, and correct fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or Law enforcement agency.

Mission Statement

Our mission is to pay claims correctly the first time, and that mission begins with the understanding that we need to proactively detect fraud, waste, and abuse, correct it, and prevent it from reoccurring. Since not all fraud, waste, or abuse can be prevented, Passport employs processes that retrospectively address fraud, waste, or abuse that may have already occurred. Passport strives to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care cost and to promote quality health care.

Definitions

Fraud: Under applicable federal law or KRS 205.8451-KRS205.8483, "Fraud" means an intentional deception or misrepresentation made by a recipient or a Provider with the knowledge that the deception could result in some unauthorized benefit to the recipient or Provider or to some other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste: "Waste" means generally, but is not limited to, the overutilization or inappropriate utilization of services or misuse of resources, and typically is not a criminal or intentional act

Abuse: means, Provider Abuse and Recipient Abuse, as defined in KRS 205.8451: "Provider abuse" means, with reference to a health care Provider, practices that are inconsistent with sound fiscal, business, or medical practices, and that result in unnecessary cost to the Medical Assistance Program established pursuant to this chapter, or that result in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes practices that result in unnecessary cost to the Medical Assistance Program. "Recipient abuse" means, with reference to a medical assistance recipient, practices that result
in unnecessary cost to the Medical Assistance Program or the obtaining of goods, equipment, medicines, or services that are not Medically Necessary, or that are excessive, or constitute flagrant overuse or misuse of Medical Assistance Program benefits for which the recipient is covered.

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a Federal statute that covers fraud involving any Federally funded contract or

program. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent Claim to the U.S. government for payment.
The term "knowing" is defined to mean that a person with respect to information:

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

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent Claims to the government, such as knowingly making false statements, falsifying records, double billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false Claim to be submitted.

Deficit Reduction Act

The Deficit Reduction Act ("DRA") aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

As a contractor doing business with Passport, Providers and their staff have the same obligation to report any actual or suspected violation of 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 protection rights as whistleblowers.

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. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government. Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against due to their role in disclosing or reporting a false Claim are 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.
- A clean claim is a claim that is submitted without any errors or omissions and can be processed without additional information or verification. A clean claim cannot be a claim on appeal and cannot be contested (that is, not reasonably believed to be fraudulent and not subject to a necessary release, consent, or assignment) and supported with adequate and accurate medical records at the time service was rendered.
- Compensation for special damage 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 payments until compliance is met. Passport will take steps to monitor Passport contracted Providers to ensure compliance with the Law.
Clean Claim: A clean Claim is one that is accurate, complete (that is, includes all information necessary to determine Passport by Molina Healthcare liability), not a claim on appeal, and not contested (that is, not

reasonably believed to be fraudulent and not subject to a necessary release, consent, or assignment), and supported with adequate and accurate medical records at the time service was rendered.

Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

Anti-Kickback Statute ("AKS") is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying referrals is a crime. The statute covers the payers of kickbacks, those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration.

Passport conducts all business in compliance with Federal and State Anti-Kickback Statutes (AKB) statutes and regulations and Federal and State marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

What is AKB?

AKB statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by Federal and State health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. **Examples** of prohibited AKB actions include a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

Under **Passport's policies**, Providers may not offer, solicit an offer, provide, or receive items of value of any kind that are intended to induce referrals of Federal health care program business. Providers must not, directly, or indirectly, make or offer items of value to any third party, for the purpose of obtaining, retaining, or directing our business. This includes giving, favors, preferential hiring, or anything of value to any government official.

Marketing Guidelines and Requirements

Providers must conduct all marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations – both State and Federal.

Under **Passport's policies**, Marketing means any communication, to a beneficiary who is not enrolled with Passport, that can reasonably be interpreted as intended to influence the beneficiary to enroll with Passport's Medicaid, Marketplace, or Medicare products. This also includes communications that can be interpreted to influence a beneficiary to not enroll in or to disenroll from another Health Plan's products.

Restricted marketing activities vary from state-to-state but generally relate to the types and form of communications that health plans, Providers and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach, and other types of communications.

Stark Statute

Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to

services provided only by Practitioners, rather than by all health care Providers.

Sarbanes-Oxley Act of 2002

Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Examples of Fraud, Waste and Abuse by a Provider

The types of questionable Provider schemes investigated by Passport by Molina Healthcare include, but are not limited to the following:

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Passport Member for Covered Services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.
- Billing and providing for services to Members that are not Medically Necessary.
- Billing for services, procedures and/or supplies that have not been rendered or for appointments that Members failed to keep.
- Billing for a covered service rather than the non-covered service that was rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Passport identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Misrepresentation of actual dates of service, or the member who received the service.
- Falsifying information in order to justify coverage of a service

Examples of Fraud, Waste, and Abuse by a Member

The types of questionable Member schemes investigated by Passport include, but are not limited to, the following:

- Benefit sharing with persons not entitled to the Member's benefits.
- Conspiracy to defraud Medicaid.
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.

- Forgery related to health care.
- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that they do not suffer from, and the Member sells the medication to someone else.

Cooperating with Special Investigation Unit Activities

The Special Investigation Unit may conduct prepayment, concurrent, or post-payment review. Providers will cooperate with Special Investigation Unit activities and will provide requested documentation to the unit following the timelines indicated in such requests. Failure to cooperate may result in further administrative action, up to and including termination of the Provider contract, and/or recovery of overpayment identified.

Review of Provider Claims and Claims System

Passport Claims Examiners are trained to recognize unusual billing practices, which are key in trying to identify fraud, waste, and abuse. If the Claims Examiner suspects fraudulent, abusive, or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance Alertline/reporting repository.

The Claims payment system utilizes system edits and flags to validate those elements of Claims are billed in accordance with standardized billing practices; ensure that Claims are processed accurately and ensure that payments reflect the service performed as authorized.

Passport performs auditing to ensure the accuracy of data input into the Claims system. The Claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected, and a thorough review of system edits is conducted to detect and locate the source of the errors

Provider Profiling

Passport by Molina Healthcare performs Claims audits to detect potential external health care fraud, waste, or abuse. These audits of Provider billings are based on objective and documented criteria. Passport uses a fraud, waste, and abuse detection software application designed to score and profile Provider and Member billing behavior and patterns. The software utilizes a fraud finder engine to identify various billing behaviors, billing patterns, known schemes, as well as unknown patterns by taking into consideration a Provider or Member's prior billing history. The software statistically identifies what is expected based on prior history and specialty norms, including recognition of pattern changes from those identified in profiled historical paid Claims data and ongoing daily Claims batches. If a score reaches a certain parameter or threshold, the Provider or Member is placed on a list for further review.

Passport will inform the Provider of the billing irregularities and request an explanation of the billing practices. The Compliance department, with the aid of the Special Investigation Unit, may conduct further investigation and take action as needed.

Prepayment Fraud, Waste, and Abuse Detection Activities

Through implementation of Claims edits, Passport's Claims payment system is designed to audit Claims concurrently, in order to detect and prevent paying Claims that are inappropriate.

Passport has a pre-payment Claims auditing process that identifies frequent correct coding billing errors ensuring that Claims are coded appropriately according to State and Federal coding guidelines. Code edits relationships and edits are based on guidelines from specific State Medicaid Guidelines, Centers for Medicare, and Medicaid Services (CMS), Federal CMS guidelines, AMA and published specialty specific coding rules. Code Edit Rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medical Medically Unlikely Edit table, the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/ National Coverage Determination (LCD/NCD) and State-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB). Additionally, Passport may, at the request of a state program or at its own discretion, subject a Provider to prepayment reviews whereupon Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided, or insufficient information is provided to substantiate a charge, the Claim will be denied until such time that the Provider can provide sufficient accurate support.

Post-payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Passport by Molina Healthcare under the Provider Agreement or at Law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Passport shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination there of.

Provider will provide Passport, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Passport, in Passport'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 Passport 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 Passport and without charge to Passport. In the event Passport identifies fraud, waste or abuse, Provider agrees to repay funds or Passport may seek recoupment.

If a Passport auditor is denied access to Provider's records, all of the Claims for which Provider received payment from Passport is immediately due and owing. If Provider fails to provide all requested documentation for any Claim, the entire amount of the paid Claim is immediately due and owing. Passport may offset such amounts against any amounts owed by Passport to Provider. Provider must comply with all requests for documentation and records timely (as reasonably requested by Passport) and without charge to Passport. Claims for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Passport, Provider is required to allow Passport to conduct audits of its pertinent records to verify the services performed and the payment Claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and

other applicable privacy Laws.

Claim Auditing

Passport shall use established industry Claims adjudication and/or clinical practices, State/ Commonwealth, and Federal guidelines, and/or Passport's policies and data to determine the appropriateness of the billing, coding, and payment.

Provider acknowledges Passport's right to conduct pre- and post-payment billing audits. Provider shall cooperate with Molina Healthcare Inc.'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 Passport's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in overpayment.

In reviewing medical records for a procedure, Passport may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims that Passport paid in error. The estimated proportion, or error rate, may be projected across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/ regulatory investigation and/or compliance reviews and may be vendor assisted. Passport asks that you provide Passport, or Passport's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If the Special Investigations Unit suspects that there is fraudulent or abusive activity, Passport may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Passport reserves the right to recover the full amount paid or due to you.

Provider Education

When Passport identifies through an audit or other means a situation with a Provider (e.g., coding, billing) that is either inappropriate or deficient, Passport may determine that a Provider education visit is appropriate.

Passport will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a corrective action plan (CAP) to Passport addressing the issues identified and how it will cure these issues moving forward.

Medical Records Submissions

In accordance with your contract with Passport by Molina Healthcare, which allows for the review of Claims, please submit **complete** medical records for all of the Members indicated for the dates of service provided. This includes, but is not limited to the following:

- Patient information sheets (completed by patient, parent, or guardian)
- Financial records including superbills, copayments, copies of identification cards, and patient intake forms
- Provider orders

- Diagnostic test results
- Referral/authorization requests and forms
- Physician progress notes
- Medication records
- Graphic reports
- Emergency room records
- History and physical notes
- Operative reports
- Lab requisitions and lab reports

Please photocopy each record. Make sure all copies are complete and legible and contain both sides of each page, including page edges. Complete copies should include specific records to support the services provided and be separated by patient in chronological order.

All records should be sent via a trackable manner (e.g., certified mail). Please return a copy of the records request letter with the medical records to the following address:

Molina Healthcare, Inc.
Attn: Special Investigation Unit 200
Oceangate, Suite 100 Long Beach, CA
90802

Molina Healthcare, Inc. must be in receipt of the requested document within 15 calendar days from the receipt of request. *Failure to submit requested documentation could result in the retrospective denial of Claims and other sanctions.*

HIPAA Requirements and Information

HIPAA (Health Insurance Portability and Accountability Act) Passport's

Commitment to Patient Privacy

Protecting the privacy of Members' personal health information is a core responsibility that Passport takes very seriously. Passport is committed to complying with all Federal and State Laws regarding the privacy and security of Members' protected health information (PHI).

Provider Responsibilities

Passport expects that its contracted Providers will respect the privacy of Passport Members (including Passport Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI. Passport provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Passport uses and discloses their PHI and includes a summary of how Passport safeguards their PHI.

Telehealth/Telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under State and Federal Law, including:

- 42 C.F.R. Part 2 regulations

- Health Information Technology for Economic and Clinical Health Act, ("HITECH Act")

Uses and Disclosure of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of services[2].
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
    a. Quality improvement
    b. Disease management
    c. Care management and care coordination
    d. Training Programs
    e. Accreditation, licensing, and credentialing

Importantly, this allows Providers to share PHI with Passport for our health care operations activities, such as HEDIS® and Quality Improvement.

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patient Records under 42 USC § 290dd-2 and 42 CFR Part 2 (collectively, "42 CFR Part 2") apply to any entity or individual providing federally assisted alcohol or drug abuse prevention treatment. "SUD Records" means PHI that includes substance use disorder treatment information that is protected under 42 CFR Part 2. Providers that are Part 2 Programs must comply with the requirements of 42 CFR Part 2, as amended from time to time.

SUD Records are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information,42 CFR Part 2 is more restrictive than HIPAA and does not allow disclosure without the patient's written consent except as set forth in 42 CFR Part 2. Any disclosure of SUD Records to Molina with the written consent of the patient, by a Provider that is a Part 2 Program, must meet the notice requirements of 42 CFR Part 2, and shall include a copy of the patient's consent or a clear explanation of the scope of the consent provided.

Providers that are Part 2 Programs pursuant to 42 CFR Part 2 must promptly inform Molina, in writing, that they are a Part 2 Program.

Inadvertent Disclosures of PHI

Passport may, on occasion, inadvertently misdirect or disclose PHI pertaining to Passport Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Passport Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction, and non-disclosure of any such misdirected PHI upon the reasonable request of Passport.

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[1]See, Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.
[2]See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable Law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable State Law.

Patient Rights

Patients are afforded various rights under HIPAA. Passport Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

1. **Notice of Privacy Practices**

   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. **Requests for Restrictions on Uses and Disclosures of PHI**

   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**

   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

4. **Requests for Patient Access to PHI**

   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.

5. **Request to Amend PHI**

   Patients have a right to request that the Provider amend information in their designated record set.

6. **Request Accounting of PHI Disclosures**

Patients may request an accounting of disclosures of PHI made by the Provider during the preceding 6-year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability and integrity of Passport Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cybersecurity measures. Providers should recognize that identity theft – both financial and medical – is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity – such as health insurance information – without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Passport.

HIPAA Transactions and Code Sets

Passport strongly supports the use of electronic transactions to streamline health care administrative activities. Passport Providers are encouraged to submit Claims and other transactions to Passport using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and Encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advices

Passport is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Passport's website at passporthealthplan.com for additional information regarding HIPAA standard transactions.

1. Click on the area titled "Health Care Professional"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets"

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions.

National Provider Identifier (NPI)

Providers must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Passport and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within thirty

(30) days and should also be reported to Passport within thirty (30) days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters submitted to Passport.

Additional Requirements for Delegated Providers and Atypical Providers

Providers that are delegated for Claims and Utilization Management activities ("Delegated Providers") are the "Business Associates" of Passport for the delegated functions performed on behalf of Molina. Providers that provide services to Members but who are not health care providers under HIPAA ("Atypical Providers") are the Business Associates of Passport. Under HIPAA, Passport must obtain contractual assurances from all Business Associates that they will safeguard Member PHI. Delegated Providers and Atypical Providers must agree to various contractual provisions required under HIPAA's Privacy and Security Rules, including entering into a Business Associate Agreement with Passport. Delegated and Atypical Providers agree to comply with the following HIPAA Business Associate Agreement requirements:

HIPAA Required Business Associate Agreement

Applicability: This HIPAA Required Business Associate Agreement ("BAA") sets forth the requirements with which the Business Associate must comply when it receives or has access to Protected Health Information ("PHI") in the performance of Services under the Agreement(s) and with respect to that PHI.

1. DEFINITIONS

Unless otherwise provided for in this BAA, terms used in this BAA shall have the same meanings as set forth in the HIPAA Rules including, but not limited to the following: "Availability," "Confidentiality," "Covered Entity," "Data Aggregation," "Designated Record Set," "Health Care Operations," "Integrity," "Minimum Necessary," "Notice of Privacy Practices," "Required By Law," "Secretary," and "Subcontractor." Specific definitions are as follows:

"Breach" shall have the same meaning as the term "breach" at 45 CFR 164.402.

"Business Associate" shall have the same meaning as the term "business associate" at 45 CFR 160.103 and in reference to the party to this BAA, shall mean the Provider subject to this BAA.

"Compliance Date" shall mean, in each case, the date by which compliance is required under the referenced provision of the HIPAA, the HITECH Act or the HIPAA Rules, as applicable; provided that, in any case for which that date occurs prior to the effective date of this BAA, the Compliance Date shall mean the effective date of this BAA.

"Covered Entity" or "Molina" shall mean Passport by Molina Healthcare.

"Electronic Protected Health Information" or "Electronic PHI" shall have the same meaning as the term "electronic protected health information" at 45 CFR 160.103.

"HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

"Party or Parties" shall mean Covered Entity and Business Associate who parties to this BAA.

"Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" at 45 CFR 160.103.

"Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

"Security Incident" shall have the same meaning as the term "security incident" at 45 CFR 164.304.

"Security Rule" means the Security Standards for the Protection of Electronic Protected Health Information, set forth at 45 CFR Parts 160 and 164.

"Services" shall mean, to the extent and only to the extent they involve the creation, use, maintenance, transmission, or disclosure of PHI, the services provided by the Business Associate to Molina under the Agreement(s), including those set forth in this BAA, as amended by written consent of the parties from time to time.

"SUD Records" means PHI that includes substance use disorder treatment information that is protected under 42 USC §290dd-2 and 42 CFR Part 2 (collectively, "42 CFR Part 2").

"Unsecured PHI" shall have the same meaning as the term "unsecured Protected Health Information" at 45 CFR 164.402.

2. GENERAL PROVISIONS

2.1 Effect. This BAA supersedes any prior business associate agreement between the Parties and those portions of any Agreement between the Parties that involve the disclosure of PHI by Molina to Business Associate. To the extent any conflict or inconsistency between this BAA and the terms and conditions of any Agreement exists, the terms of this BAA shall prevail.

2.2 Amendment. Molina may, without Business Associate's consent, amend this BAA to maintain consistency and/or compliance with any state or federal law, policy, directive, regulation, or government sponsored program requirement, upon forty-five (45) business days' notice to the Business Associate unless a shorter timeframe is necessary for compliance. Molina may otherwise materially amend this BAA only after forty-five (45) business days prior written notice to the Business Associate and only if mutually agreed to by the Parties as evidenced by the amendment being executed by each Party hereto. If the Parties fail to execute a mutually agreeable amendment within forty-five (45) days of the Business Associate's receipt of Molina's written notice to amend this BAA, Molina shall have the right to immediately terminate this BAA and any Agreement(s) between the Parties which may require the Business Associate's use or disclosure of PHI in performance of services described in such Agreement(s) on behalf of Molina.

3. SCOPE OF USE AND DISCLOSURE

3.1 The Business Associate may use or disclose PHI as required to provide Services and satisfy its obligations under the Agreement(s), if such use or disclosure of PHI would not violate the Privacy Rule.

3.2 The Business Associate may not use or further disclose PHI in a manner that would violate the Privacy Rule if done by Molina, except that the Business Associate may use or disclose PHI as necessary:

a. for the proper management and administration of the Business Associate as provided in Section 3.3;

and to provide Data Aggregation services relating to the Health Care Operations of Molina if required under the Agreement.

3.3 The Business Associate may use or disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Any disclosures of PHI under this section may be made only if:

a. the disclosures are required by law, or the Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

3.4 The Business Associate shall not request, use or release more than the Minimum Necessary amount of PHI required to accomplish the purpose of the use or disclosure and shall comply with 42 U.S.C. § 17935(b) as of its Compliance Date. The Business Associate hereby acknowledges that all PHI created or received from, or on behalf of, Molina, is as between the Parties, the sole property of Molina.

3.5 The Business Associate or its agents or Subcontractors shall not perform any work outside the United States of America that involves access to, use of, or disclosure of, PHI without the prior written consent of Molina in each instance. Further, the Business Associate or its agents or Subcontractors shall not transmit or store PHI outside of the United States of America without Molina's prior written consent.

3.6 The Business Associate agrees to be fully bound by the requirements of 42 CFR Part 2 upon receipt of any SUD Records disclosed under this Agreement. The Business Associate shall not use or disclose SUD Records except as necessary for the Business Associate to perform Services. The Business Associate shall not redisclose any SUD Records to a third party, except to a contract agent acting on the Business Associate's behalf to provide Services or back to Molina. The contract agent may only redisclose such information to the Business Associate or Molina. The Business Associate and any contract agent shall not disclose SUD Records for use in any civil, criminal, administrative or legislative proceeding against the individual who is the subject of the SUD Record and shall immediately notify Molina of any such request. The Business Associate must ensure that any such contract agent agrees in writing to these same restrictions and obligations set forth in this Section.

4. OBLIGATIONS OF THE BUSINESS ASSOCIATE

The Business Associate shall:

4.1 Not use or disclose PHI other than permitted or required by this BAA or as Required by Law.

4.2 Establish and use appropriate safeguards to prevent the unauthorized use or disclosure of PHI.

4.3 Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of Molina. The Business Associate shall, as of the Compliance Date, comply with the applicable standards at Subpart C of 45 CFR Part 164.

4.4 Promptly report to Molina any unauthorized use or disclosure of PHI, Breach of Unsecured PHI, or Security Incident, within no more than five (5) days, after Business Associate becomes aware of the unauthorized use or disclosure of PHI, Breach of Unsecured PHI or Security Incident. The Business Associate shall take all reasonable

steps to mitigate any harmful effects of such unauthorized use or disclosure, Breach of Unsecured PHI, or Security Incident. The Business Associate shall indemnify Molina against any losses, damages, expenses or other liabilities including reasonable attorney's fees incurred as a result of the Business Associate's or its agent's or Subcontractor's unauthorized use or disclosure of PHI, Breach of Unsecured PHI, or Security Incident, including, but not limited to, the costs of notifying individuals affected by a Breach of Unsecured PHI and the provision of two years of credit monitoring and identity protection services to the affected individuals. Indemnification is subject to an ability to demonstrate that no agency relationship exists between the parties.

4.5 The Business Associate shall, following discovery of a Breach of Unsecured PHI, notify Molina of such Breach as required at 45 CFR 164.410, without unreasonable delay, and in no event more than thirty (30) days after the discovery of the Breach. The notification by the Business Associate to Molina shall include: (1) the identification of each individual whose Unsecured PHI was accessed, acquired, used or disclosed during the Breach; and (2) any other available information that Molina is required to include in its notification to individuals affected by the Breach including, but not limited to, the following:

a. a brief description of what happened, including the date of the Breach and the date of the discovery of the Breach;

b. a description of the types of Unsecured PHI that were involved in the Breach; and

c. a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches.

4.6 In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any Subcontractors or agents that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.

4.7 Within ten (10) days of receiving a request, make available PHI in a Designated Record Set to Molina as necessary to satisfy Molina's obligations under 45 CFR 164.524.

4.8 Within fifteen (15) days of receiving a request, make any amendment(s) to PHI in a Designated Record Set as directed or agreed to by Molina pursuant to 45 CFR 164.526.

4.9 Maintain and make available to Molina, within twenty (20) days of receiving a request, the information required to provide an accounting of disclosures to the individual as necessary to satisfy Molina's obligations under 45 CFR 164.528.

4.10 Make its internal practices, books and records relating to the use or disclosure of PHI received from or on behalf of Molina available to Molina or the U. S. Secretary of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

4.11 To the extent the Business Associate conducts Standard Transaction(s) (as defined in the HIPAA Rules) on behalf of Molina, Business Associate shall comply with the HIPAA Rules, "Administrative Requirements," 45 C.F.R. Part 162, by the applicable compliance date(s) and shall not: (a) change the definition, data condition or use of a data element or segment in a standard; (b) add any data elements or segments to the maximum defined data set; (c) use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s); or (d) change the meaning or intent of the standard's implementation specifications. The Business Associate shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate

documentation of such compliance) under subsection (h) of Title 42 U.S.C. Section 1320d-2.

4.12 To the extent the Business Associate is to carry out one or more of Molina's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to Molina in the performance of such obligation(s).

5. MISCELLANEOUS

5.1 Indemnification. In addition to any indemnities set forth in the Agreement(s), each party will indemnify and defend the other party from and against any and all claims, losses, damages, expenses or other liabilities, including reasonable attorney's fees, incurred as a result of any breach by such party of any representation, warranty, covenant, agreement or other obligation expressly contained herein by such party, its employees, agents, Subcontractors or other representatives.

5.2 Interpretation. Any ambiguity in this BAA shall be interpreted to permit compliance with the HIPAA Rules.

5.3 No Third Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

5.4 Governing Law and Venue. This BAA shall be governed by Kentucky law notwithstanding any conflicts of law provisions to the contrary. The venue shall be the jurisdiction where the applicable services were received by Molina.

5.5 Compliance with Confidentiality Laws. The Business Associate acknowledges that it must comply with all applicable laws that may protect the confidentiality of PHI or other personally identifiable information received and will comply with all such laws.

5.6 Notices. Any notices to be given hereunder to Molina shall be made via certified U.S. Mail or express courier to Molina's address given below, and/or (other than for the delivery of fees) via email to the email listed below:

Molina Healthcare, Inc.

200 Oceangate Blvd., Suite 100

Long Beach, CA 90802

Attn: Privacy Official

Email: PrivacyOfficial@MolinaHealthcare.com

6. TERM AND TERMINATION OF BAA

6.1 Term. The Term of this BAA shall be effective as of the effective date set forth in the first paragraph of this BAA, and shall terminate on date that the last Agreement remaining in force between the parties is terminated or expires, or on the date Molina terminates for cause as authorized in paragraph 6.2 below, whichever is sooner.

6.2 Termination for Cause. Notwithstanding any other provision of this BAA or the Agreement(s), Molina may terminate this BAA and any or all Agreement(s) upon five (5) days written notice to Business Associate if Molina

determines, in its sole discretion, that Business Associate has violated a material term of this BAA.

6.3 Obligations of Business Associate Upon Termination. Upon termination of this BAA for any reason, Business Associate shall return to Molina or, if agreed to by Molina, destroy all PHI received from Molina, or created, maintained, or received by Business Associate on behalf of Molina, that the Business Associate still maintains in any form. If PHI is destroyed, Business Associate agrees to provide Molina with certification of such destruction. Business Associate shall not retain any copies of PHI except as Required by Law. If return or destruction of all PHI, and all copies of PHI, received from Molina, or created, maintained, or received by Business Associate on behalf of Molina, is not feasible, Business Associate shall:

a. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section 6, for as long as Business Associate retains the PHI; and

b. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set forth in Section 3 above which applied prior to termination.

6.4 Survival. The obligations of Business Associate under this Section shall survive the termination of this BAA and remain in force as long as Business Associate stores or maintains PHI in any form or format (including archival data). Termination of the BAA shall not affect any of the provisions of this BAA that, by wording or nature, are intended to remain effective and to continue in operation.

Reimbursement for Copies of PHI

Passport does not reimburse Providers for copies of PHI related to our Members. These requests may include, although are not limited to, the following purposes:

- Utilization Management.
- Care Coordination and/or Complex Medical Care Management Services
- Claims Review
- Resolution of an Appeal and/Grievance
- Anti-Fraud Program Review
- Quality of Care Issues
- Regulatory Audits
- Risk Adjustment
- Treatment, Payment and/or Operation Purposes
- Collection of HEDIS® medical records

Information Security and Cybersecurity

NOTE: This section (Information Security and Cybersecurity) is only applicable to Providers who have been delegated by Passport to perform a health plan function(s), and in connection with such delegated functions.

1. Definitions:
   a. "Passport Information" means any information: (i) provided by Passport to Provider; (ii) accessed by Provider or available to Provider on Passport's Information Systems; or

(iii) any information with respect to Passport or any of its consumers developed by Provider or other third parties in Provider's possession, including without limitation any Passport Nonpublic Information.

b. "Cybersecurity Event" means any actual or reasonably suspected contamination, penetration, unauthorized access or acquisition, or other breach of confidentiality, data integrity or security compromise of a network or server resulting in the known or reasonably suspected accidental, unauthorized, or unlawful destruction, loss, alteration, use, disclosure of, or access to Passport Information. For clarity, a Breach or Security Incident as these terms are defined under HIPAA constitute a Cybersecurity Event for the purpose of this section. Unsuccessful security incidents, which are activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, do not constitute a Cybersecurity Event under this definition so long as no such incident results in or is reasonably suspected to have resulted in unauthorized access, use, acquisition, or disclosure of Passport Information, or sustained interruption of service obligations to Passport.

c. "HIPAA" means the Health Insurance Portability and Accountability Act, as may be amended from time to time.

d. "HITECH" means the Health Information Technology for Economic and Clinical Health Act, as may be amended from time to time.

e. "Industry Standards" mean as applicable, codes, guidance (from regulatory and advisory bodies, whether mandatory or not), international and national standards, relating to security of network and information systems and security breach and incident reporting requirements, all as amended or updated from time to time, and including but not limited to the current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:

   i. HIPAA and HITECH
   ii. HITRUST Common Security Framework
   iii. Center for Internet Security
   iv. National Institute for Standards and Technology ("NIST") Special Publications 800.53 Rev.5 and 800.171 Rev. 1, or as currently revised
   v. Federal Information Security Management Act ("FISMA")
   vi. ISO/ IEC 27001
   vii. Federal Risk and Authorization Management Program ("FedRamp")
   viii. NIST Special Publication 800-34 Revision 1 – "Contingency Planning Guide for Federal Information Systems."
   ix. International Organization for Standardization (ISO) 22301 – "Societal security – Business continuity management systems – Requirements."

f. "Information Systems" means all computer hardware, databases and data storage systems, computer, data, database and communications networks (other than the Internet), cloud platform, architecture interfaces and firewalls (whether for data, voice, video or other media access, transmission or reception) and other apparatus used to create, store, transmit, exchange or receive information in any form.

g. "Multi-Factor Authentication" means authentication through verification of at least two of the following types of authentication factors: (1) knowledge factors, such as a

password; (2) possession factors, such as a token or text message on a mobile phone; (3) inherence factors, such as a biometric characteristic; or (4) any other industry standard and commercially accepted authentication factors.

h. "Nonpublic Information" includes:
   i. Passport's proprietary and/or confidential information;
   ii. .Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, "nonpublic personal information", "personal data", "personally identifiable information", "personal information" or any other similar term as defined pursuant to any applicable law; and
   iii. Protected Health Information as defined under HIPAA and HITECH.

2. Information Security and Cybersecurity Measures. Provider shall implement, and at all times maintain, appropriate administrative, technical, and physical measures to protect and secure the Information Systems, as well as Nonpublic Information stored thereon, and Passport Information that are accessible to, or held by, Provider. Such measures shall conform to generally recognized industry standards and best practices and shall comply with applicable privacy and data security laws, including implementing and maintaining administrative, technical, and physical safeguards pursuant to HIPAA, HITECH, and other applicable U.S. federal, state, and local laws.
   a. Policies, Procedures, and Practices. Provider must have policies, procedures and practices that address its information security and cybersecurity measures, safeguards, and standards, including as applicable, a written information security program, which Passport shall be permitted to audit via written request, and which shall include at least the following:
      i. Access Controls. Access controls, including Multi-Factor Authentication, to limit access to the Information Systems and Passport Information accessible to or held by Provider.
      ii. Encryption. Use of encryption to protect Passport Information, in transit and at rest, accessible to or held by Provider.
      iii. Security. Safeguarding the security of the Information Systems and Passport Information accessible to or held by Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, regular (three or more annually) third party vulnerability assessments,

      physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene.
      iv. Software Maintenance. Software maintenance, support, updates, upgrades, third party software components and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable Industry Standards.
   b. Technical Standards. Provider shall comply with the following requirements and technical standards related to network and data security:
      i. Network Security. Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include, but are not limited to, the applicable Industry Standards.
      ii. Cloud Services Security: If Provider employs cloud technologies, including infrastructure as a service (IaaS), software as a service (SaaS) or platform as a

service (PaaS), for any services, Provider shall adopt a "zero-trust architecture" satisfying the requirements described in NIST 800-207 (or any successor cybersecurity framework thereof).

iii. Data Storage. Provider agrees that any and all Passport Information will be stored, processed, and maintained solely on designated target servers or cloud resources. No Passport Information at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Provider's designated backup and recovery processes and is encrypted in accordance with the requirements set forth herein.

iv. Data Encryption. Provider agrees to store all Passport Information as part of its designated backup and recovery processes in encrypted form, using a commercially supported encryption solution. Provider further agrees that any and all Passport Information, stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption, and the Federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2").

v. Data Transmission. Provider agrees that any and all electronic transmission or exchange of system and application data with Passport and/or any other parties expressly designated by Passport shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with FIPS PUB 140-2 and the Data Re-Use requirements set forth herein.

vi. Data Re-Use. Provider agrees that any and all Passport Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement and this section. Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Provider. Provider further agrees that no Passport Information or data of any kind shall be transmitted, exchanged, or otherwise passed to other affiliates, contractors or interested parties, except on a case-by-case basis as specifically agreed to in advance and in writing by Passport

3. Business Continuity ("BC") and Disaster Recovery ("DR"). Provider shall have documented procedures in place to ensure continuity of Provider's business operations, including disaster recovery, in the event of an incident that has the potential to impact, degrade, or disrupt Provider's delivery of services to Passport.
   a. Resilience Questionnaire. Provider shall complete a questionnaire provided by Passport to establish Provider's resilience capabilities.
   b. BC/DR Plan.
      i. Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format ("BC/DR Plan"). The BC/DR Plan shall identify the service level agreement(s) established between Provider and Passport. The BC/DR Plan shall include the following:
         a. Notification, escalation and declaration procedures.
         b. Roles, responsibilities and contact lists.
         c. All Information Systems that support services provided to Passport.

d. Detailed recovery procedures in the event of the loss of people, processes, technology and/or third-parties or any combination thereof providing services to Passport.
e. Recovery procedures in connection with a Cybersecurity Event, including ransomware.
f. Detailed list of resources to recover services to Passport including but not limited to: applications, systems, vital records, locations, personnel, vendors, and other dependencies.
g. Detailed procedures to restore services from a Cybersecurity Event including ransomware.
h. Documented risk assessment which shall address and evaluate the probability and impact of risks to the organization and services provided to Passport. Such risk assessment shall evaluate natural, man-made, political and cybersecurity incidents.

ii. To the extent that Passport Information is held by Provider, Provider shall maintain backups of such Passport Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.
iii. Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.

c. Notification. Provider shall notify Passport's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed twenty-four (24) hours, of either of the following:

i. Provider's discovery of any potentially disruptive incident that may impact or interfere with the delivery of services to Passport or that detrimentally affects Provider's Information Systems or Passport's Information.
ii. Provider's activation of business continuity plans. Provider shall provide Passport with regular updates by telephone or email (provided herein) on the situation and actions taken to resolve the issue, until normal services have been resumed.

d. BC and DR Testing. For services provided to Passport, Provider shall exercise its BC/DR Plan at least once each calendar year. Provider shall exercise its cybersecurity recovery procedures at least once each calendar year. At the conclusion of the exercise, Provider shall provide Passport a written report in electronic format upon request. At a minimum, the written report shall include the date of the test(s), objectives, participants, a description of activities performed, results of the activities, corrective actions identified, and modifications to plans based on results of the exercise(s).

4. Cybersecurity Events.

a. Provider agrees to comply with all applicable data protection and privacy laws and regulations. Provider will implement best practices for incident management to identify, contain, respond to, and resolve Cybersecurity Events.
b. In the event of a Cybersecurity Event that threatens or affects Passport's Information Systems (in connection with Provider having access to such Information Systems); Provider's Information Systems; or Passport Information accessible to or held by Provider, Provider shall notify Passport's Chief Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as

promptly as possible, but in no event later than twenty-four (24) hours from Provider's discovery of the Cybersecurity Event.

i. In the event that Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve Passport Information, Provider shall notify Passport's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within twenty-four (24) hours following such payment.

ii. Within fifteen (15) days of such a ransom payment that involves or may involve Passport Information, Provider shall provide a written description of the reasons for which the payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment, and evidence of all due diligence and sanctions checks performed in compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.

c. Notification to Passport's Chief Information Security Officer shall be provided to: Passport Chief Information Security Officer

Telephone: 844-821-1942
Email: CyberIncidentReporting@molinahealthcare.com
Passport Chief Information Security Officer
Passport by Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

d. In the event of a Cybersecurity Event, Provider will, at Passport's request, (i) fully cooperate with any investigation concerning the Cybersecurity Event by Passport,(ii) fully cooperate with Passport to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers, and (iii) be liable for any expenses associated with the Cybersecurity Event including without limitation: (a) the cost of any required legal compliance (e.g., notices required by applicable law), and (b) the cost of providing two years of credit monitoring services or other assistance to affected consumers. In no event will Provider serve any notice of or otherwise publicize a Cybersecurity Event involving Passport Information without the prior written consent of Passport.

e. Following notification of a Cybersecurity Event, Provider must promptly provide Passport any documentation requested by Passport to complete an investigation, or, upon request by Passport, complete an investigation pursuant to the following requirements:

i. make a determination as to whether a Cybersecurity Event occurred;

ii. assess the nature and scope of the Cybersecurity Event;

iii. identify Passport's Information that may have been involved in the Cybersecurity Event; and

iv. perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of Passport Information.

f. Provider must provide Passport the following required information regarding a Cybersecurity Event in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Passport concerning the Cybersecurity Event. The information provided to Passport must include at least the following, to the extent known:

i. the date of the Cybersecurity Event;
ii. a description of how the information was exposed, lost, stolen, or breached;
iii. how the Cybersecurity Event was discovered;
iv. whether any lost, stolen, or breached information has been recovered and if so, how this was done;
v. the identity of the source of the Cybersecurity Event;
vi. whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
vii. a description of the specific types of information accessed or acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the consumer;
viii. the period during which the Information System was compromised by the Cybersecurity Event;
ix. the number of total consumers in each State affected by the Cybersecurity Event;
x. the results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;
xi. a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur; a copy of Provider's privacy policy and a statement outlining the steps Provider will take to investigate and if requested by Passport, the steps that Provider will take to notify consumers affected by the Cybersecurity Event; and the name of a contact person who is familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

g. Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon Passport's request.

5. Right to Conduct Assessments; Provider Warranty. Provider agrees to fully cooperate with any security risk assessments performed by Passport and/or any designated representative or vendor of Passport. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments. If Passport performs a due diligence/security risk assessment of Provider, Provider (i) warrants that the services provided pursuant to the Provider Agreement will be in compliance with generally recognized industry standards and as provided in Provider's response to Passport's due diligence/security risk assessment questionnaire; (ii) agrees to inform Passport promptly of any material variation in operations from what was provided in Provider's response to Passport's due diligence/security risk assessment; and (iii) agrees that any material deficiency in operations from those as described in the Provider's response to Passport's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider Agreement.
6. Other Provisions. Provider acknowledges that there may be other information security and data protection requirements applicable to Provider in the performance of services which may be addressed in an agreement between Passport and Provider but are not contained in this section.

7. Conflicting Provisions. In the event of any conflict between the provisions of this section and any other agreement between Passport and Provider, the stricter of the conflicting provisions will control.

11. Claims and Compensation

Payer ID	61325
Availity Essentials Portal	Availity.com
Clean Claim Timely Filling	CMS-1500: 365 calendar days from date of service UB-04: 365 calendar days after the discharge for inpatient services or the Date of Service for outpatient services

Electronic Claims Submission

Passport strongly encourages participating Providers to submit Claims electronically, including secondary Claims. Electronic Claims submission provides significant benefits to the Provider including:

- Helps to reduce operation costs associated with paper Claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces Claim delays since errors can be corrected and resubmitted electronically.
- Eliminates mailing time and Claims reach Passport faster.

Passport offers the following electronic Claims submission options:

- Submit Claims directly to Passport via the Availity Essentials Portal.
- Submit Claims to Passport via your regular EDI clearinghouse.

Availity Essentials Portal

The Availity Essentials Portal is a no cost online platform that offers a number of Claims processing features:

- Submit Professional (CMS1500) and Institutional (CMS-1450 [UB04]) Claims with attached files.
- Correct/Void Claims.
- Check Claims status.
- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP).
- Create and manage Claim Templates.
- Create and submit a Claim Appeal with attached files.
- Manage overpayment invoices (Inquire, Dispute, and Resolve)

Clearinghouse

Passport uses Change Healthcare as its gateway clearinghouse. Change Healthcare has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse

If you do not have a clearinghouse, Passport offers additional electronic claims submissions options as shown by logging onto the Availity Essentials portal.
Passport accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports ensure Claims are received for processing in a timely manner.
When your claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgment from your clearinghouse
- You should also receive a 277CA response file with initial status of the claims from your clearinghouse
- You should refer to the Passport Companion Guide for information on the response format and messages
- You should contact your local clearinghouse representative if you experience any problems with your transmission

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider should contact their Provider Services Representative for additional support.

Timely Claim Filing

Providers shall promptly submit to Passport Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Passport and shall include all medical records pertaining to the Claim if requested by Passport or otherwise required by Passport's policies and procedures. Claims must be submitted by Provider to Passport within 365 calendar days after the discharge for inpatient services or the Date of Service for outpatient services unless otherwise specified in a provider's contract. If Passport is not the primary payer under coordination of benefits or third-party liability, Provider must submit Claims to Passport within 365 calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Passport within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

There are exceptions to the timely filing requirements. These include:

- In cases of retro-eligibility assignment, another MCO recoupment letter
- For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date of the primary EOB

The following items are not acceptable as evidence of timely submission:

- Claim front-end rejections are not considered clean claims
- A copy of the Provider's billing screen

Claim Submission

Participating Providers are required to submit Claims to Passport with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines, as well as any criteria explicitly required in the Provider Billing Manual as well as any criteria explicitly required in the Claim Form Instructions. Providers must utilize electronic billing though a clearinghouse or the Availity Essentials Portal whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims,

837P for professional Claims, and 837D for dental Claims). For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim submission instructions on the Member's Passport ID card.

Providers must bill Passport for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility Claims, the date of discharge.

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Passport as soon as possible, not to exceed 30 calendar days from the change.

Required Elements

Electronic submitters should use the Implementation Guide and Passport Companion Guide for format and code set information when submitting or receiving files directly with Passport. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state-specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Passport website under EDI>Companion Guides for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate State from the dropdown list on the top of the page. In addition to the Passport Companion Guide, it is also necessary to use the State Health Plan specific companion guides, which are also available on our Passport website for your convenience (remember to choose the appropriate state from the drop-down list).

Electronic Claim submissions will adhere to specifications for submitting medical Claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5.

The following information must be included on every Claim, whether electronic or paper:

- Member name, date of birth and Member ID number.
- Member's gender.
- Member's address.
- Date(s) of service.
- Valid International Classification of Diseases diagnosis and procedure codes.
- Valid revenue, CPT or HCPCS for services or items provided.
- Valid Diagnosis Pointers.
- Total billed charges.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification number (TIN).
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API).
- 10-digit National Provider Identifier (NPI) of the Billing Provider or Group.
- Rendering Provider information when different than billing.
- Billing/Pay-to Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.

- National Drug Code (NDC), unit of measure and quantity for medical injectables
- E-signature.
- Service Facility Location information.
- Any other state-required data

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of Claims submission. This validation will apply to all Provider data submitted and applied to atypical and out-of-state Providers.

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the Claim. Please refer to any criteria explicitly required in the Provider Billing Manual as well as any criteria required in the claim form instructions.

EDI (Clearinghouse) Submission

Corrected Claim information submitted via EDI submission is required to follow electronic Claim standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 7. The 837 Claim format allows you to submit changes to Claims that were not included on the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called "Claim frequency codes." Using the appropriate code, you can indicate that the Claim is an adjustment of a previously submitted finalized Claim. Use the below frequency codes for Claims that were previously adjudicated.

Claims Frequency Code	Description	Action
7	Use to replace an entire Claim	Passport will adjust the original Claim. The corrections submitted represent a complete replacement of the previously processed Claim
8	Use to eliminate a previously submitted Claim.	Passport will void the original Claim from records based on request.

When submitting Claims noted with Claim frequency code 7 or 8, the original Claim number, must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original Claim number can be obtained from the 835 Electronic Remittance Advice (ERA). Without the original Claim number, adjustment requests will generate a compliance error, and the Claim will reject.

Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original Claim number will not be adjusted.

Paper Claim Submissions

Participating Providers should submit Claims electronically. If electronic Claim submission is not possible, please submit paper Claims to the following address:

Passport by Molina Healthcare
PO Box 36090
Louisville, KY 40233

Please keep the following in mind when submitting paper Claims:

- Paper Claim submissions are not considered to be "accepted" until received at the appropriate Claims P.Oo Box; Claims received outside of the designated PO Box will be returned for appropriate submission
- Paper Claims are required to be submitted on original red and white CMS-1500 Claim forms.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.
- Claims must be typed with either 10- or 12-point Times New Roman font, using black ink
- Link to paper Claims submission guidance from CMS: cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500

Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms. The descriptions of each field for a CMS-1500.

Passport strongly encourages participating Providers to submit Corrected Claims electronically via EDI or the Availity Essentials Portal.

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 Claim form (paper Claims).
- Claim number being corrected must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper Claim, or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

Note: The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for CMS-1500 Claim forms or the UB Editor (Uniform Billing Editor) for CMS-1450 (UB-04) Claim forms.

Corrected Claims must be sent within **365 calendar days** of the date of service of the Claim.

Corrected Claims submission options:

- Submit Corrected Claims directly to Passport via the Availity Essentials portal
- Submit Corrected Claims to Passport via your regular EDI clearinghouse

Claims Denied for Missing Additional Documentation

Claims denied for missing or additional documentation requirements such as consent forms, invoices, explanation of benefits from other carriers, or itemized bills are not considered claim appeals. To process your claim, these documents, along with a claim, must be received by the claims department within timely filing requirements. Do not include a provider appeal form with a claim submission. Please mail claims denied for missing or additional documentation to:

KY Medicaid Claims
Passport by Molina Healthcare
PO Box 36090
Louisville, KY 40233

KY Marketplace Claims
Passport by Molina Healthcare
PO Box 43433
Louisville, KY 40253

Coordination of Benefits (COB) and Third-Party Liability (TPL)

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, or self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the Member.

COB

Medicaid is always the payer of last resort, and Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Passport Members. If third party liability can be established, Providers must bill the primary payer and submit a primary explanation of benefits (EOB) to Passport for secondary Claim processing. In the event that coordination of benefits occurs; Provider shall be reimbursed based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOB and other required documents. Passport will pay claims for prenatal care and preventive pediatric care (EPSDT) and then seek reimbursement from third parties. If services and payment have been rendered prior to establishing third party liability, an overpayment notification letter will be sent to the Provider requesting a refund including third party policy information required for billing.

TPL

Subrogation - Passport retains the right to recover benefits paid for a Member’s health care services when a third party is responsible for the Member’s injury or illness to the extent permitted under State and Federal law and the Member’s benefit plan. If third party liability is suspected or known, please refer pertinent case information to Passport's vendor at:

- Katch IQ, at submitreferrals@katchiq.com

Hospital-Acquired Conditions (HAC) and Present on Admission Program (POA)

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a

hospital stay that could have been reasonably prevented by the use of evidenced-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting".
The following is a list of CMS Hospital Acquired Conditions. CMS reduces payment for hospitalizations complicated by these categories of conditions that were not Present on Admission:

1) Foreign Object Retained After Surgery
2) Air Embolism
3) Blood Incompatibility
4) Stage III and IV Pressure Ulcers
5) Falls and Trauma
    a) Fractures
    b) Dislocations
    c) Intracranial Injuries
    d) Crushing Injuries
    e) Burn
    f) Other Injuries
6) Manifestations of Poor Glycemic Control
    a) Hypoglycemic Coma
    b) Diabetic Ketoacidosis
    c) Non-Ketotic Hyperosmolar Coma
    d) Secondary Diabetes with Ketoacidosis
    e) Secondary Diabetes with Hyperosmolarity
7) Catheter-Associated Urinary Tract Infection (UTI)
8) Vascular Catheter-Associated Infection
9) Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10) Surgical Site Infection Following Certain Orthopedic Procedures:
    a) Spine
    b) Neck
    c) Shoulder
    d) Elbow
11) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
    a) Laparoscopic Gastric Restrictive Surgery
    b) Laparoscopic Gastric Bypass
    c) Gastroenterostomy
12) Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13) Latrogenic Pneumothorax with Venous Catheterization
14) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a) Total Knee Replacement
    b) Hip Replacement

What this means to Providers

- Acute IPPS Hospital Claims will be returned with no payment if the POA indicator is coded incorrectly or missing; and,
- No additional payment will be made on IPPS hospital Claims for conditions that are acquired during the patient's hospitalization.

If you would like to find out more information regarding the Medicare HAC/POA program, including billing

requirements, the following CMS site provides further information: cms.hhs.gov/HospitalAcqCond/

Passport Coding Policies and Payment Policies

Frequently requested information on Passport's Coding Policies and Payment Policies is available on Passporthealthplan.com website under the Policies tab. Questions can be directed to your Provider Services representative.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate Claims. Passport requires coding of both diagnoses and procedures for all Claims as follows:

- For diagnoses, the required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM.
- For procedures:
  - Professional and outpatient Claims require the Healthcare Common Procedure Coding System, Current Procedural Terminology Level 1 (CPT codes), Level 2 and 3 Healthcare Common Procedure Coding System (HCPCS codes)
  - Inpatient hospital Claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System).

Furthermore, Passport requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

Passport utilizes a Claims adjudication system that encompasses edits and audits that follow State and Federal requirements as well as administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
  - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUEs). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Passport will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit the professional organization standard may be used.
  - In the absence of State guidance, Medicare National Coverage Determinations (NCDs).
  - In the absence of State guidance, Medicare Local Coverage Determinations (LCDs).
  - CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific Claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Passport policies based on the appropriateness of health care and Medical Necessity.
- Payment policies published by Passport.

Lesser of Logic

Unless otherwise specific in writing, it is Passport's policy to reimburse providers the lesser of the billed charges or the contracted reimbursement rate for all services and payment methodologies, including but not limited to bundled services, fee schedule-based services, drugs, and per diems.

Telehealth Claims and Billing

Providers must follow CMS guidelines as well as State-level requirements.

All telehealth Claims for Passport Members must be submitted to Passport with correct codes for the plan type in accordance with applicable billing guidelines. For guidance, please refer to Passport's Telemedicine, Telehealth Services and Virtual Visits policies as outlined below:

- 907 KAR 3:170 Telehealth Services coverage and Reimbursement
- KY PHE Flexibilities Tracker April 2023
- 900 KAR 12:005 Telehealth Terminology and Requirements

Telehealth services are reimbursable if they are appropriate and safe to be delivered by the technology used and not prohibited by the Provider's licensing board. All telehealth Claims for Passport Members must be submitted to Passport with correct codes for the plan type in accordance with applicable billing guidelines.

For additional guidance, please refer to the resources located under the Telehealth Program, 907 KAR 3:170 Telehealth Services Coverage and Reimbursement.

National Correct Coding Initiative (NCCI)

CMS has directed all Federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act. Passport uses NCCI standard payment methodologies.

NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUEs) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General Coding Requirements

Correct coding is required to properly process Claims. Passport requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CPT and HCPCS Codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely

reimbursement, codes must be effective on the date of service (DOS) for which the procedure or service was rendered and not the date of submission.

Modifiers

Modifiers consist of two (2) alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component.
- Service or procedure has a technical component.
- Service or procedure was performed by more than one physician.
- Unilateral procedure was performed.
- Bilateral procedure was performed.
- Service or procedure was provided more than once.
- Only part of a service was performed.

For a complete listing of modifiers and their appropriate use, consult the AMA CPT and the HCPCS code books.

ICD-10-CM/PCS Codes

Passport utilizes International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules and will deny Claims that do not meet Passport's ICD-10 Claim Submission Guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes

Place of Service Codes (POS) are two-digit codes placed on health care professional Claims (CMS 1500) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS for the procedure/ service on that line.

Type of Bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC's) Official CMS-1450 (UB-04) Data Specifications Manual.

Revenue Codes

Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official CMS-1450 (UB-04) Data Specifications Manual.

Diagnosis Related Group (DRG)

Facilities contracted to use DRG payment methodology to submit Claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate Claim payment.

Passport processes DRG Claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Passport-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the Claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

National Drug Code (NDC)

The National Drug Code number (NDC) must be reported on all professional and outpatient Claims when submitted on the CMS-1500 Claim form, CMS-1450 (UB-04) or its electronic equivalent.

Providers will need to submit Claims with both HCPCS and NDC codes with the exact NDC that appears on the medication packaging in the 5-4-2 digit format (i.e., xxxxx-xxxx-xx) as well as the NDC units and descriptors. Claims submitted without the NDC number will be denied.

Coding Sources

Definitions

CPT – Current Procedural Terminology 4th Edition; an American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

HCPCS – HealthCare Common Procedural Coding System; a CMS maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM – International Classification of Diseases, 10th revision, Clinical Modification.

ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

ICD-10-PCS - International Classification of Diseases, 10th revision, Procedure Coding System used to report procedures for inpatient hospital services.

Claim Auditing

Passport shall use established industry Claims adjudication and/or clinical practices, State/ Commonwealth and Federal guidelines, and/or Passport's policies and data to determine the appropriateness of the billing, coding, and payment. Provider acknowledges Passport's right to conduct pre- and post-payment billing audits. Provider shall cooperate with Molina Healthcare Inc.'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 Passport's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.
In reviewing medical records for a procedure, Passport may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This sample gives an estimate of the proportion of Claims Passport paid in error. The estimated proportion, or error rate, may be projected across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/ regulatory investigation and/or compliance reviews and may be vendor assisted. Passport asks that you provide Passport, or Passport's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Passport's Special Investigations Unit suspects that there is fraudulent or abusive activity, we may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Passport reserves the right to recover the full amount paid or due to you.

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Passport or contracted medical group/IPA have agreed in writing to an alternate schedule, Passport will process the Claim for service within 30 days after receipt of Clean Claims.

The receipt date of a Claim is the date Passport receives notice of the claim.

Electronic Claim Payment

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs, and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Passport uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery.

Additional information about EFT/ERA is available at passporthealthplan.com or by contacting our Provider Services Department.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of Claim payment, Passport determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment. Providers will receive an overpayment request letter if the overpayment is identified in accordance with State and CMS guidelines. Providers will be given the option to either:

1. Submit a refund to satisfy overpayment,
2. Submit request to offset from future claim payments, or
3. Dispute overpayment findings.

A copy of the overpayment request letter and details are available in the Availity Essential Portal. In the Overpayment Application section, Providers can make an inquiry, contest, and overpayment with supporting documentation, resolve and overpayment, or check status. This is Passport's preferred method of communication.

Instructions will be provided on the overpayment notice and overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are Passport standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the policy number, effective date, term date, and subscriber information. For members with Commercial COB, Passport will pursue reclamation billing for identified overpayments if the primary insurer is a Commercial payer, in which Passport will seek reimbursement of funds directly from the primary payer. Providers will not receive an overpayment request letter in these scenarios pursuant to state guidelines for commercial recoveries. For members with Medicare COB Passport will provide notice within 540 days from the claim's paid date if the primary insurer is a Medicare plan. A provider may resubmit the claim with an attached primary EOB after submission to the primary payer for payment. Passport will adjudicate the claim and pay or deny the claim in accordance with claim processing guidelines.

A Provider shall pay a Claim for an Overpayment made by Passport which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider. If a Provider does not repay or dispute the overpaid amount within the timeframe allowed Passport may offset the overpayment amount(s) against future payments made to the Provider.

Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Passport, or the date that the Provider receives a payment from Passport that reduces or deducts the overpayment.

Claim Disputes/Reconsiderations/Appeals

Information on Claim Disputes/Reconsiderations/Appeals is located in the Appeals and Grievances section of this Provider Manual.

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Passport to the Provider. Balance billing a Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance, and deductible amounts.

Fraud, Waste, and Abuse

Failure to report instances of suspected fraud, waste, and abuse is a violation of the Law and subject to the penalties provided by Law. Please refer to the Compliance section of this Provider Manual for more information.

Encounter Data

Each Provider, capitated Provider or organization delegated for Claims processing is required to submit

Encounter data to Passport for all adjudicated Claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted at least weekly, and within 30 days from the date of service in order to meet Commonwealth and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N837I – Institutional, 837P – Professional, and 837D – Dental. Data must be submitted with Claims level detail for all noninstitutional services provided.

Passport has a comprehensive automated and integrated Encounter data system capable of supporting all 837 file formats and proprietary formats if needed.

Providers must correct and resubmit any encounters which are rejected (non-HIPAA compliant) or denied by Passport. Encounters must be corrected and resubmitted within fifteen (15) days from the rejection/denial.
Passport has created 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

When Encounters are filed electronically Providers should receive two (2) types of responses:

- First, Passport will provide a 999 acknowledgement of the transmission.
- Second, Passport will provide a 277CA response file for each transaction.

12. Complaints, Grievance and Appeals Process

Definitions

Adverse Benefit Action- also known as, Adverse Benefit Determination. As defined in 42 C.F.R. 438.400(b), is:

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting or effectiveness of a covered benefit
- Reduction, suspension, or termination of a service previously authorized by the Department, its agent or Passport
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner, as defined by Department
- Failure of Passport by Molina Healthcare or a Prepaid Health Insurance Plan (PHIP) to act within the time frames required by 42 CFR 438.408(b)
- For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 42CFR 438.52(b)(2)(ii), to obtain services outside Passport's network or
- Denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

Appeal - A request for review of an Adverse Benefit Action or a decision by or on behalf of Passport by Molina Healthcare related to the Covered Services provided, or the payment for the service.

Authorization - An approval of a Prior Authorization request for payment of services and is provided only after Passport by Molina Healthcare agrees the treatment is necessary.

Department - Department for Medicaid Services (DMS).

Member Grievance - Any expression of dissatisfaction about us or the way we operate, as defined in C.F.R. 438.400

Provider Appeal – A provider's post service appeal to review a Utilization Management authorization denial

Provider Claim Appeal – A provider's appeal to review a claim denial or the amount of reimbursement

Provider Grievance – An expression of dissatisfaction about matters other than an adverse benefit determination

Member Grievance Process

A Member or Member's representative, including the legal guardian of a minor Member or incapacitated adult or a Provider acting on behalf of the Member, with written consent, may submit a Grievance at any time after they experience any dissatisfaction, orally or in writing to any of the following submission methods:

- Hand delivered to the Passport by Molina Healthcare locations
- Toll-free contact center at (800) 578-0603
- Fax at (833) 415-0673

- Email: MHK_Enrollee_GnA@MolinaHealthcare.com

Postal mail: Passport by Molina Healthcare
Attention: Appeals and Grievances
P.O.Box36030
Louisville, KY 40233-6030

Upon receipt of the Grievance, an acknowledgement letter will be mailed to the Member within 5 days after receipt of their Grievance. The acknowledgement letter will confirm receipt of the Grievance and provide an expected date of its resolution. A Grievance specialist will conduct the review and will mail a resolution letter to the Member within 30 calendar days from the date the Grievance is received by Passport, unless a 14-calendar day extension is agreed upon. The resolution letter may not take the place of the acknowledgement letter, unless a decision is reached before the acknowledgement letter is sent, then one letter shall be sent including the acknowledgement and the decision. The resolution letter will include:

- The results/findings of the Grievance
- All information considered in the investigation of the Grievance and
- The date of the Grievance resolution.

Please note: If the Member wishes to use a representative, the Member must complete an Appointment of Representative (AOR) statement. The Member and the person who will be representing the Member must sign the AOR statement. For authorized representative purposes, written consent unique to an Appeal or State Fair Hearing shall be required for the Appeal or State Fair Hearing. A single written consent shall not qualify as written consent for more than one of the following: Hospital Admission, Physician or other Provider visit, or Treatment plan.

Member Appeals Process

Members have the right to file an Appeal of an Adverse Benefit Action taken by Passport by Molina Healthcare. An Appeal may also be filed on the Member's behalf by an authorized representative or a Provider with the Member's written consent. Appeals received from Providers that are on the Member's behalf for denied services with requisite consent of the Member are deemed Member Appeals. To Appeal, the Member, or the Member's representative, may file any type of Member Appeal request either orally or in writing to one of the following submission methods:

- Hand delivered to the Passport by Molina Healthcare locations.
- Toll-free contact center at (800) 578-0603
- Email: MHK_Enrollee_GnA@MolinaHealthcare.com
- Fax at (833) 415-0673

Postal mail: Passport by Molina Healthcare
Attention: Appeals & Grievances
P.O. Box 36030
Louisville, KY 40233-6030

The Appeal must be received verbally or in writing within 60 calendar days of the date of the Adverse Action. If an Appeal is filed orally via Passport's Contact Center, the request must be followed up with a written, signed Appeal to Passport by Molina Healthcare within 10 calendar days of the oral filing. For oral filings, the time frames for resolution begin on the date the oral filing was received by Passport. Unless

written confirmation of a standard oral Appeal request is received, the case is closed as an upheld Appeal and Appeal rights are exhausted. The written follow-up requirement does not apply to qualifying Expedited Appeal requests.

An acknowledgement letter will be sent to the Member no later than 5 days after the Appeal is received confirming receipt and will provide the expected date of resolution. An Appeal Specialist will ensure the appeal is reviewed as expeditiously as the Members' health condition requires.

A resolution letter to the Member will be mailed no later than 30 calendar days from the receipt of the Appeal unless the Member requests a 14-calendar day extension. Passport may also request a 14-day extension. If Passport requests the extension, we will give the Member written notice and the extension reason for the extension within two working days of the decision to take an extension.

If the Provider files an Appeal on the Member's behalf, Passport will respond to the Provider and Member. The Provider shall give a copy of the notice to the Member or inform the Member of the provisions of the notice.

Passport will continue to provide benefits to a Member, if the Member requested a continuation of benefits, until one of the following occurs:

- The Member withdraws the Appeal
- 14 calendar days have passed since the date of the resolution letter, if the resolution of the Appeal was against the Member and the Member has not requested a State Fair Hearing or taken any further action or
- A State Fair Hearing decision adverse to the Member has been issued

Passport will not take or threaten to take any punitive action against any Provider acting on behalf of or in support of a Member in requesting an Appeal or an Expedited Appeal.

Passport ensures that the decision makers assigned to Appeals were not involved in previous levels of review or decision making. When deciding an Appeal of a denial based on lack of Medical Necessity, a Grievance regarding denial of expedited resolution of an Appeal, or a Grievance or Appeal involving clinical issues, the Appeal reviewers will be healthcare professionals with clinical expertise in treating the Member's condition/disease or will have sought advice from Providers with expertise in the field of medicine related to the request.

Expedited Appeals Process and Timeline

An Appeal will be expedited in response to the clinical urgency of the situation, i.e., when a delay would jeopardize a Member's life or materially jeopardize a Member's health. A request to expedite may come from the Member, Member's representative, or a Provider. If an appeal request qualifies for expedited, written member consent will not be required. If an appeal request does not qualify for expedited, written member consent is required.

An expedited Appeal will be acted on quickly and a decision will be made within 72 hours from the date the Appeal request is received either orally or in writing. If we determine the request does not meet the Commonwealth's definition of an expedited Appeal, we will immediately transfer the Appeal to the process and timeframes for a Standard Appeal resolution, in which a 30-day period will begin on the date we receive the original Appeal request, and we'll also notify the Member and the Provider.

State Fair Hearing for Members

A Member or their authorized representative may request a State Fair Hearing if they are dissatisfied with an action that has been taken by Passport by Molina Healthcare only after they have exhausted Passport's internal Appeal process. Members may be required to pay the cost of services provided while the appeal or State Fair Hearing is pending. The request for a hearing must be in writing and specify the reason for the request, indicate the date of service or the type of service denied and be postmarked or filed within 120 days from the date Passport's adverse resolution letter issued at the conclusion of the MCO internal Appeal process. Passport will provide documentation supporting our adverse decision within five days of receipt of the notice from the Department that a request for a State Fair Hearing has been filed by a Member. Documentation will also be made available to the Member or their legal counsel upon written request. If Passport does not comply with the above requirements or participate in and present evidence at the State Fair Hearing an automatic ruling will be made by the Department in favor of a Member.

Request a State Fair Hearing at one of the following submission methods:

- Email: DMS.hearings@ky.gov
- Fax: (502) 564-0223
- Phone: (502) 564-9394
- Mail: Department for Medicaid Services, Appeals and Complaints Branch
  Attention: Administrative Hearings
  275 E. Main Street, Mail Stop 6E-D
  Frankfort, KY 40621

Member Assistance Services

Members are provided reasonable assistance in completing forms and other procedural steps for an Appeal including, but not limited to, providing interpreter services and toll-free telephone numbers with TTY capability.

Provider Grievance

Providers have the right to file a Grievance no later than 60 calendar days from the date the Provider becomes aware of the issue generating the Grievance. Written resolution will be provided to the Provider within 30 calendar days from the date the Grievance is received by Passport. If additional time is needed, Passport shall orally request a 14-day extension from the Provider. If the Provider requests the extension, we will comply and approve the extension.

Provider may file a grievance at one of the following submission methods:

- Availity Essentials Portal at Availity.com (preferred submission method)
- Fax: (866)-315-2572
- Verbally: (800)-578-0775
- Email: MHK_Provider_GnA@molinahealthcare.com
- Postal Mail: Appeals & Grievances
  Passport by Molina Healthcare
  P.O.Box36030
  Louisville, KY 40233-6030

Provider Appeal and Provider Claims Appeal

A Provider may request an Appeal regarding a claim denial or the amount of reimbursement on their own behalf by mailing, by emailing, by the Availity Essentials portal, or by faxing a DMS or Passport Provider Appeal Form with supporting documentation such as medical records to Passport by Molina Healthcare. A provider may appeal a post-service Utilization Management authorization denial utilizing the same submission methods. Providers may file via:

- Availity Essentials Portal at Availity.com (preferred submission method)
- Fax:(866) 315-2572
- E-mail: MHK_Provider_GnA@MolinaHealthcare.com
- Postal mail: Appeals & Grievances
  Passport by Molina Healthcare
  P.O.Box36030
  Louisville, KY 40233

Providers have 60 calendar days from the date of our adverse determination to file an Appeal. Appeals submitted after that time will be rejected for untimely filing. If the Provider feels they filed the Appeal within the appropriate time frame, then the Provider may submit documentation showing proof of timely filing. The only acceptable proof of timely filing is fax confirmation, a registered postal receipt signed by a representative of Passport or similar receipt from other commercial delivery services.

Upon receipt of all required documentation, Passport by Molina Healthcare has 30 calendar days to review the Appeal and to render a decision to reverse or affirm the prior denial and/ or reimbursement. If additional time is needed, Passport shall or ally request a 14-calendar day extension from the Provider. If the Provider requests the extension, we will comply and approve the extension.

It is the responsibility of the Provider to submit all the necessary documentation with their Appeal within 60 calendar days of the denial to prevent a denial for lack of Information. Any information received after that time frame will not be reviewed.

Medical records and patient information shall be supplied at the request of Passport or appropriate regulatory agencies when required for Appeals. The Provider is not allowed to charge Passport or the Member for copies of medical records provided for this purpose.

Reversal of Denial

If it is determined during the review that the Provider has complied with Passport by Molina Healthcare protocols and/or that the Appealed services were Medically Necessary, then the denial will be reversed. The Provider will be notified of this decision in writing. If a Claim has been previously submitted and denied, it will be adjusted for payment after the decision to reverse the denial that has been made. Passport will ensure that Claims are processed and comply with federal and state requirements.

Affirmation of Denial

If it is determined during the review that the Provider did not comply with Passport protocols and/or Medical Necessity was not established, then the denial will be upheld. The Provider will be notified of this decision in writing. For denials based on Medical Necessity, the criteria used to make the decision will be provided in the letter. The Provider may also request a copy of the benefit provision, guideline, protocol, and other similar criteria used in making the Appeal decision by sending a written request to the Appeals addresses listed in the decision letter.

External Independent Third-Party Review

In accordance with 907KAR 17:035, if a Provider receives an adverse final decision of a denial, in whole or in part, of a health service [including a denial, in whole or in part, involving Emergency Services, or Claim for reimbursement related to this service, the Provider may request an external independent third-party review. A Provider may only do so after first completing an internal Appeal process with Passport by Molina Healthcare. A request for external independent third-party review must be submitted to Passport by Molina Healthcare within 60 days of receiving the final partially overturned or upheld appeal decision letter from us. If a Provider has not received a final appeal decision letter outlining the external independent third-party review rights, your internal appeal must be completed prior to the external independent third-party review submission.

Requests for external independent third-party reviews may be submitted to Passport by Molina Healthcare via one of the following methods:

- E-mail: ReviewRequests@passporthealthplan.com
- Fax: (502) 585-8334

Mail: Passport by Molina Healthcare
Attention: External Independent Third-Party Review Request
PO Box 36030
Louisville, KY 40233

Passport will confirm receipt of your request for external independent third-party review within five business days of receiving your request.

As required by 907 KAR 17:035, if you request an external independent third-party review, we will forward to the Department for Medicaid Services all documentation submitted by you during the Appeal process within 15 business days of receiving your request. No additional documentation will be allowed for consideration by the external independent third-party review.

Additionally, if Passport's decision is upheld by the external independent third-party review, Providers have the right to request an administrative hearing in accordance with 907KAR 17:040 within 30 calendar days of the Department's written notice. You must submit your request for an administrative hearing by one of the following submission methods:

- Email: DMS.hearings@ky.gov
- Fax: (502) 564-0223
- Phone: (502) 564-9394
- Mail:
  Department for Medicaid Services, Appeals and Complaints Branch
  Attention: Administrative Hearings
  275 E. Main Street, Mail Stop 6E-D
  Frankfort, KY 40621

If the administrative hearing officer upholds Passport's decision, the Provider must reimburse the Department for Medicaid Services in the amount of $600.00 (per hearing) within thirty (30) days of the issuance of the final order.

Reporting

Grievance and appeal trends are reported to the Quality Improvement Committee quarterly. This trend report

includes a quantitative review of trends, qualitative or barriers analysis, and identification of interventions that address key drivers. An annual evaluation of grievance and appeal analysis is then completed and presented to the Quality Improvement Committee for evaluation. If required by the state or CMS, reporting is submitted to the Appropriate Agency as needed.

Record Retention

Passport will maintain all Grievance and Appeal documentation that is hand-delivered or sent by mail, email, fax, and Availity Essentials Portal electronically in a secure area and be accessible for a minimum of 10 years after the final decision. All records shall be maintained and available for review by authorized federal and state personnel during the entire term of this Contract and for a period of 10 years after termination of this Contract, except that when an audit has been conducted, or audit findings are unresolved. In such case records shall be kept for a period of 10years in accordance with 42 C.F.R. 438.2and 907KAR 1:672, or as amended or until all issues are finally resolved, whichever is later.

13. Credentialing and Recredentialing

The Credentialing Program ensures that Molina Healthcare, Inc., and its subsidiaries, including Passport by Molina Healthcare, maintain a network of high-quality providers who meet established standards and criteria. Passport is committed to delivering exceptional healthcare services to the communities we serve. Additional information is available in the Credentialing Policy and Procedure, which can be requested by contacting your Passport Provider Services representative.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification, and additional information as required. The information gathered is confidential, and disclosure is limited to parties who are legally permitted to have access to the information under State and Federal Law.

The Credentialing Program has been developed in accordance with State and Federal requirements and the standards of the National Committee for Quality Assurance (NCQA).

The Credentialing Program undergoes an annual review and is revised and updated as necessary to ensure continued compliance and alignment with current standards and best practices.

Non-Discriminatory Credentialing and Recredentialing

Passport does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status, or patient types (e.g., Medicaid) in which the practitioner specializes. This does not preclude Passport from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Types of Practitioners Credentialed & Recredentialed

Practitioners and groups of Practitioners with whom Passport contracts must be credentialed prior to the contract being implemented. Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral health care practitioners who are licensed, certified, or registered by the State to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Doctoral or master's-level psychologists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Medical Doctors (MD)
- Naturopathic Physicians

- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists
- Speech and Language Pathologists
- Telemedicine Practitioners

Criteria for Participation in the Passport Network

Passport has established clear criteria, along with the verification of sources used to confirm these standards, for evaluating and selecting practitioners for participation in the Passport network. These criteria are designed to assess each practitioner's ability to deliver safe, effective, and quality care. This policy outlines the requirements applied to applicants for initial credentialing, recredentialing, and ongoing participation within the Passport network. To remain eligible for participation, Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documents provided by Passport.

Passport reserves the right to exercise discretion in applying criteria and to exclude Practitioners who do not meet the criteria. Passport may, after considering the recommendations of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined such waiver is necessary to meet the needs of Passport and the community it serves. The refusal of Passport to waive any requirement shall not entitle any Practitioner to a hearing or any other rights of review.

Passport reserves the right to apply credentialing criteria at its discretion and may exclude practitioners who do not meet established standards. The Practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the Passport network. If the Practitioner does not provide this information, the credentialing application will be deemed incomplete and will result in an administrative denial or administrative termination from the Passport network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application –** Practitioners must submit to Passport a complete credentialing application either from CAQH ProView or other State mandated practitioner applications. The attestation must be signed within one hundred-twenty (120) days of submission. The application must include all required documents.
- **License, Certification or Registration –** Practitioners must hold a current and valid license, certification, or registration to practice in their specialty in every State in which they will provide care and/or render services for Passport Members. Telemedicine practitioners must hold an active license in both the state where they are physically located and the state in which the member receiving care resides.
- **DEA or CDS Certificate –** Practitioners must hold a current, valid, unrestricted Drug

Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Practitioners must have a DEA or CDS in every State where the Practitioner provides care to Passport Members. If a Practitioner has a pending DEA/CDS certificate and has never had disciplinary action taken related to their DEA and/or CDS, or chooses not to have a DEA and/or CDS certificate, the Practitioner must provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number. If a Practitioner does not have a DEA or CDS because it has been revoked, restricted, or relinquished due to disciplinary reasons, the Practitioner is not eligible to participate in the Passport network.

- **Specialty –** Practitioners must only be credentialed in the specialty in which they have adequate education and training. Practitioners must confine their practice to their credentialed area of practice when providing services to Passport Members.
- **Education –** Practitioners must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency Training –** Practitioners must have satisfactorily completed residency training from an accredited program in the specialties in which they are practicing. Passport only recognizes programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States; or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, Podiatric residencies are required to be 3 years in length. If the podiatrist has not completed a three year residency or is not board certified, the podiatrist must have five years of work history practicing podiatry.
- **Fellowship Training –** Fellowship training is verified when a practitioner will be advertised in the directory in their fellowship specialty. Passport only recognizes fellowship programs accredited by ACGME, AOA, CFPC, and CODA.
- **Board Certification –** Board certification in the practitioner's specialty is not mandatory. Initial applicants who are not board certified may be considered for participation if they have successfully completed residency training in their specialty through an accredited program. Passport recognizes certification only from the following Boards:
    - American Board of Medical Specialties (ABMS)
    - American Osteopathic Association (AOA)
    - American Board of Foot and Ankle Surgery (ABFAS)
    - American Board of Podiatric Medicine (ABPM)
    - American Board of Oral and Maxillofacial Surgery
    - American Board of Addiction Medicine (ABAM)
    - College of Family Physicians of Canada (CFPC)
    - Royal College of Physicians and Surgeons of Canada (RCPSC)
    - Behavioral Analyst Certification Board (BACB)
    - National Commission on Certification of Physician Assistants (NCCPA)
- **General Practitioners –** Practitioners who are not board certified and have not completed training from an accredited program are only eligible to be considered for participation as a General Practitioner in the Passport network. To be eligible, the Practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five

years without any gaps in work history. Passport will consider allowing a Practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a General Practitioner if the Practitioner is applying to participate as a Primary Care Physician (PCP), or as an Urgent Care or Wound Care Practitioner. General Practitioners providing only wound care services do not require five years of work history as a PCP.

- **Nurse Practitioners & Physician Assistants –** In certain circumstances, Passport may credential a Practitioner who is not licensed to practice independently. In these instances, it would also be required that the Practitioner providing the supervision and/or oversight be contracted and credentialed with Passport.
- **Work History –** Practitioners must supply the most recent five-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six months, the Practitioner must clarify the gap verbally or in writing. The organization will document verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one year, the Practitioner must clarify the gap in writing.
- **Malpractice History –** Practitioners must supply a history of malpractice and professional liability Claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims, and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice –** Practitioners are required to fully disclose the history of all licensures, certification, and registration actions, including denials, revocations, terminations, suspensions, restrictions, reductions, limitations, sanctions, probations, and non-renewals. Additionally, practitioners must report any instance of voluntarily or involuntarily relinquishing, withdrawing, or failing to proceed with an application to avoid adverse action or investigation, or while under investigation related to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At the time of initial application, the Practitioner must not have any pending or open investigations from any State or governmental professional disciplinary body[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action, or the equivalent.
- **Medicare, Medicaid and other Sanctions and Exclusions –** Practitioners must not be currently sanctioned, excluded, expelled, or suspended from any State or Federally funded program including but not limited to the Medicare or Medicaid programs. Practitioners must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioners must disclose all debarments, suspensions, proposals for debarments, exclusions, or disqualifications under the nonprocurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare Opt Out –** Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Passport network for any Medicare or Dual (Medicare/Medicaid) lines of business.

- **Social Security Administration Death Master File –**Practitioners are required to provide a valid Social Security Number, which must not appear on the Social Security Administration's Death Master File
- **Medicare Preclusion List –** Practitioners currently listed on the Preclusion List may not participate in the Passport network for any Medicare or Dual (Medicare/Medicaid) lines of business.
- **Professional Liability Insurance –** Practitioners must have and maintain professional malpractice liability insurance with limits that meet Passport criteria. This coverage shall extend to Passport Members and the Practitioners' activities on Passport's behalf. Practitioners maintaining coverage under Federal tort or self-insured policies are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to Perform –** Practitioners must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Lack of Present Illegal Drug Use –** Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions –** Practitioners must disclose if they have ever had any of the following:
    - Criminal Conviction – including any convictions, guilty pleas, or adjudicated pretrial diversions for crimes against person such as murder, rape, assault, and other similar crimes.
    - Financial Crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes.
    - Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act.
    - Any crime related to fraud, kickbacks, healthcare fraud, claims for excessive charges, unnecessary services, or services which fail to meet professionally recognized standards of health care, patient abuse or neglect, controlled substances, or similar crimes at the time of initial credentialing, Practitioners must not have any pending criminal charges in the categories listed above.
- **Loss or Limitations of Clinical Privileges –** At initial credentialing, Practitioners must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. During recredentialing, practitioners are required to disclose any past or current issues related to the loss or restriction of clinical privileges at all facilities or organizations where they have held privileges since the previous credentialing cycle.
- **Hospital Privileges –** Practitioners must list all current hospital privileges on their credentialing application. All current privileges must be in good standing.
- **NPI –** Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).

[3] If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

Notification of Discrepancies in Credentialing Information & Practitioner's Right to Correct Erroneous Information

Passport by Molina Healthcare will notify the Practitioner immediately in writing if credentialing information obtained from other sources varies substantially from that provided by the Practitioner. Examples include but are not limited to: actions on a license, malpractice claims history, board certification actions, sanctions, or exclusions. Passport is not required to reveal the source of information if the information is obtained to meet organization credentialing verification requirements, or if disclosure is prohibited by Law.
Practitioners have the right to correct erroneous information in their credentialing file. Practitioners' rights are published on the Passport website and are included in this Provider Manual.
The notification sent to the Practitioner will detail the information in question and will include instructions to the Practitioner indicating:

- Their requirement to submit a written response within 10 calendar days of receiving notification from Passport by Molina Healthcare.
- In their response, the Practitioner must explain the discrepancy, may correct any erroneous information, and may provide any proof that is available.
- The Practitioner's response must be sent to:

  Molina Healthcare, Inc. Attention:
  Credentialing Director
  22522 – 29th Drive SE, #L-210
  PO Box 4004
  Bothell, WA 98041

Upon receipt of notification from the Practitioner, Passport by Molina Healthcare will document receipt of the information in the Practitioner's credentialing file. Passport will then re-verify disputed primary source information. If the primary source information has changed, correction will be made immediately to the Practitioner's file. The Practitioner will be notified in writing that the correction has been made. . If the primary source information remains inconsistent with the Practitioner's information, the Credentialing department will notify the Practitioner.

If the Practitioner does not respond within 10 calendar days, processing will be discontinued, and network participation will be administratively denied or terminated.

Practitioner's Right to Review Information Submitted to Support Their Credentialing Application

Practitioners have the right to review their credentialing file at any time. Practitioners' rights are published on the Passport website and are included in this Provider Manual.

The Practitioner must notify the Credentialing department and request an appointment time to review their file and allow up to seven calendar days to coordinate schedules. The Medical Director and the Director responsible for Credentialing, or the Quality Improvement Director will be present. The Practitioner has the right to review all information in the file with the exception of peer references or recommendations protected by Law from disclosure.

Practitioners may only copy documents they have personally submitted to Passport by Molina

Healthcare, such as the credentialing application and any accompanying attachments. No other documents within the credentialing file may be copied.

Practitioner's Right to be Informed of Application Status

Upon request, Practitioners have the right to be informed of the status of their application by telephone, email, or mail. Practitioners' rights are published on the Passport website and are included in this Provider Manual. Passport will respond to the request within two (2) working days. Passport will share application status and note any missing information or information not yet verified.

Notification of Credentialing Decisions

A letter is sent to every Provider notifying them of the Professional Review Committee or Medical Director decision regarding their participation in the Passport network.

Notification is issued within 30 calendar days of receiving either a provider's credentialing request or a completed uniform credentialing form, whichever occurs first. This timeframe allows for conversion of the credentialing form to electronic format, completion of third-party verifications, and determination and communication of the credentialing decision. The 30-day period does not begin until all requested information and documentation has been provided by the applicant. Copies of all correspondence are maintained in the provider's credentialing file. Provider participation effective dates are based on the date Passport receives a complete and verified application.

Recredentialing

Passport recredentials each Practitioner at least every 36 months. Failure to respond to recredentialing efforts may result in termination from the Passport network.

Excluded Providers

An 'Excluded Provider' refers to an individual provider or any entity whose officer, director, agent, manager, or individual with ownership or controlling interest has been convicted of offenses specified under Section 1128 of the Social Security Act (SSA), excluded from participation in Medicare or Medicaid, assessed civil monetary penalties under Section 1128, or maintains a contractual relationship with an entity convicted of such offenses.

Pursuant to section 1128 of the SSA, Passport and its Subcontractors may not subcontract with an Excluded Provider/person. Passport and its Subcontractors shall terminate subcontracts immediately when Passport and its Subcontractors become aware of such excluded Provider/ person or when Passport and its Subcontractors receive notice. Passport and its Subcontractors certify that neither it nor its Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Passport and its Subcontractors are unable to certify any of the statements in this certification, Passport and its Subcontractors shall attach a written explanation to the Agreement.

Ongoing Monitoring of Sanctions and Exclusions

Passport monitors the following agencies for Practitioner sanctions and exclusions between recredentialing cycles for all Practitioner types and takes appropriate action against Providers when instances of poor quality are identified. If a Passport Practitioner is found to be sanctioned or excluded,

the Practitioner's contract will be immediately terminated, effective the same date the sanction or exclusion was implemented.

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **The OIG High Risk list** – Monitor for individuals or facilities who refused to enter into a Corporate Integrity Agreement (CIA) with the federal government on or after October 1, 2018.
- **State Medicaid Exclusions** – Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** –Monitor for Medicare exclusions through the Centers for Medicare and Medicaid Services (CMS) MED online application site.
- **Medicare Preclusion List** – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database** – Passport enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM)** – Monitor for Practitioners sanctioned by SAM.

  Passport also monitors the following for all Practitioner types between recredentialing cycles:

  - Member Complaints/Grievances
  - Adverse Events
  - Medicare Opt Out
  - Social Security Administration Death Master File

Effective 07/01/2025, Passport will monitor the timely renewal of healthcare licenses for all Practitioner types. In the event a Practitioner does not renew their state license prior to the expiration date, Passport may take action up to and including payment suspension for dates of service on or after license expiration or termination from applicable Passport Provider networks.

Provider Appeal Rights

When the Professional Review Committee suspends or terminates a practitioner's contract due to concerns regarding quality of care or professional conduct, a certified letter is issued to the practitioner detailing the adverse action and the reasons for the decision. The notification also includes information regarding the practitioner's right to a fair hearing, as required by applicable laws and regulations.

14. Delegation

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Passport. Passport may delegate:

- Utilization Management
- Credentialing and Recredentialing
- Claims
- Complex Care Management
- CMS Preclusion List Monitoring
- Other clinical and administrative functions

When Passport delegates any clinical or administrative functions, Passport remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/Accountable Care Organization (ACO)/vendor must be in compliance with Passport's established delegation criteria and standards. Passport's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Passport's standards and best practices.

Delegation Reporting Requirements

Delegated entities contracted with Passport must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and reviewed by Passport Delegation Oversight staff for compliance with performance expectations within the timeline indicated by Passport.

Corrective Action Plans and Revocation of Delegated Activities

If it is determined that the delegate is out of compliance with Passport's guidelines or regulatory requirements, Passport may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Passport may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Passport determines that is the best course of action.
If you have additional questions related to delegated functions, please contact your Passport Contract Manager.

15. Pharmacy

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Passport's goal is to provide our Members with high-quality, cost-effective drug therapy. Passport works with the Kentucky Department for Medicaid Services (DMS) and our Providers to ensure medications used to treat a variety of conditions and diseases are offered. Passport covers prescription and certain over-the-counter drugs through the Kentucky Preferred Drug List (PDL).

Pharmacy Network

Members must use their Passport ID card to get prescriptions filled. Passport's network includes retail, long term care, and specialty pharmacies. Additional Information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting passporthealthplan.com or calling Passport at (800) 578-0775.

Drug Utilization Review Board

The Molina Healthcare, Inc. Drug Utilization Review (DUR) Board acts as an advisory board to the Molina Healthcare, Inc. National Pharmacy &Therapeutics (P&T) Committee for all drug utilization program activities. Drug utilization review program activities help to ensure that prescriptions for outpatient drugs are appropriate, Medically Necessary, and not likely to result in adverse medical consequences. The Molina Healthcare, Inc. DUR Board leverages professional medical protocols and data analytics to assist in reviewing trends of prescribing and dispensing of prescriptions over time. The Board meets quarterly to review and make recommendations to the National Pharmacy and Therapeutics Committee on retrospective drug utilization review criteria to identify and develop educational initiatives to improve prescribing or dispensing practices and periodically, evaluates established criteria and their usage as well as the educational initiatives.
MedImpact performs retrospective DUR (rDUR) monitoring of approved endeavors on a quarterly basis. If identified, providers may receive a letter outlining the rDUR findings from MedImpact.
MedImpact will follow up on the effectiveness of the letter campaign by analyzing provider compliance to the recommendations supplied.

Pharmacy Coordinated Services Program (CSP)

The Pharmacy Coordinated Services Program (CSP) is a care management program, please see Healthcare Services section for information regarding this program.

Drug Formulary

Passport keeps a list of drugs, devices, and supplies that are covered under the plan's pharmacy benefit. The list shows all the prescription and over-the-counter products Members can get from a pharmacy. Some medications require prior authorization (PA) or have limitations on age, dosage and/or quantities. The pharmacy program does not cover all medications. For a complete list of covered medications please visit passporthealthplan.com.

Information on procedures to obtain these medications is described within this document and also available on the Passport website passporthealthplan.com.
All Kentucky Medicaid Managed Care Organizations (MCO), including Passport, partners with one Pharmacy Benefit Manager (PBM), MedImpact, for pharmacy claims processing and pharmacy prior authorizations (PA). All outpatient drugs, including over-the-counter (OTC) drugs, will be covered under a single KY formulary and Preferred Drug List (PDL) managed by MedImpact. This does not include Physician Administered Drugs, which will continue to be managed by Passport under the medical benefit.

Formulary Medications

Formulary medications with PA may require the use of first-line medications before they are approved. Information on procedures to obtain these medications is described within the document and is also available on the Passport website at passporthealthplan.com.

Quantity Limitations

In some cases, Members may only be able to receive certain quantities of medication. Information on limits can be found in the formulary document. passporthealthplan.com. Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age Limits

Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) alerts for the appropriate use of pharmaceuticals.

Step Therapy

Plan restrictions for certain Formulary drugs may require that other drugs be tried first. The Formulary designates drugs that may process under the pharmacy benefit without prior authorization if the Member's pharmacy fill history with Molina shows other drugs have been tried for certain lengths of time. If the Member has trialed certain drugs prior to joining Molina, documentation in the clinical record can serve to satisfy requirements when submitted to Molina for review. Drug samples from Providers or manufacturers are not considered as meeting step therapy requirements or as justification for exception requests.

Non-Formulary Medications

Non-formulary medications may be considered for exception when formulary medications are not appropriate for a particular Member or have proven ineffective. Requests for formulary exceptions should be submitted using a PA form which is available on the Passport website at www.passporthealthplan.com.Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity. The use of a manufacturer's samples of Non-Formulary or "Prior Authorization Required" medications does not override Formulary requirements.

Generic Substitution

Generic drugs should be dispensed when preferred by the PDL. If the use of a particular brand name non-preferred drug becomes medically necessary as determined by the Provider, PA must be obtained through the standard PA process.

New to Market Drugs

Newly approved drug products will not normally be placed on the formulary during their first six months on the market. During this period, access to these medications will be considered through the PA process.

Medications Not Covered

There are some medications that are excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes may not part be of the benefit. Specific exclusions can be found in the formulary at passporthealthplan.com.

CGT Access Model

The Centers for Medicare & Medicaid Services (CMS) CGT Access Model creates a collaborative partnership among CMS, manufacturers, and state Medicaid agencies, offering an innovative approach to administering outcomes-based agreements and enhancing access to life-saving treatments. Beginning in 2026, DMS and Molina will be participating in this partnership for two medications, namely Casgevy and Lyfgenia for the indication of Sickle Cell Disease.

CMS credentialed, registered, and specially trained providers will need to bill the drug claim on an outpatient facility form and must also be enrolled with DMS as a Kentucky Medicaid rendering provider and group. Per DMS instructions, prior authorization will be required, and a single case agreement will be issued to the provider by Molina.

Please note that under this model, the 340B Drug Pricing Program does **not** apply. Discounts available through the 340B program are not applicable to drugs administered in inpatient settings even if such drugs are considered "covered outpatient drugs". State selected model drugs **must not** be acquired through the 340B program for administration to model beneficiaries. Claims submitted with the 340B modifier may be denied. Additional information about the model can be found using the following link: https://www.cms.gov/priorities/innovation/innovation-models/cgt

Submitting a Prior Authorization Request

Only completed PA request forms will be processed; the following information MUST be included for the request form to be considered complete:

- Member first name, last name, date of birth and identification number.
- Prescriber first name, last name, NPI, phone number and fax number.
- Drug name, strength, quantity, and directions of use.
- Diagnosis.

Passport's decisions are based upon the information included with the PA request. Clinical notes are recommended. If clinical information and/or medical justification is missing MedImpact/ Passport will either fax or call your office to request clinical information be sent into complete review. To avoid delays in decisions, be sure to complete the PA form in its entirety, including medical justification and/or supporting clinical notes. The PA forms can be found here. There are separate forms for pharmacy benefit (retail) and medical benefit drugs (physician administered). Please select the appropriate form and if requesting a medical benefit drug, please include the HCPCS code on the form.

Pharmacy benefit drugs must be requested using the MedImpact PA form and faxed to MedImpact at (858) 357-2612. For physician administered drugs, fax a completed medical benefit PA form to Passport at (844) 802-1406. A blank Pharmacy PA Request Form may be obtained by accessing passporthealthplan.com or by calling (800) 578-0775

Member and Provider "Patient Safety Notifications"

Passport has a process to notify Members and Providers regarding a variety of safety issues which include voluntary recalls, FDA required recalls and drug withdrawals for patient safety reasons. This is also a

requirement as an NCQA-accredited organization.

Specialty Pharmaceuticals, Injectable and Infusion Services

Many specialty medications are covered by Passport through the pharmacy benefit using National Drug Codes (NDCs) for billing and specialty pharmacy for dispensing to the Member or Provider. Some of these same medications maybe covered through the medical benefit using the Healthcare Common Procedure Coding System (HCPC) via electronic medical Claim submission.

Passport will review the requested medication for the most cost-effective, yet clinically appropriate benefit of select medications. All reviewers will first identify Member eligibility, any Federal or State regulatory requirements, and the Member specific benefit plan coverage prior to determination of benefit processing.

Newly FDA approved medications may be considered non-formulary or non-preferred and subject to non-formulary or non-preferred policies and other utilization criteria until a coverage decision is rendered by the Kentucky Medicaid Pharmacy and Therapeutics Committee. "Buy and-bill" drugs are pharmaceuticals which a Provider purchases and administers, and for which the Provider submits a Claim to Passport for reimbursement

Passport completes Utilization Management for certain Healthcare Administered Drugs. For any drugs on the prior authorization list that use a temporary C code or other temporary HCPCS code that is not unique to a specific drug, which are later assigned a new HCPCS code, will still require prior authorization for such drug even after it has been assigned a new HCPCScode, until otherwise noted in the Prior Authorization list.

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Passport requires Providers to adhere to Passport's drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding Opioid and pain safety as needed.

Passport is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Passport Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at passporthealthplan.com under the Health Resource tab. Please consult with your Provider Services representative or reference the medication formulary for more information on Passport's Pain Safety Initiative

16. Risk Adjustment Accuracy and Completeness

What is Risk Adjustment?

The Centers for Medicare & Medicaid Services (CMS) defines Risk Adjustment as a process that helps accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive accurate payment for services provided to Passport Members and prepares for resources that maybe needed in the future to treat Members who have chronic conditions.

Your role as a provider

As a Provider, complete and accurate documentation in a medical record is critical to a Member's quality of care. We encourage Providers to record all diagnoses to the highest specificity. This will ensure Molina receives adequate resources to provide quality programs to you and our Members.

For a complete and accurate medical record, all Provider documentation must:

- Address clinical data elements (e.g., diabetic patient needs an eye exam or multiple comorbid conditions) provided by Molina and reviewed with the Member
- Be compliant with the CMS National Correct Coding Initiative (NCCI)
- Use the correct ICD-10 code by documenting the condition to the highest level of specificity
- Only use diagnosis codes confirmed during a Provider visit with the Member. The visit may be face-to-face or telehealth, depending on state or CMS requirements.
- Contain a treatment plan and progress notes
- Contain the Member's name and date of service
- Have the Provider's signature and credentials

Interoperability

The Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for Molina Members by using one of the automated methods available and supported by the Provider's electronic medical records (EMR), including but not limited to Epic Payer Platform, Direct Protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource).

The CDA or CCD document should include signed clinical note or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) Consolidated Clinical Data Architecture (CCDA) standard.

The Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for Molina Members to the interoperability vendor designated by Molina.

The Provider will participate in Molina's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the HIPAA-compliant mechanism for exchanging health care information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If the Provider does not have a Direct Address, the Provider will work with its EMR vendor to set up a Direct Messaging Account, which also supports the CMS requirement of having the Provider's Digital Contact Information added in NPPES.
- If the Provider's EMR does not support the Direct Protocol, the Provider will work with Molina's established interoperability partner to get an account established.

Contact information

For questions about Molina's risk adjustment programs, please contact your Molina Provider Relations representative

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