Provider Orientation

2023

Today we'll go over….

- Who your Provider Service Representative is and how they can assist you.
- Molina's Utilization Management Process
- Molina's Appeals & Grievances Process
- How you can team up with Molina to bring better quality healthcare to your patients
- Care Management Support
- How and where to submit claims
- What we're doing in the community
- How to register as a new provider or make updates

…. And more!

We have reserved an hour after the presentation for conversations with your PSRs and other Molina staff present today, please hold all questions and comments until after the presentation.

MOLINA® HEALTHCARE

Thank you for partnering with us!

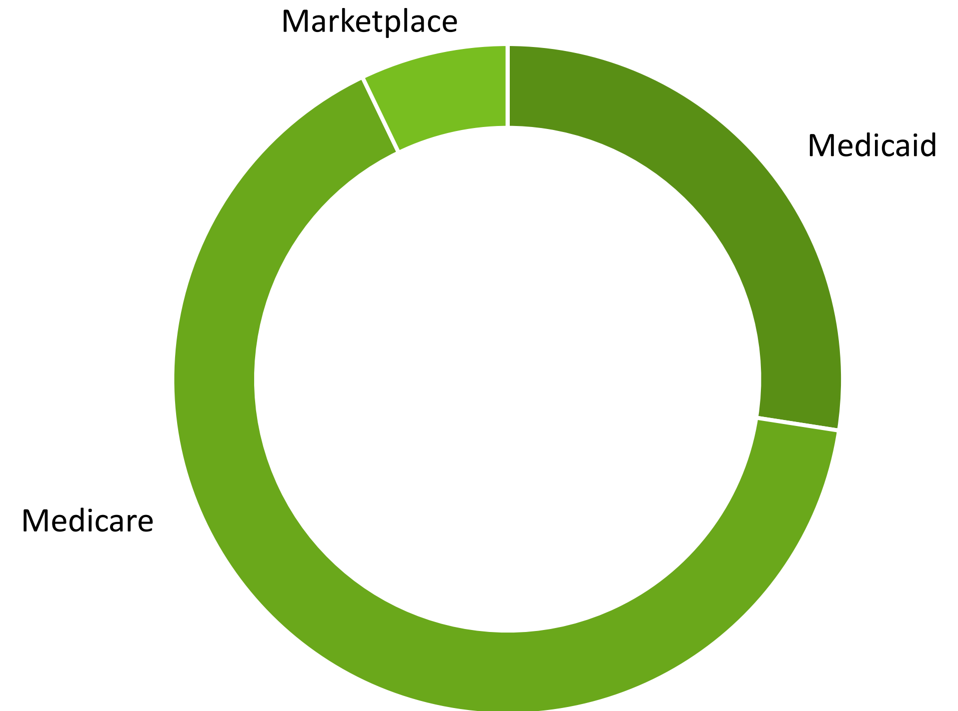
Within our population we have great diversity. There are always opportunities that we can watch for cultural differences, domestic violence, abuse or neglect. Our health plan members are often vulnerable individuals.

They may have difficulty with language or literacy, and they are beset by social and economic problems that can complicate their ability to obtain care.

Through our partnership with you, we can make a real difference in their lives.

Molina Membership

Molina has been in Idaho since **2018**
And now serving over **13,000** members!



The service areas covered by Molina Healthcare in Idaho beginning January 1st, 2023, are:

Molina Medicare Choice Care (HMO) – Ada, Bannock, Bingham, Bonneville, Canyon, Gem, Jerome, Madison, Payette, Twin Falls
Molina Medicare Complete Care (HMO D-SNP) – Ada, Bannock, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Cassia, Elmore, Fremont, Gem, Jefferson, Kootenai, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, Twin Falls
Molina Medicare Complete Care Select (HMO D-SNP) – Ada, Bannock, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Cassia, Elmore, Fremont, Gem, Jefferson, Kootenai, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, Twin Falls

Other products offered by Molina are Medicaid and Marketplace

MOLINA® HEALTHCARE

Provider Services

Keshia Schneider

Provider Services Team

Your **Personal Advocates** helping you navigate and partner with the Molina team.

We provide education about:

- **Credentialing** a new provider or making a change to an existing credentialed provider in your group.
- **New Provider** Welcome Orientations.
- Coordination with **Claims** Research and Resolution Teams.
- Education on **resources** available for providers and members.
- **Availity** training.
- **Contacts** for all departments within Molina.
- **Healthcare updates** and education.
- Provider **office staff** education and offsite visits.
- **EDI claims** submission and EFT setup.
- Yearly **MOC Attestation**
- And more…

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Need help from your PSR Team?

- **Shari Wheeler**

Provider Services Representative

Email: Shari.Wheeler@molinahealthcare.com
Phone: (801) 572-7602

Specialties: Atypical Providers, Certified Family Homes, PCS, Assisted Living & Hospice

- **Stephanie Sanders**

Provider Services Representative

Email: Stephanie.Sanders2@molinahealthcare.com
Phone: (208) 586-3178

Specialties: Provider Groups, DME, Ancillary & Behavioral Health

- **Chelsey Anderson**

Provider Services Representative

Email: chelsey.anderson@molinahealthcare.com
Phone: (801) 613-7889

Specialties: Hospitals, Skilled Nursing & EMS

- **Keshia Schneider**

Provider Services Manager

Email: Keshia-skye.Schneider@molinahealthcare.com
Phone: (801) 613-1918

General PSR Email Box: MHIDProviderSvcReq@MolinaHealthCare.Com

Molina of Idaho Territory

Covered Counties:

- Ada County
- Bannock County
- Bingham County
- Boise County
- Bonner County
- Bonneville County
- Boundary County
- Canyon County
- Cassia County
- Elmore County
- Fremont County
- Gem County
- Jefferson County
- Jerome County
- Kootenai County
- Madison County
- Minidoka County
- Nez Perce County
- Owyhee County
- Payette County
- Power County
- Twin Falls County

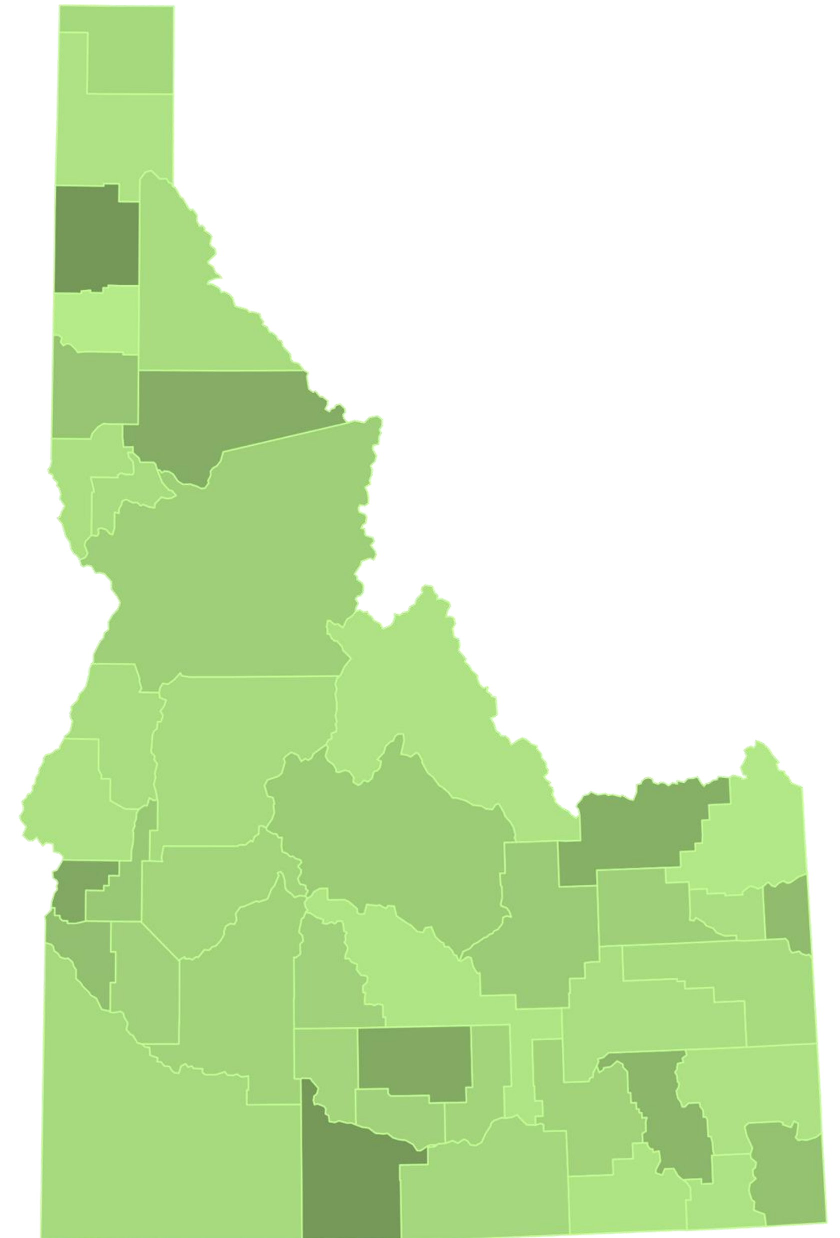
Plans Available in Idaho:

- Medicaid Plus
- Molina Medicare Choice (HMO)
- Molina Medicare Complete Care (HMO D-SNP)
- Molina Medicare Complete Care Select (HMO D-SNP)

Molina Medicare Choice Care (HMO) Ada, Bannock, Bingham, Bonneville, Canyon, Gem, Jerome, Madison, Payette, Twin Falls

Molina Medicare Complete Care (HMO D-SNP) Ada, Bannock, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Cassia, Elmore, Fremont, Gem, Jefferson, Kootenai, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, Twin Falls

Molina Medicare Complete Care Select (HMO D-SNP) Ada, Bannock, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Cassia, Elmore, Fremont, Gem, Jefferson, Kootenai, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, Twin Falls



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Contact Center

Keshia Schneider

Contact Center

The **Member and Provider Contact Center** supports multiple products across all states to assist our members and providers.

- **Benefit and Eligibility** questions
- **Provider Network** inquiries
- **PCP** updates
- **Authorization** inquiries
- **Claim Status** and inquiries
- **Grievance and Appeals**

Provider Customer Service can be reached at:

Medicare (844) 239-4914
Medicaid Plus and Marketplace: (844) 808-1383

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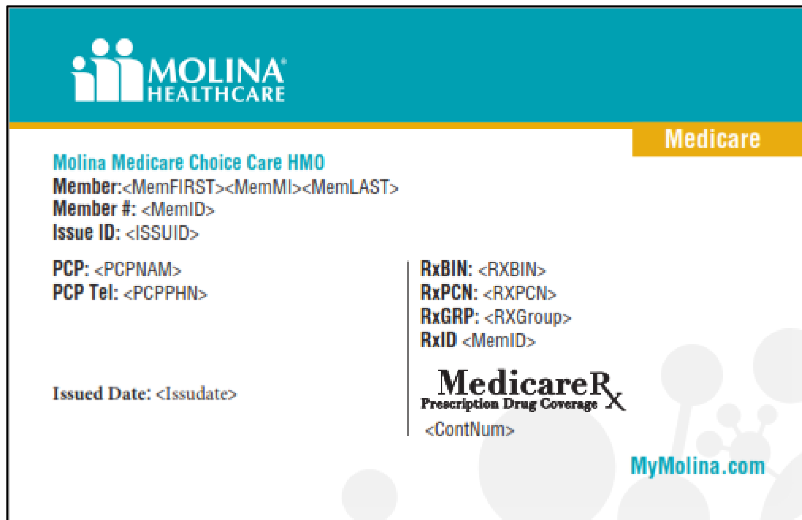
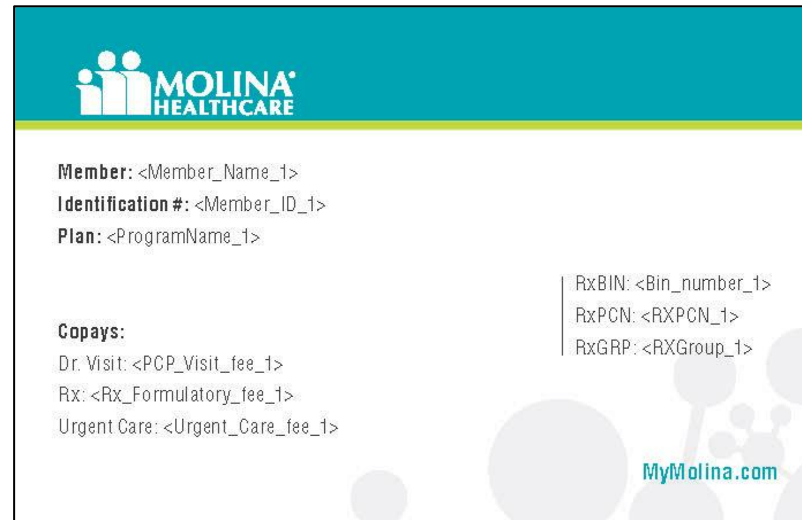
Member ID Card Examples

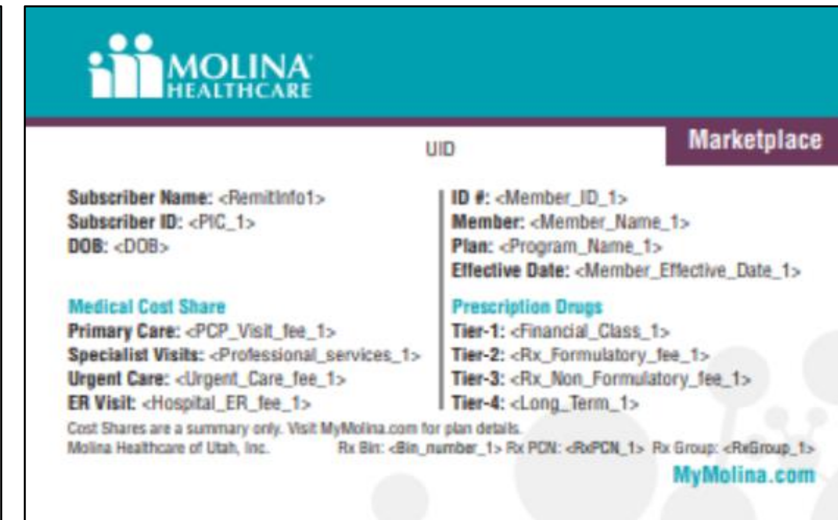
Medicare



Medicaid



Marketplace



Community Engagement

Yvette Primero

Molina Healthcare of Idaho 2023

1 Community Sponsorship	Sponsorship at a local level that supports partner events promoting healthy communities.
2 **Molina Cares Accord**	Molina's community investment platform and our commitment to building stronger communities
3 **Signature Events**	Molina initiated events that help us meet community members where they are at to promote health and well-being.
4 **Provider Engagement**	Partnerships that enable us to support the agencies, partners, and individuals who are in community.

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Molina Healthcare of Idaho 2023 Events At-A-Glance

- **Facilitated two $25, 000 and one $10,000 Molina Cares Accord grants in benefitting community initiatives that address quality of life and access to healthcare in Idaho**
- **Participated in 15 community health and resource fairs and events throughout Idaho**
- **Actively participated on seven community advisory boards**
- **Hosted and collaborated on the Molina Leadership Advisory meetings and Membership Advisory meetings for Idaho**
- **Partnered with agencies to support continuing education needs for agencies such as ICOA Ombudsman trainings, SHIBA volunteer trainings, and CFH SMART provider workshops**
- **Supported Idaho community health initiatives lead by community partners including the: Consortium for Idahoans with Disabilities, Idaho Care Giver Alliance, and Western Idaho Community Health Coalition**

Provider Registration

Chelsey Anderson

Idaho Department of Health & Welfare Provider Registration

- When Molina Healthcare of Idaho (MHI) receives notification from the Idaho Department of Health & Welfare (IDHW) that a provider is not registered with the State, MHI will terminate the effected lines of business, including Medicaid and Medicare.
- When the provider becomes registered/recredentialed with the Idaho Department of Health & Welfare, and requests to be reinstated with MHI, the provider will need to send an e-mail notification to their Provider Relations Representative.
- Provider Group Roster Template (PP)
- If the request from the provider to be reinstated with MHI is less than 180 days from the date that the provider was reinstated by the IDHW, MHI will use the IDHW reinstatement date. (This will be verified by MHI through the IDHW website).
- If the request from the provider to be reinstated with MHI is greater than 180 days from the date that the provider was reinstated by IDHW, MHI will use the provider's request date with MHI for reinstatement as the effective date.
- Current timely filing rules will be followed by MHI.

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CAQH

- CAQH ProView is more than a credentialing database. Available at no cost to you, CAQH ProView eliminates duplicative paperwork with organizations that require your professional and practice information for claims administration, credentialing, directory services, and more.
- **Link:** https://proview.caqh.org/Login/Index?ReturnUrl=%2fPR

FIRST TIME HERE?

1. Dentists: Sign in or register for the first time at the American Dental Association's portal. Register on ADA
2. If you received a welcome email, use the link in your email to begin the sign in process.
3. If you are new to CAQH ProView, register now.

Practice Manager Sign In
Participating Organization Sign In

Providers must be registered with the state before Molina can add them to the network.

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Pharmacy

Chelsey Anderson

Idaho Medicaid Plus Pharmacy Benefit Overview

- **Covered Drugs**
  - Idaho Medicaid Plus (IMPlus) Preferred drugs for coverage are found on the online drug formulary.
  - Many drugs not listed on the drug formulary are eligible for coverage, however, a Medication Exception Prior Authorization Request must be submitted with all necessary clinical documentation.

- Medications or Diagnoses that are **not covered:**
  - Diagnoses that are excluded for coverage as **determined by federal or Idaho Medicaid administrative rules** such as**:**
    - Treatments for fertility or sexual dysfunction, weight loss, weight gain, anorexia, or cosmetic treatments
  - **Drugs that are covered under Medicare Part D** are not eligible for coverage under the Idaho Medicaid Plus plan according to IDHW and federal rules including the Social Security Act.

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Idaho Medicaid Plus Pharmacy Benefit Overview

- The following non-Medicare Part D drugs are eligible for coverage under the IMPlus benefit:
  - Lipase Inhibitors (subject to PA)
  - Prescription Cough & Cold Symptomatic Relief
  - Therapeutic vitamins, including:
    - Injectable Vitamin B12 (Cyanocobalamin and Analogues)
    - Vitamin K and Analogues
    - Pediatric Vitamin-Fluoride preparations
    - Legend Prenatal vitamins for Pregnant or Lactating Women
    - Legend Folic Acid drugs including oral drugs combined with Vitamin B12 and/or iron salts (without additional ingredients)
    - Legend Vitamin D and analogues
  - Prescriptions for the following non-legend (over the counter) products:
    - Insulin
    - Tobacco Cessation
    - Oral Iron Salts
    - Permethrin

Idaho Marketplace Pharmacy Benefit Overview

- Idaho Marketplace Formulary
- Marketplace Medical (Physician Administered) Preferred Drug List
- Specialty Medication Administration Site of Care Policy: medically necessary services must be rendered in the least intensive/cost-effective site that is appropriate for the drug infusion
- **Drug Prior Authorization Criteria and Clinical Policies** can be found on the marketplace website for providers under Drug List
- **HCPCS/CPT PA look up tool** can be found on the provider marketplace website using the Forms & Documents tab, under the Prior Authorization section
- Pharmacy Locator Tool (In-network pharmacies)—found under the Members webpage dropdown menu, select "Find a Pharmacy"
- Drug Prior Authorization Forms
    - Pharmacy benefit drugs: Medication Exception Request
    - Medical Benefit (HCPCS/J-code) Drug PA Form

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Medicare Formulary Resources

- Choice Care Plan
- Choice Care Select Plan
- Choice Care Plus Plan
- Complete Care Plan
- Complete Care Select Plan
- Comfort Care Plan
- Connect Care Plan

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CVS Caremark Mail Service Pharmacy Program

Members who take one or more medications regularly (known as long-term drugs or maintenance medications) can use the CVS Caremark Mail Service Pharmacy Program to have their prescription drug(s) mailed to their home. Each order contains up to a 90-day supply per prescription.

Step 1

Make sure drug(s) are available through mail service.

- Generally, the drugs available through mail service are drugs that members take on a regular basis for a chronic or long-term medical condition.
- Some long-term drugs aren't available through mail service (for example, tier 5 specialty drugs and covered ID FIDE-SNP Medicaid drugs).
- Members should check the plan's Formulary or call Member Services to find out if their prescription drug(s) are available through mail service.
- Drugs on the plan's Formulary that are not available through the CVS Caremark Mail Service Program are marked as "NM" for No Mail Order.

Step 2

Doctor needs to write a prescription.

- To start, the member needs to have their doctor write a 90-day prescription with up to 3 refills (if appropriate) to be filled through the CVS Caremark Mail Service Program. This is the maximum supply the doctor can prescribe for mail service.
- If the member needs their prescription drug(s) right away, they should ask their doctor to also write a 2nd prescription for up to a 31-day supply. The member can fill this 2nd prescription at a network pharmacy while they wait for their mail service delivery to arrive.
- Whether the member uses mail service or purchases their long-term drugs at a network retail drugstore, they should talk to their doctor about getting a prescription for 90-days to save them money.

CVS Caremark Mail Service Pharmacy Program

Step 3

Order

Members can choose one of these 4 options to order their prescription drug(s) by mail through the CVS Caremark Mail Service Pharmacy Program:

Mail	Online	Phone	Doctor
Members can complete and mail the CVS Caremark Mail Service Order Form to the address printed on the form. Payment (if required) must be made to process. The form is attached to the Mail Order Prescription Service Notice the member got in their Welcome Kit. It is also posted on the Plan Materials page on our public website. For new orders, members need to include their prescription. If payment is required, Members can pay online from: their checking account, using Bill Me Later®, or a credit card. Or members can mail a check or money order. If they mail in a payment, members should not send cash.	Members can go to caremark.com, sign in, and place their order online 24/7. If the member has never been to the caremark.com website, they can click on Register Now to create account. Once logged in, the member will need to: ▪ Click Prescriptions for a drop down menu, ▪ Then select Start Mail Service and follow the online steps to place their order.	Members can call the CVS Caremark toll-free number 24/7 to place an order. Members will need to provide their: ▪ Member number (found on their plan member ID card), ▪ Prescription name(s) and the dosage amount for each drug, ▪ Doctor's name and phone number, and ▪ Mailing address. Members can even use the CVS Caremark toll-free number to order refills 24/7.	Members can give their doctor's office the CVS Caremark phone number and ask their doctor to call, fax, or ePrescribe their prescription(s) 24/7. To place an order, the doctor will need the member's: ▪ Member number (found on the plan member ID card), ▪ Date of birth, and ▪ Mailing address.

That's it! Once CVS Caremark receives the order and payment (if required) it should take about 10 days for the member to receive their order. If the order does not arrive in time members can call CVS Caremark.

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Medicare Part D Help

If you or a member need assistance with any Formulary-related issue or simply have questions about drug coverage in general, please call our Medicare Pharmacy Department.

Members universal phone number – (800) 665-3086,

TTY 711, 7 days a week, 8 a.m. to 8 p.m., plans local time.

Member Services will assist members with basic questions or inquiries such as:

- Is the member's drug on our Formulary?
- If the member is asking for a prescription to be covered or has paid out-of-pocket for a prescription drug, transfer the member to our Medicare Pharmacy Department to initiate a coverage determination.
- To help the member find a network pharmacy close to their home.

If the member needs additional help, Member Services will warm transfer the call to our Medicare Pharmacy Call Center.

Medical Drug Billing “Helpful Hints”—NDC digits

11-Digit National Drug Code (NDC)

The 11-digit National Drug Code (NDC) number must be reported on all professional and outpatient claims when submitted on the CMS-1500 and UB-04 claim forms, or electronic equivalent.

Providers will need to submit claims with both Health Care Common Procedure Coding System (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.

The NDC is a unique 11-digit numeric identifier assigned to medications under Section 510 of the United States Federal Food, Drug, and Cosmetic Act. This 11-digit NDC is structured as 5-4-2 segments:

- The first 5 digits represent the drug manufacturer and are assigned by the FDA
- The remaining 6 digits, assigned by the manufacturer, specify the product and package size.

10-Digit National Drug Code (NDC)

When the package of a drug only includes a 10-digit NDC number, the 10 digits must be converted to 11 digits by adding a leading zero to only one segment as indicated below:		
If the first segment contains only four digits, add a leading zero to the segment Ex. 09999-9999-99	If the second segment contains only three digits, add a leading zero to the segment Ex. 99999-0999-99	If the third segment contains only one digit, add a leading zero to the segment Ex. 99999-9999-09

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Prior Authorization "Helpful Hints" for a Timely Review

- Drugs that are not found on the formulary/preferred drug list or have a **PA indicator** next to the drug name on the formulary will require prior authorization for coverage
  - **Prior Authorization requirements can change quarterly**—please reference the most current formulary, PA matrix, or CPT/HCPCS code look up tool
- Use the correct Prior Authorization Form (as discussed on previous slides) and the correct fax number, which is found on the upper right-hand corner of every PA form
- If a prior authorization is **successfully received**, a fax is automatically generated and sent to your office titled **"Acknowledgement of Receipt"**
- Always submit relevant chart notes/clinical documentation with every PA request
- If the Molina reviewer needs more information in consideration of the PA request, a **"Notice of Insufficient Information"** will be faxed to your office
  - If your office does not respond to requests for more information, the coverage decision will be made using the original, incomplete information submitted
- The final coverage decision will be faxed or sent electronically to your office including any approvals, denials, or closures
- *Please do not submit any drug PA requests using the Availity; doing so may result in delays for your request*

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Healthcare Services

Stephanie Sanders

Utilization Management and Prior Authorization

How to obtain a Prior Authorization

Prior Authorizations can be obtained by:

- Faxing PA form to UM Team
- Submit through the Availity

	PHONE	FAX
Medicaid	(888) 483-0760	(866) 472-0589
Marketplace	(855) 322-4081	(833) 322-1061
Medicare MMP	(855) 322-4081	(844) 251-1451
Medicare	(855) 322-4081	(844) 251-1450

*Service hours 8am-5pm local M-F, unless otherwise specified

Prior authorization request forms can be found on www.molinahealthcare.com

Prior authorization requests and supporting documentation can be submitted via Mail at:

Medicaid & Marketplace
Molina Healthcare of Utah, Inc.
Attn: Healthcare Services Dept.
7050 Union Park Center, Suite 200
Midvale, UT 84047

Medicare
Molina Healthcare
Attn: Medicare Utilization Management
200 Oceangate, Suite 100
Long Beach, CA 90802

Prior Authorization Matrixes

Molina's preferred method is the Code Look Up Tool on the Molina Healthcare website under Health Care Professionals.

Health Care Professionals (molinahealthcare.com)

State

Health Plan Benefit

LOB

CPT / HCPCS Code

Lookup

- Medicaid - Provider Forms (molinahealthcare.com)
- Medicare - Medicare Providers (molinahealthcare.com)
- Marketplace - Forms and Documents (molinamarketplace.com)

Please note – Absence of the code on the PA tool lookup does not guarantee coverage or payment

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Case Management Structure

*Molina Healthcare's Integrated Care Management program is a collaborative process aimed at meeting an individual's health needs, promoting quality of life, addressing social determinants of health and obtaining the best possible outcomes for the member, delivering the right care, at the right time, in the right setting.

*Molina care managers use information from the assessment process to develop and implement individualized care plans with the member in a timely manner based on the member's own identification of primary health concern in addition to other available data.

*Interdisciplinary Care Team (ICT): involves working collaboratively with the member's entire healthcare team to prevent duplication of services and improve health outcomes.

*Program is primarily conducted telephonically, however, can do face to face as when beneficial.

*Care Management Team Includes: Social Workers, Registered Nurses, Substance Abuse Counselors & Community Connectors.

Molina Care Management

Improving Care One Member at a Time

- Less fragmented care
- Member centric/Improved outcomes
- Use of Motivational Interviewing, to empower and encourage self advocacy for sustained benefits
- Connection to services available in the community (non-covered benefits)
- Reduces member frustration
- ICT working together to ensure care plan goals are met.
- Acts as the member's advocate.
- Delivery of service at the Right place, Right time and Right level of care
- Medication reconciliation (Poly Pharmacy)
- Early identification of health concerns leading to improved PCP engagement
- Improved Health Literacy amongst the most vulnerable populations.
- Continuity of Care (90-day transition period)

Inquiries for Care Management can be sent to the Director of Care Management;

Crystal Shipler at Crystal.Shipler@molinahealthcare.com or call 801-561-3405.

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Appeals and Grievances

Stephanie Sanders

Provider Appeals

If the Provider would like to dispute the processing, payment or nonpayment of a claim, the dispute shall be classified as a Provider Appeal.
The Appeal must be filed within the specified timeframe from the date of the Health Plan's Action.

Marketplace - 180 calendar days

Medicaid Plus- 60 calendar days

Medicare - 60 calendar days if PAR

Providers should submit the following documentation:

- Any medical records or documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request.
- The **claim number clearly** marked on all supporting documents. We process the appeal based on the claim number provided.

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Submitting Provider Appeals Forms

Forms may be submitted via Availity, fax, or mail.

Appeals submitted via Availity at:

https://availity.com/molinahealthcare

Medicaid Plus & Marketplace Appeal Form

www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/id/Medicaid/Forms/appeals-form.pdf

Medicare does not require a form; however, records will be required.

Medicaid Plus & Marketplace Appeals:
Molina Healthcare of Utah, Inc.
Attn: Appeals and Grievance, Complaints Dept
PO Box 182273
Chattanooga, TN 37422
Fax: 877-682-2218 Attn: Appeals

Medicare Appeals to:
Molina Contracted Provider Appeals
PO Box 22811
Long Beach, CA 90801
Fax: 562-499-0610

Claims

Shari Wheeler

Molina is Green

EDI Claims Submission Required

Molina Healthcare is going green and continues to deliver excellent customer service in part through the deployment of electronic provider support services. Molina asks all contracted providers to submit claims electronically. Electronic claim submission provides benefits to providers including faster claim processing, increased overall efficiencies, improved processing accuracy and reduced HIPAA violations.

Molina offers the following **electronic claims submission options**:

- Submit Claims directly to Molina Healthcare of Idaho via the Availity & Legacy Portals: **Availity Provider Portal** **Legacy Provider Portal**
- Submit Claims to Molina through your EDI clearinghouse using Payer **ID 61799**. Please refer to our website www.molinahealthcare.com for additional information.

Molina requires an Itemized Bill on all claims that exceed $100k in billed charges. If Itemized is not received with the original claim the provider is to submit a corrected claim and include the itemized.

The Provider Portal offers the following claim submission functions:

- Submit Professional (CMS1500) and Institutional (UB/UB-04) Claims and upload attachments
- Submit corrected claims, void claims
- Check claim statuses and more

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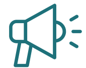
Black and White Claim Submissions

In order to accurately process paper claim submissions, a provider must bill on acceptable claim forms to ensure accuracy of the data being input into our systems.

CMS guidelines state: "For both CMS-1500 and UB-04 Claims, the only acceptable claim forms are those printed in Flint OCR Red, J6986, (or exact match) ink. Although a copy of the CMS-1500 and UB-04 form can be downloaded, copies of the form cannot be used for submission of claims, since your copy may not accurately replicate the scale and OCR color of the form. Please resubmit on red-lined form.

The clearinghouses began rejecting claims on our behalf that are not submitted on the appropriate forms effective 10/01/2022.

You can find Medicare CMS-1500 completion and coding instructions, as well as the print specifications in Chapter 26 of the Medicare Claims Processing Manual (Pub.100-04).



Any paper claims submissions received outside of the appropriate Claims PO Box will be returned to the submitting provider.

Medicaid & Marketplace
Molina Healthcare of Idaho
PO Box 22617
Long Beach, CA 90801

Medicare
Molina Healthcare
PO Box 22811
Long Beach, CA 90801

Corrected Claims Submission

- Providers can submit corrected claims when **changing** or **adding** information, such as a change in coding.
- There are **2** ways to submit a corrected claim to Molina Healthcare:
  1. Electronic Data Interchange (EDI)
  2. Molina Healthcare's Availity Portal
- Tips on submitting corrected claims:
  - **Always** submit through Web Portal or electronically
  - **Do Not** submit corrected claims through the claims appeals or reconsideration process
  - **Always** included the number 7 in box 22 along with the original claim that is being corrected on a CMS 1500. For a UB04 use the number 7 as the last digit in your type of bill
  - **Do Not** submit a corrected claim with only the codes that were edited by Molina Healthcare on the original claim

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Medical Drug Billing "Helpful Hints" for claims processing

- All **outpatient drug claims** from hospitals/outpatient facilities and physicians must include the HCPCS code, HCPCS units, National Drug Code (NDC), NDC unit of measure (ex: mL, gm, etc), and quantity of NDC units.
  - **Inpatient claims** also require this information when a claim line is submitted with a **drug HCPCS code** for reimbursement.
- This HCPCS and NDC information must be included for accuracy, transparency, and safety reasons for both **paper claims** (CMS 1500 and UB-04) and Electronic Data Interchange **(EDI) transactions (837)**
- **Each drug package shows the NDC for the drug**. Please bill for the actual drug NDC that is administered. Billing an NDC from a reference file (such as the Redbook), when it is not the actual drug administered, is considered fraudulent billing.
- NDC information gives essential drug details including the drug manufacturer, name, dose, strength, package size, and quantity.
- ***If the NDC information is missing or invalid, the drug claim line(s) may be denied***.
- The following slides will demonstrate how to correctly provide the NDC information for both paper claim forms and electronic transactions

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EFT and EDI Contacts

EFT

ECHO Health Inc.	
Website	To Register or for Returning Users, please visit www.providerpayments.com
Customer Service	(888) 834-3511

EDI/ERA

Submitting Electronic Claims, Referral Certification and Authorization	
Website	To enroll, please visit https://enrollments.echohealthinc.com
Customer Service (835 Files)	(888) 834-3511
Email (835 Files)	EDI@echohealthinc.com

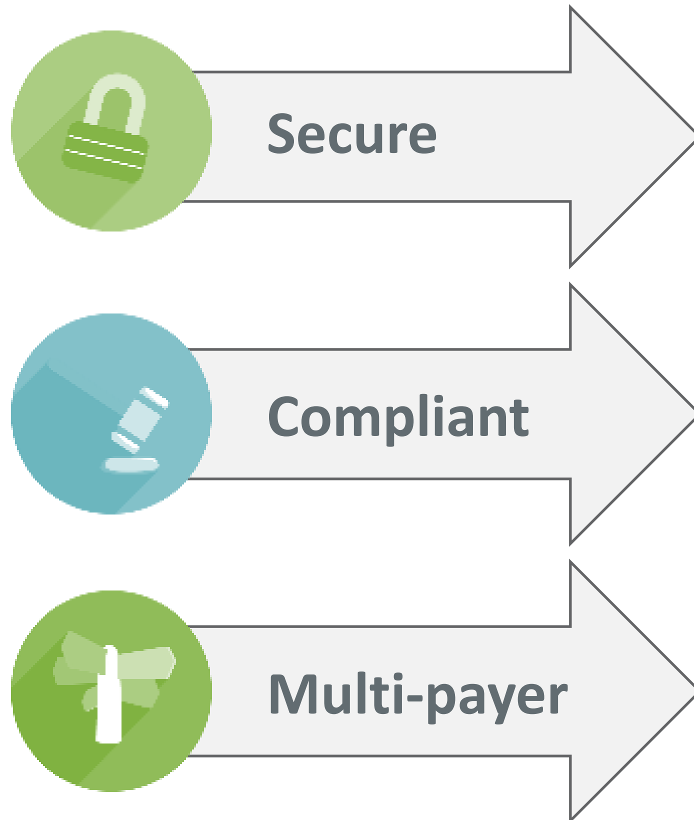
Important Announcement:

Molina Healthcare is working to simplify and improve payment transactions for your business, offering more choice in payment methods. Beginning 09/06/2022 Molina partnered with Change Healthcare and ECHO Health, Inc. (ECHO) to provide payment solutions to better meet provider needs.

Availity

Shari Wheeler

Why Availity?



Availity Portal offers secure online access to multiple health plans, and the ability to manage business transactions through a single, easy-to-use site.

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Availity Features

	Feature	Description
1	Submit Claims	with direct-entry forms including option to submit corrected claims and COB (primary, secondary, tertiary claims).
2	**Check eligibility and benefits**	including an option to send a message to the payer.
3	**Follow-up on claims**	with claim status, remittance viewer, electronic attachments, and more.
4	**Access payer-specific applications and resources**	through a dedicated payer space as well as time saving tools like express entry for selecting providers, patients, and codes.

Getting Started

- Unregistered Organizations
  - Go to www.availity.com/molinahealthcare
- Existing Availity Portal Users
  - In Availity Portal, select **Help and Training > Get Trained**.
  - In the Availity Learning Center (ALC) that opens in a new browser tab, search the catalog by keyword “Molina”.

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Upcoming Live Availity Webinars

Knowing the ins and outs of working with Molina can be invaluable in streamlining your workflow. That's why Availity and Molina are teaming up to offer a live webinar, "Availity Essentials Provider Portal Overview for Molina Providers".

- We'll show you how to work with Molina on Availity and access popular Single Sign On (SSO) capabilities. Here's a preview of what you'll learn:
  - Submit and view claims
  - Check eligibility and benefits
  - File appeals and correct eligible claims
  - Upload supporting documentation using the send attachments feature
  - Directly message Molina Healthcare from within the Claim Status and E&B transactions
  - Access these SSO capabilities through Molina's Payer Space: Authorizations, Member Roster, and Reports

Webinar Dates and Times

Join Availity and Molina for Availity Essentials Provider Portal Overview for Molina Healthcare Providers on these dates:

- Tuesday, December 5 @ 1:00 p.m. ET - Availity Essentials Provider Portal Overview for Molina Healthcare Providers - Live Webinar, 12/5/2023 -TBD

Bonus! For your convenience, all attendees will receive a handout with tips on accessing the Availity tools that they can use for Molina.

To register for one of the above training sessions, log into Availity Essentials and proceed to the Help & Training section located at the top right of the screen and select Get Trained. Once in the training catalog, go to the Sessions tab at the top of the page and then you will see the above trainings listed as **Availity Essentials Provider Portal Overview for Molina Providers – Live Webinar.**

Quality Improvement & Risk Adjustment

Jennifer Moorman

Quality Improvement

- Medicare Star ratings
- Medicaid State and Medicare CMS Regulatory Compliance
- NCQA Accreditation
- Provider Engagement Program
  - Provider Quality Bonus
  - Missing Services Lists
- Provider and Member Satisfaction
- Member Outreach Programs

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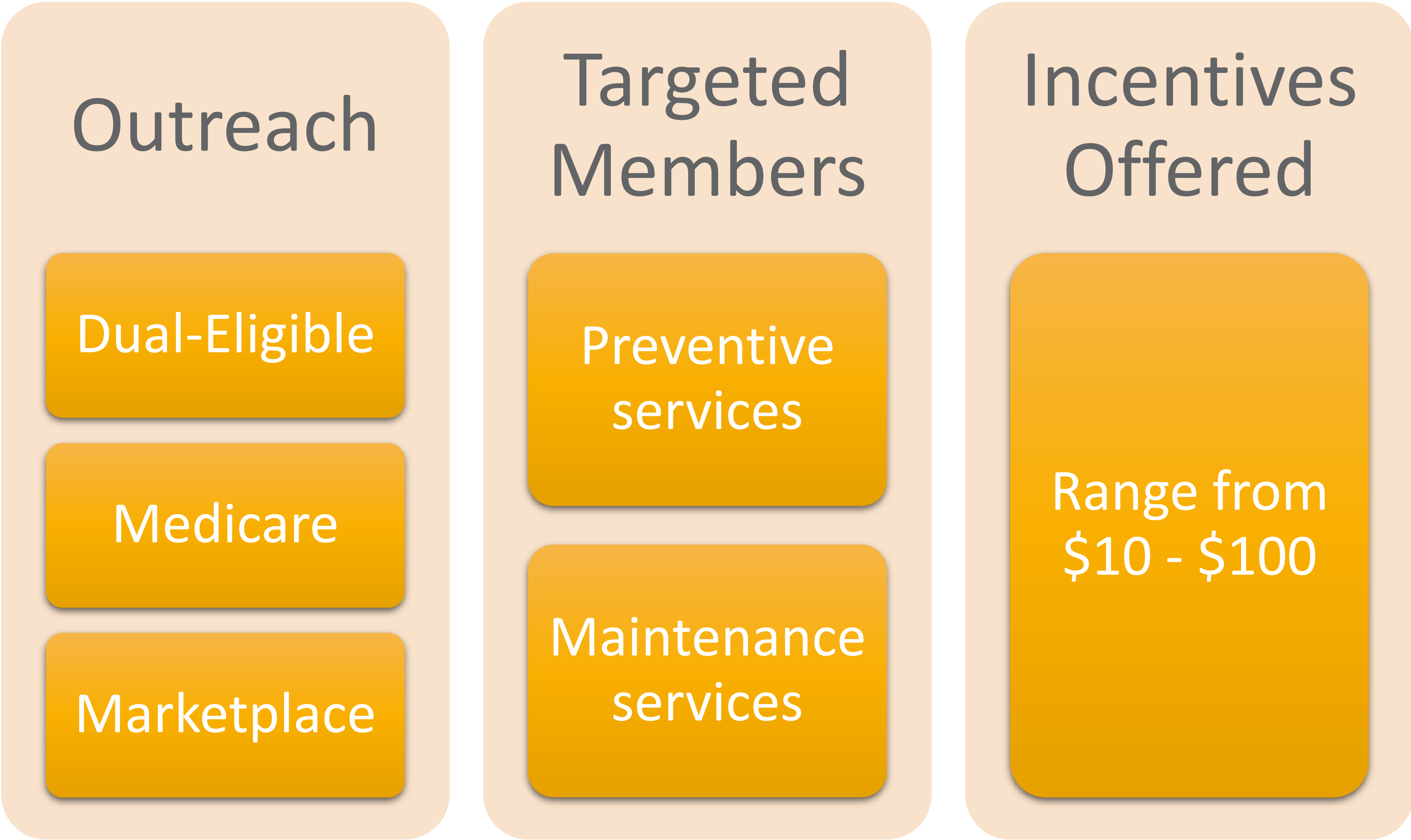
2023 Member Outreach and Incentive Programs



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2023 Molina Healthcare Idaho Medicare Healthy Reward Incentive Program

Molina Healthcare Idaho Medicare members can earn gift cards by completing healthy activities and preventive screenings.

Measure	Reward Amount
Breast cancer screening	$75
Colon cancer screening	$50
Controlling blood pressure	$35
Diabetes (A1c)	$50
Diabetes (Eye)	$100
Flu shot	$35
Osteoporosis management	$50
Annual wellness visit	$35

Questions? If your Molina members have any additional questions about the program, please direct them to call (844) 485-1046, TTY 711; Monday – Friday, 8 a.m. - 5 p.m. (MDT).

HEDIS® Measures

Purpose – Ensure every Molina Healthcare member has an assessment of all needed HEDIS® metrics within the outlined timeframes.

Provider Goals
▪ Complete all appropriate needed HEDIS® metrics for all members.
▪ Ensure all services performed are documented on claims/encounters for all members assigned to the provider.
▪ Reduce HEDIS® chart review by: ○ Comprehensive coding ○ Supplemental data file ○ Remote EMR access

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

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Provider Support

- Provider Incentives and programs to promote patient wellness and preventive care.

- HEDIS® Tip Sheets on the Availity Portal; Performance reporting; Designated Quality Specialist.

- HEDIS® metric reports and missing service reports available.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

Medicare Quality Performance Measures

2023 Medicare Star HEDIS® Measures
Breast Cancer Screening (BCS)
Care for Older Adults (COA - M) – Medication Review
Care for Older Adults (COA - P) – Pain Assessment
Colon Cancer Screening (COL)
Controlling High Blood Pressure (CBP)
Eye Exam for Patients with Diabetes (EED) – Eye Exam
Hemoglobin A1C for Patients with Diabetes (HBD) – HbA1c Adequate Control (<8%)
Kidney Health Evaluation for Patients with Diabetes (KED)
Medication Adherence for Hypertension (RAS antagonists)
Statin Therapy for Patients with Cardiovascular Disease (SPC)
Medication Adherence for Cholesterol (Statins)
Statin Use in Persons with Diabetes (SUPD)

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CAHPS®

(Consumer Assessment of Healthcare Providers and Systems)

Medicare

Collected by CMS

Visit the MA and PDP CAHPS website at www.MA-PDPCAHPS.org

Commercial Medicaid

CAHPS Health Plan Survey

Child Version (CPC) – Adult Version (CPA)

Collected Annually

Four global rating questions reflect overall satisfaction:

1. Rating of All Health Care
2. Rating of Health Plan
3. Rating of Personal Doctor
4. Rating of Specialist Seen Most Often
5. Preventive Services

Four composite scores summarize responses in key areas:

1. Customer Service
2. Getting Care Quickly
3. Getting Needed Care
4. How Well Doctors Communicate

Measures Collected Through CAHPS

- FVA - Flu Vaccinations for Adults Ages 18-64
- FVO - Flu Vaccinations for Adults Ages 65 and Older
- MSC - Medical Assistance With Smoking and Tobacco Use Cessation
- PNU - Pneumococcal Vaccination Status for Older Adults

Risk Management

What is Risk Adjustment?

- Reimbursement models for all lines of business based on a patient's health status, demographics, and predicted expenditures.
- Risk Adjustment Factor (RAF) scores are applied to each member and are the combination of a patient's disease burden and their demographic information.
- Accurate and comprehensive documentation of the patient's acuity of illness drives risk score accuracy.

HCC – Hierarchical Condition Category

- Typically grouped by categories of related diagnoses, often by expected cost of care.
- Health status resets January 1 requiring every appropriate HCC to be recaptured during medical examination
- Appropriate claims coding assures accurate data capture.

NCQA Accredited 2007-2026

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Questions?

Satisfaction survey below:

Orientation Survey

Thank you!

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