

Annual Mandatory D-SNP Medicare Model of Care Training

Information for providers in the Medicare network

The Centers for Medicare and Medicaid Services (CMS) requires certain contracted Medicare medical providers complete a basic training on the Molina Healthcare-specific Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC) by Dec. 31, 2023. This includes the following provider types:

- Primary Care Provider (all specialties for PCP Physicians)
- Hematology/Oncology (Gynecologic Oncology, Hematology, Hematology and Oncology/Oncology and Hematology, Medical Oncology, Oncology, Surgical Oncology)
- Obstetrics/Gynecology (Gynecology, Obstetrics and Gynecology, Obstetrics)
- Psychiatry (Child and Adolescent Psychiatry, Geriatric Psychiatry, Psychiatry)

Your practice must take action to complete this training and submit your attestation.

Microsoft Teams Training: Molina will be hosting MOC provider training sessions via Microsoft Teams to help train you, your staff, and address questions. Visit the [It Matters to Molina \(IMTM\)](#) page on our Provider Website and click on the desired training to access meeting details.

- Mon., Aug. 21, 2 to 3 p.m.
- Wed., Sept. 13, 1 to 2 p.m.
- Tues., Oct. 10, 1 to 2 p.m.
- Fri., Nov. 3, 12 to 1 p.m.
- Tues., Dec. 5, 1 to 2 p.m.

Online Training: The Molina [“2023 Model of Care Provider Training”](#) is on the Medicare Provider Website, under the “Model of Care” header.

After reviewing the training, providers should complete and submit the [“OH MOC Attestation Form”](#) located in the “Select State Form” drop-down menu.

Reminder, individual providers can fill out and submit the OH MOC Attestation Form online.

If one provider is willing to sign off for a group or clinic, the provider should not fill out and submit the OH MOC Attestation Form online, instead the provider must:

1. Export the OH MOC Attestation Form using the “Export to PDF” button on the Provider Website
2. Fill out an Excel spreadsheet of all the providers in the clinic/group and include:
 - Name of the provider giving the training
 - Clinic/Practice name
 - Clinic/Practice address
 - Tax Identification Number (TIN)
 - The method used to train office staff and providers
 - Date the office staff and providers were trained
 - Date the office staff and providers sign the attestation
3. Email the completed OH MOC Attestation Form and Excel spreadsheet to OHAttestationForms@MolinaHealthcare.com

Find additional information on CMS Model of Care requirements at [cms.gov](https://www.cms.gov) under “Regulations & Guidance,” then “Manuals,” and “Internet-Only Manuals (IOMs)” in the “CMS 100-16 Medicare Managed Care,” then “Chapter 5 – Quality Assessment,” find “Section 20.2.1 – Model of Care Elements,” then “3. SNP Provider Network,” and “C. MOC Training for the Provider Network.”

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Questions?

Provider Services – (855) 322-4079
Monday - Friday: 7 a.m. to 8 p.m. for
Medicaid, 8 a.m. to 6 p.m. for MyCare
Ohio, and 8 a.m. to 5 p.m. for Medicare
and Marketplace

Email us at OHProviderRelations@MolinaHealthcare.com

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Re: 2023 MODEL OF CARE TRAINING ATTESTATION MANDATORY REQUIREMENT

As part of required CMS mandated annual training, Molina has developed the Model of Care program for dual eligible enrollees. The Model of Care program serves as the foundation for Molina’s care management policy, procedures, and operational systems for our Medicare/Dual eligible population.

What Providers Need to Do – DEADLINE: DECEMBER 31, 2023

1. Complete training.
2. Complete and sign this form.
 - a. If it is a group training, OH MOC Attestation Form should be submitted via email by the individual with authority to sign on behalf of the group and an attendance roster must be attached.
3. Return this form via email to OHAttestationForms@MolinaHealthcare.com.

This Attestation will serve as evidence of completion for Molina’s Model of Care Provider training.

Model of Care Training Attestation Calendar Year 2023

I have received and reviewed the written materials for the Model of Care training.

Print Provider Name	
Provider Primary Specialty	
Print Clinic/Practice Name	
Clinic/Practice Address	
Signature	
Date	
TIN	
NPI	
Provider Contact Name	
Telephone Number	