Marketplace Provider Orientation

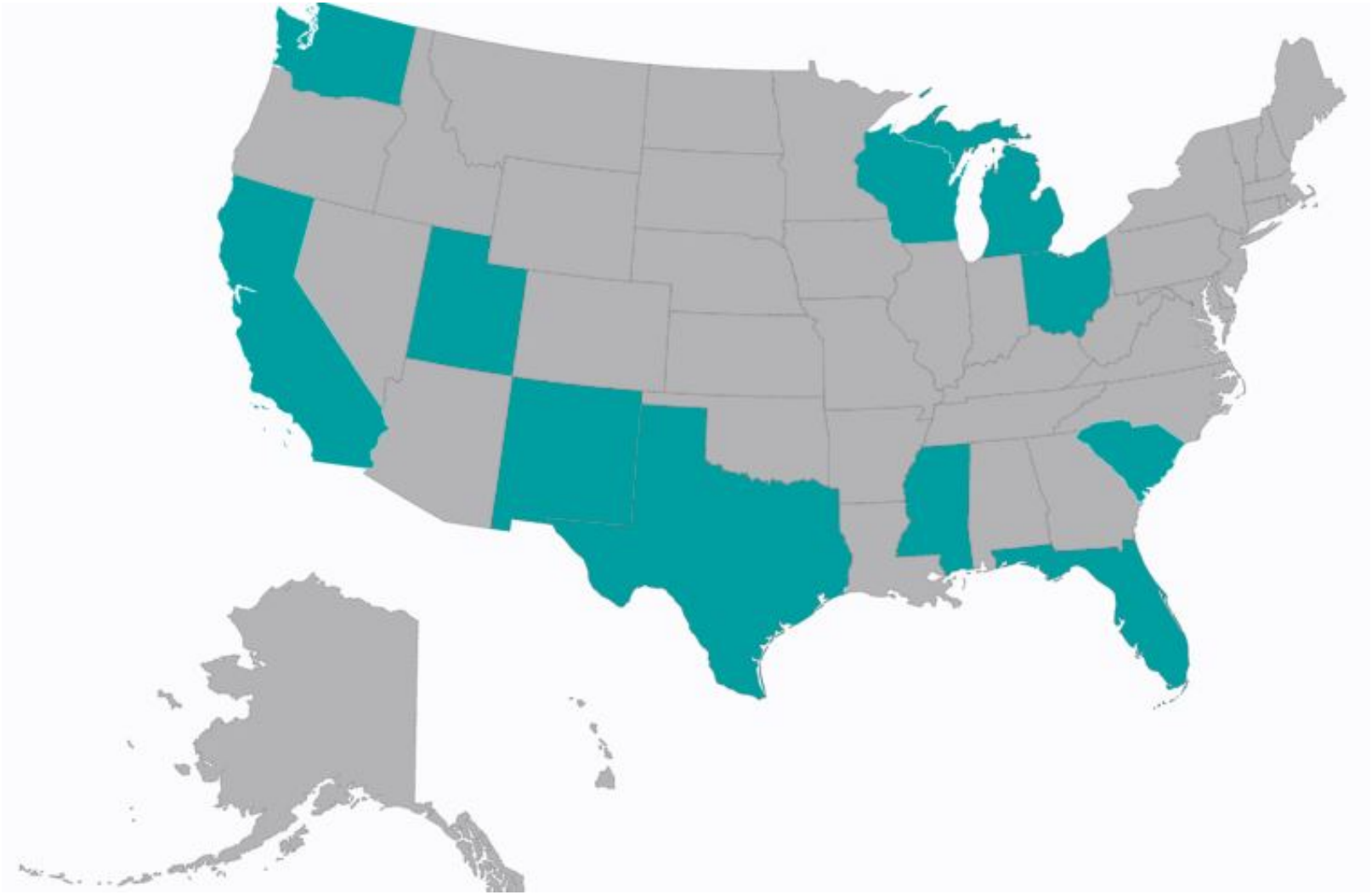
MOLINA® HEALTHCARE

The Molina Story

Three Decades of Delivering Access to Quality Care

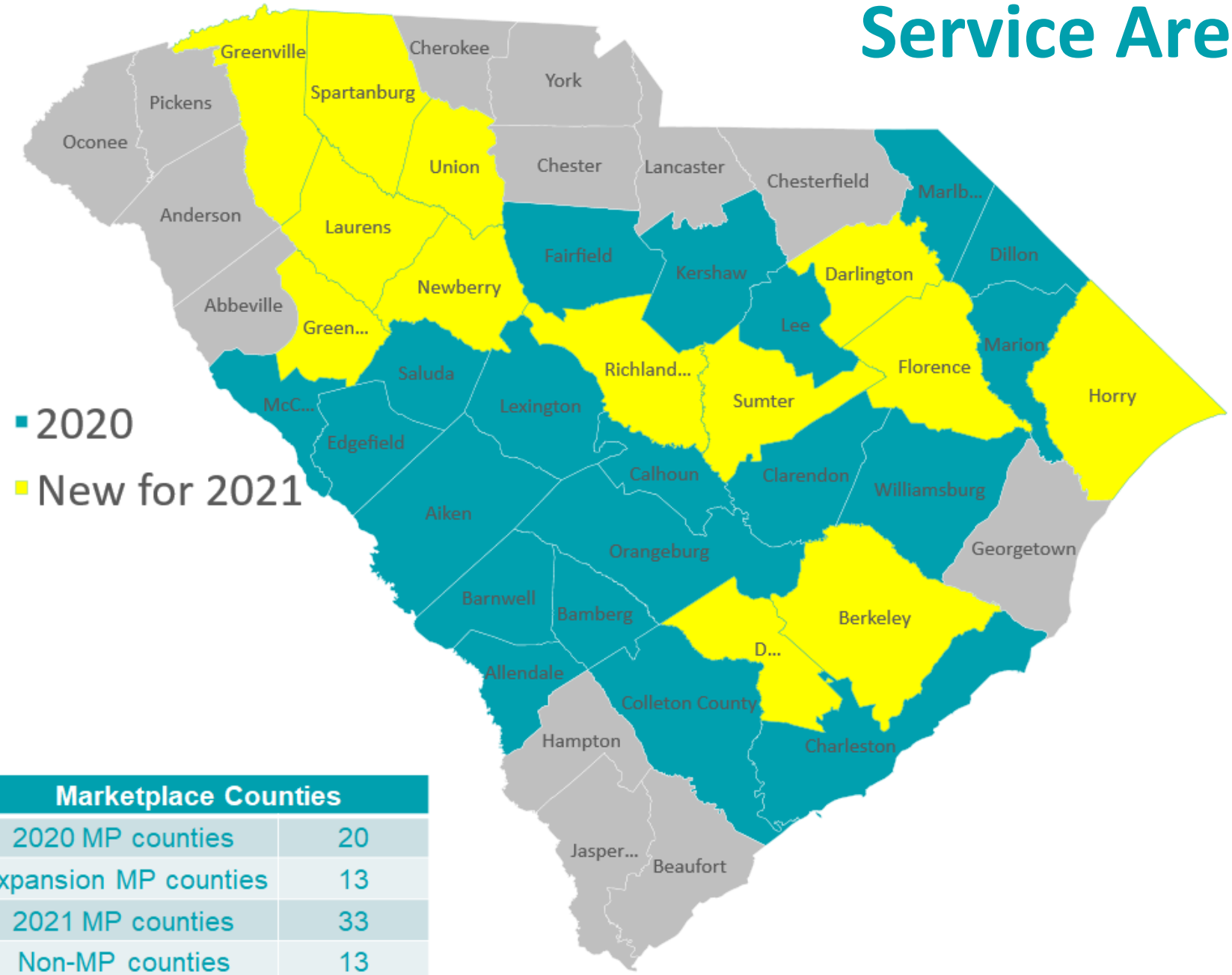
- Dr. C. David Molina founded Molina Healthcare.
- He opened a community clinic to show that caring for people was more important than their ability to pay.
- Molina currently has over 3 million members and beneficiaries.
- Molina providers NCQA-accredited care and services that focus on promoting health, wellness and improved patient outcomes.
- We treat everyone like family, just as Dr. Molina did – making Molina your extended family.

So where are we going?



Marketplace is currently in these states: Florida, Mississippi, Michigan, Ohio, South Carolina, Utah, Washington, Wisconsin, California, New Mexico, and Texas

Service Area



Marketplace Counties	
2020 MP counties	20
Expansion MP counties	13
2021 MP counties	33
Non-MP counties	13

Introduction to Health Insurance Exchange

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

- Depending on the consumer's income, the government covers part of the cost of Marketplace insurance. Molina offers Marketplace plans in eight states.
- The Marketplace is an outcome of the Affordable Care Act – more commonly known as health care reform or Obamacare.
- On the Marketplace, consumers can look at the insurance options available to them all in one place.
- The Marketplace was created as a simple way for individuals and small businesses to buy affordable health care coverage.

Marketplace Product Portfolio

The Molina Marketplace portfolio is available for Gold, Silver and Bronze plans in South Carolina. Our targeted focus is on the low-income segment to align with our Medicaid offerings.

Plans

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

Gold Plan

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

Silver Plan

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

Bronze Plan

- Great for low-income individuals because the subsidy covers the monthly premiums
- Offers good first-dollar coverage, which offsets some of the impact the of the higher cost sharing

Marketplace Required Benefits

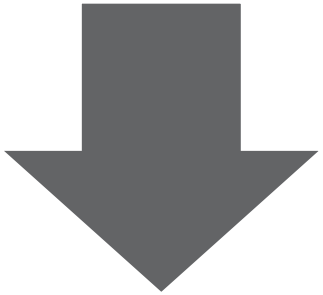
All Qualified Health Plans (QHP) must include the following 10 categories of Essential Health Benefits (EHB) defined by ACA:

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

Special Enrollment - Exceptions

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

31 days to report the qualifying event



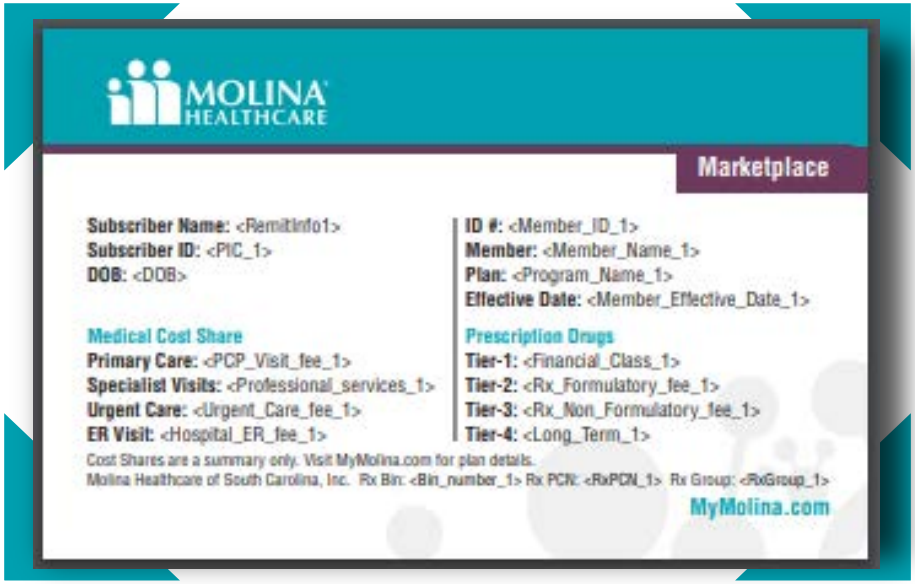
60 days from the qualifying event to select a QHP

Special Enrollment - Exceptions

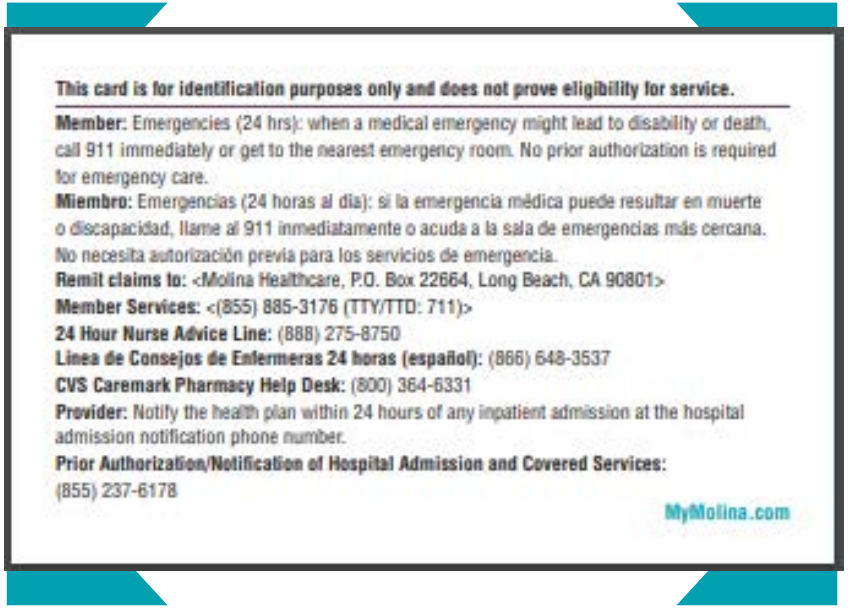
Special Enrollment Event

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

Molina Marketplace ID Card



Front



Back

Member Cost Sharing

Cost sharing is the d**eductible, copayment, or coinsurance** that members must pay for covered services provided under their Molina Marketplace plan.

Cost Sharing applies to all covered services, except preventive services, included in the Essential Health Benefits (as required by the Affordable Care Act).	It is the provider's responsibility to collect the copayment and cost share from the member to receive full reimbursement for a service.	The amount of the co-payment and other cost sharing will be deducted from the Molina payment for all claims involving cost sharing.

Binder Payment and Restrictions

The first month premium is referred to as their binder payment.

If a member does NOT make the binder payment, the coverage will not be effective.

There will be a binder restriction placed on every Marketplace member record.

Additional restrictions may also be added.

Status and eligibility of members can be obtained via our provider portal

Grace Period

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

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

Grace Period Timing

Non-APTC members are granted a 1-month grace period, and can access some or all services covered under their benefit plans. If the full past-due premium is not paid by the end of the grace period, the Non-APTC Member will be retroactively terminated to the last paid day of the last month.

SUN	MON	TUE	WED	TH	FRI	SAT
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	**15**	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Grace Period Timing

APTC members are granted a three-month grace period. During the first month, claims and authorizations will continue to be processed. Services, authorization requests and claims may be denied or have certain restrictions during the second and third months.

If the APTC member's full past-due premium is not paid by the end of the third month of the grace period, the APTC Member will be retroactively terminated to the last paid day of the first month of the grace period.

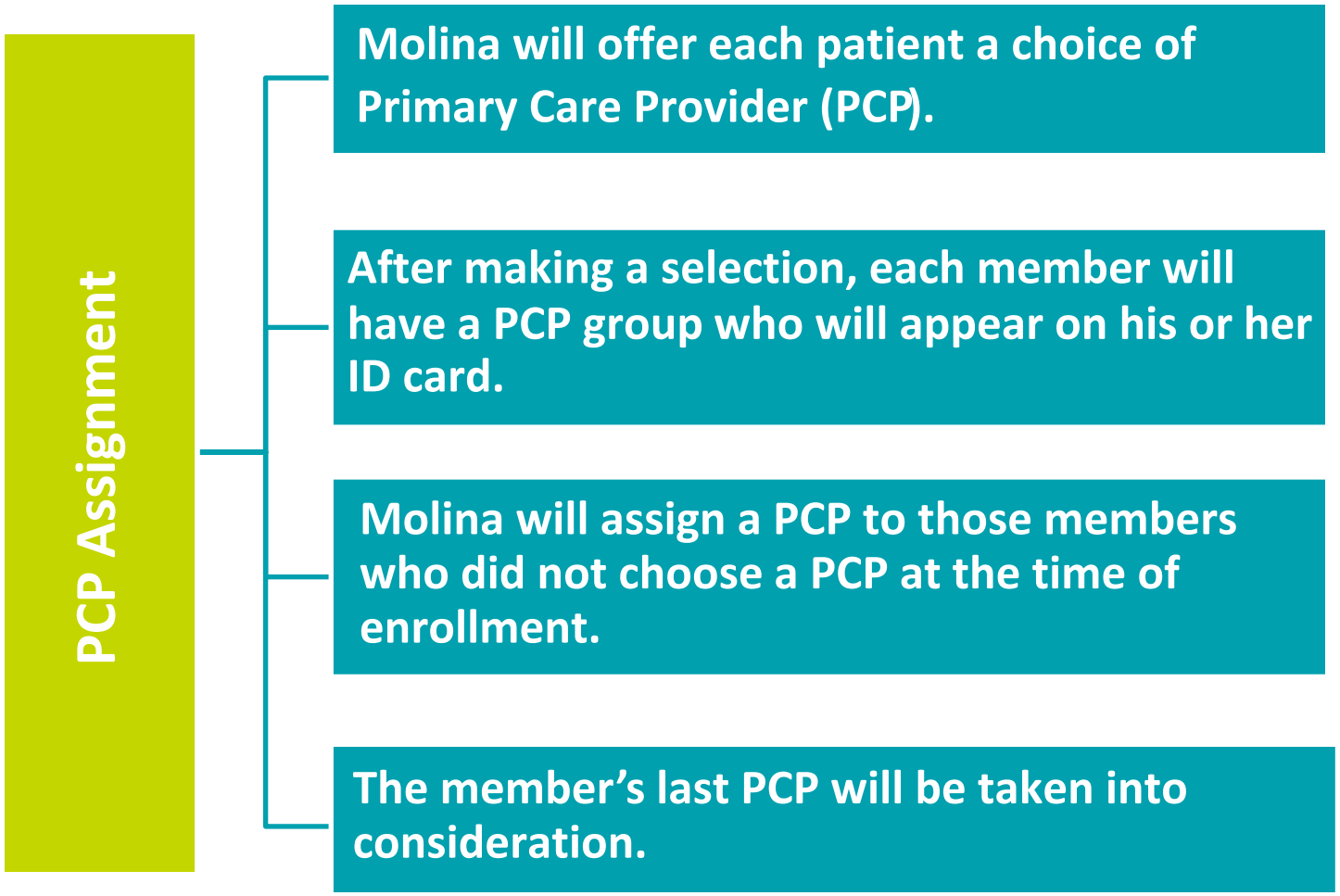
SUN	MON	TUE	WED	TH	FRI	SAT
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	**15**	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Grace Period

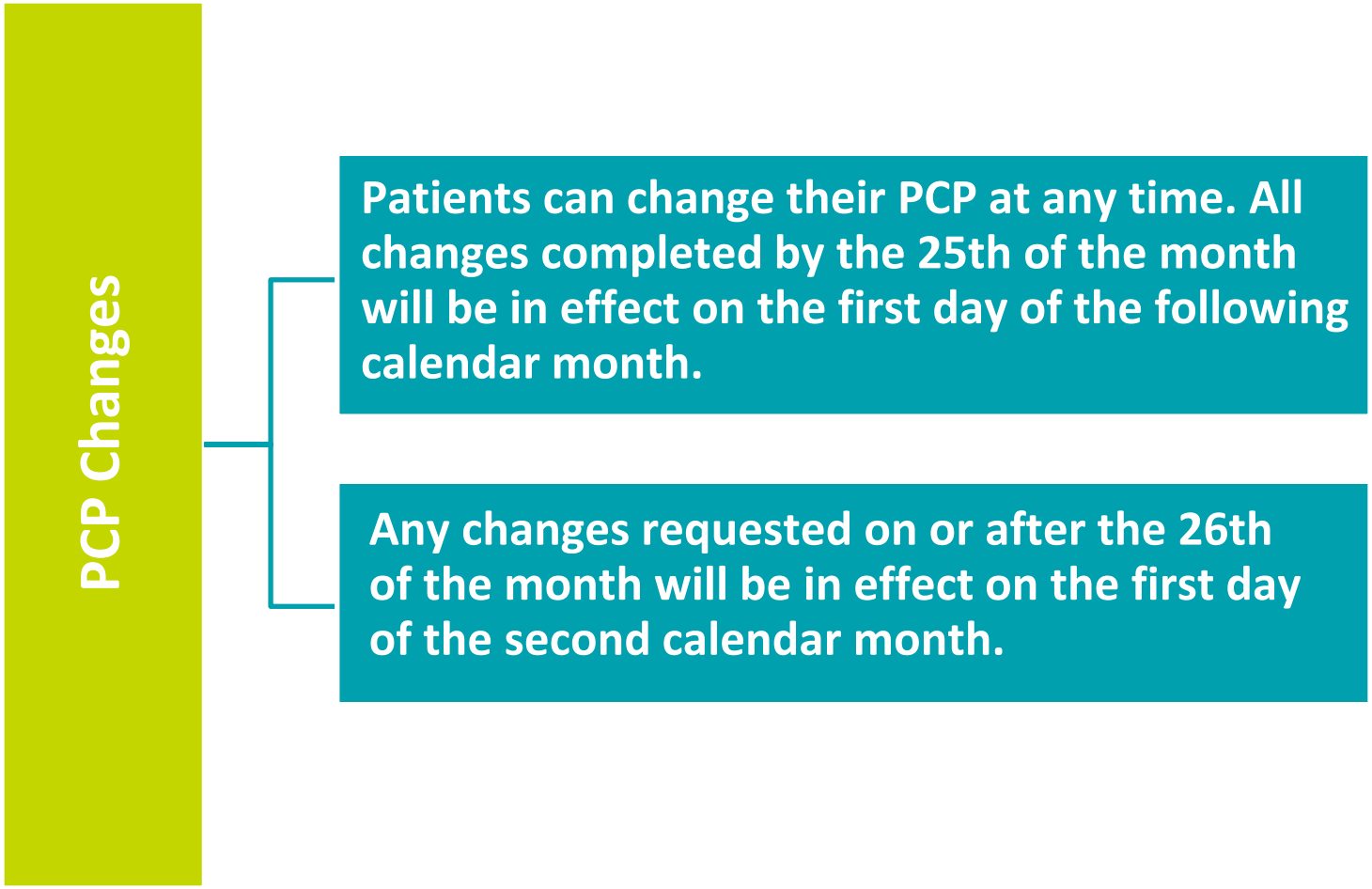
Service Alerts

- When a member is in the grace period, Molina will have a service alert on the Web Portal, Interactive Voice Response (IVR) and in the call center. This alert will provide more specific detail about where the member is in the grace period (first month vs. second and third) as well as information about how authorizations and claims will be processed during this time.
- Providers should verify the eligibility status and any service alerts when checking the eligibility of a member.
- For additional information about how authorizations and claims will be processed during this time, please refer to the Member Evidence of Coverage or contact our Provider Services department at (855) 237-6178.

Primary Care Assignment



Primary Care Provider (PCP) Changes



Prior Authorizations

Molina requires PA for specified services as long as the requirement complies with Federal or State regulations and the Molina Hospital or Provider Services Agreement. The list of services that require PA is available in narrative form, along with a more detailed list by CPT and HCPCS codes.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and state law) are excluded from the PA requirements. Molina does not "retroactively" authorize services that require PA.

Prior Authorizations

Molina will process any non-urgent requests within 5 calendar days of receipt of request. Urgent requests will be processed within 72 hours of receipt of the request.

Providers who request PA approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time medical director available to discuss medical necessity decisions with the requesting provider at (855) 237-6178.

Services that Require Prior Authorization

An example of some of the services that require prior authorization include:

- Behavioral Health
- Experimental
- Durable Medical Equipment
- Home Health/Infusion
- Non – Participating Providers or Facilities
- Cosmetic Services
- General Dental Anesthesia
- Durable Medical Equipment
- Imaging Services
- Inpatient Admissions
- Pain Management Procedures

For a complete list of services that require PA, please see our codified list **here**.

Prior Authorization Form

You can submit PAs in two different ways:

- Submit Online: Via our Provider Web Portal at https://eportal.MolinaHealthcare.com/Provider/login
- Or fax: (833) 322-1061

Hospitals

Emergency Care

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent emergency care services rendered to the member do not require PA from Molina.

Members accessing the emergency department inappropriately will be contacted by Molina Care Managers whenever possible to determine the reason for using emergency services. Care Managers will also contact the primary care provider (PCP) to ensure that members are not accessing the emergency department because of an inability to be seen by the PCP.

Hospitals

Admissions

Hospitals are required to notify Molina within 24 hours or the first working day of any inpatient admissions, including deliveries, in order for hospital services to be covered. PA is required for inpatient or outpatient surgeries.

Claims Submissions

Claims must be submitted in accordance with the guidelines and processes set forth in the "Claims" section of the provider manual.

Access to Care Standards

Providers 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, place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Members' medical (physical or mental) condition or the expectation of frequent or high-cost care may not negatively affect the care received. Providers must give Molina 30 days written notice if closing a panel to new members.

Office Wait Times

- Not to exceed 45 minutes
- Primary Care Providers (PCPs) are required to monitor waiting times and adhere to standard

After Hours Care

- Providers must have backup (on call) coverage 24/7
  - It may be an answering service or recorded message
  - It must instruct members with an emergency to hang up and call 911 or go to the nearest emergency room

Appointment Types

Medical Appointment

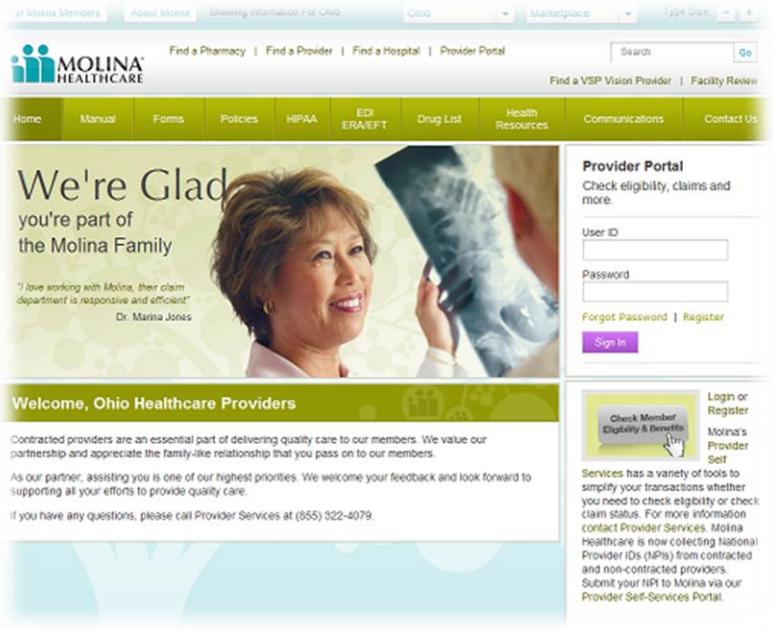
Appointment Types	Standard
Routine, Primary Care	Within 4 weeks
Urgent Care	Within 48 hours
After Hours Care	24 hours/day; 7 day/week availability
Specialty Care (High Volume)	Within 12 weeks
Specialty Care (High Impact)	Within 12 weeks
Urgent Specialty Care	Within 48 hours

Behavioral Health Appointment

Appointment Types	Standard
Life Threatening Emergency	Immediately
Non-life-Threatening Emergency	Within six hours
Urgent Care	Within 48 hours
Initial Routine Care Visit	Within 10 calendar days
Follow-up Routine Care Visit	Within 30 calendar days

Provider Online Resources

- Provider Manuals
- Provider Online Directory
- Web Portal
- Preventive & Clinical Care Guidelines
- Prior Authorization Information
- Advanced Directives
- Claims Information
- Pharmacy Information
- Health Insurance Portability & Accountability Act (HIPAA)
- Fraud, Waste & Abuse Information
- Communications & Newsletters
- Member Rights & Responsibilities
- Contact Information



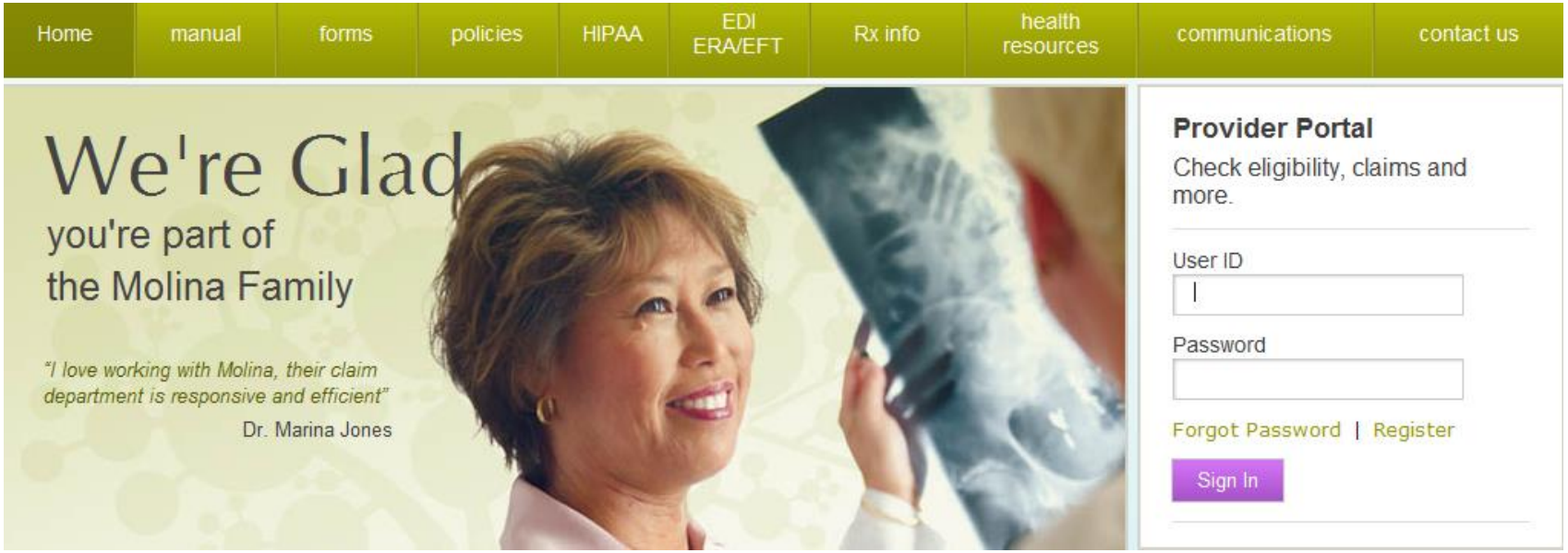
Provider Web Portal

The Web Portal is secure and available 24 hours a day, seven days a week. Register for access to our Web Portal for self-services, including:

- Member eligibility verification and history
- Coordination of benefits (COB)
- Update provider profile
- View Primary Care Provider (PCP) member roster
- Online chat with Care Manager
- Submit claims, corrected claims, and voided claims
- Claims status inquiry
- Member Nurse Advice Line call reports
- Healthcare Effectiveness Data and Information (HEDIS®) missed service alerts for members
- Status check of authorization requests
- Secure emailing with Molina

Register for Web Portal

Register **here**. You will need the TIN and your Provider Identification number or three of the following: NPI, State License Number, Medicaid Number, or DEA Number.



Registration Instructions

1. Begin registration

- Click “New Registration Process”
- Select “Other Lines of Business”
- Select state
- Select role type “Facility or Group”
- Click “Next”

2. Required Fields

- Enter first name
- Enter last name
- Enter email address
- Enter email address again to confirm

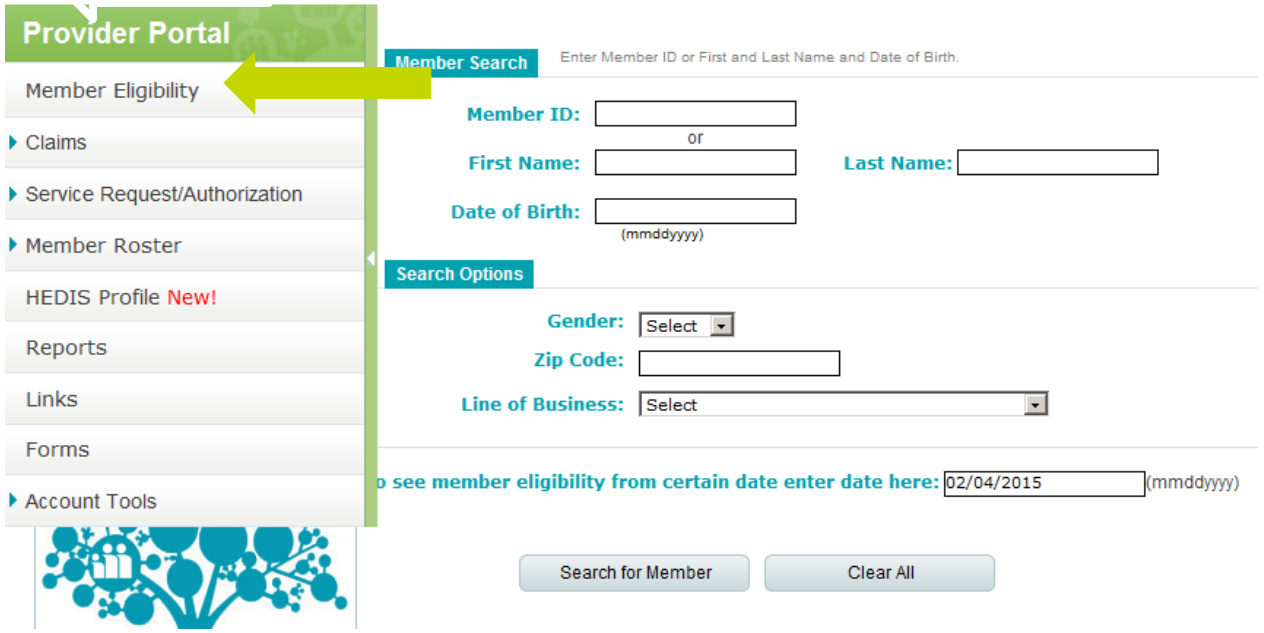
3. Username and Password

- Create user ID using 8-15 characters
- Create a unique password with 8-12 characters
- Select three security questions and answers

4. Complete Registration

- Accept “Provider Online User Agreement” by clicking on the check box
- Enter the code in the textbox as shown in the image
- Click “Register”

Member Eligibility Search



Click ***Member Eligibility*** from the main menu. Search for a Member using Member ID, First Name, Last Name and/or Date of Birth. When a match is found, the Web Portal will display the member's eligibility and benefits page.

Verifying Member Eligibility

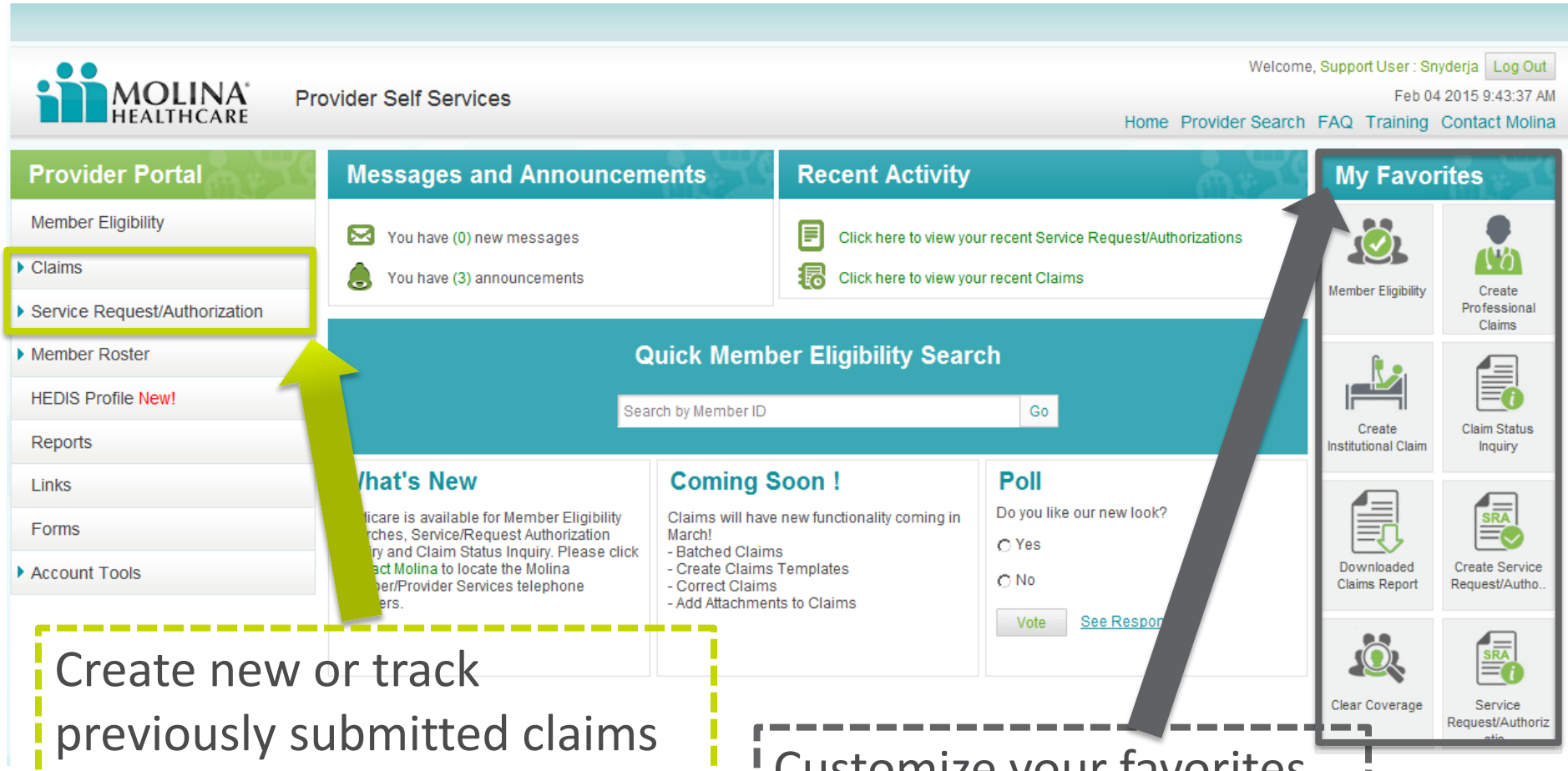
Molina offers various tools to verify member eligibility. Providers may use our online self-service Web Portal, integrated voice response (IVR) system, eligibility rosters or speak with a customer service representative.

Please note: At no time should a member be denied services because his or her name does not appear on the eligibility roster. If a member does not appear on the eligibility roster, please contact Molina for further verification.

Web Portal: https://eportal.molinahealthcare.com/Provider/login

Provider Services/24-hour IVR Automated System: (855) 237-6178

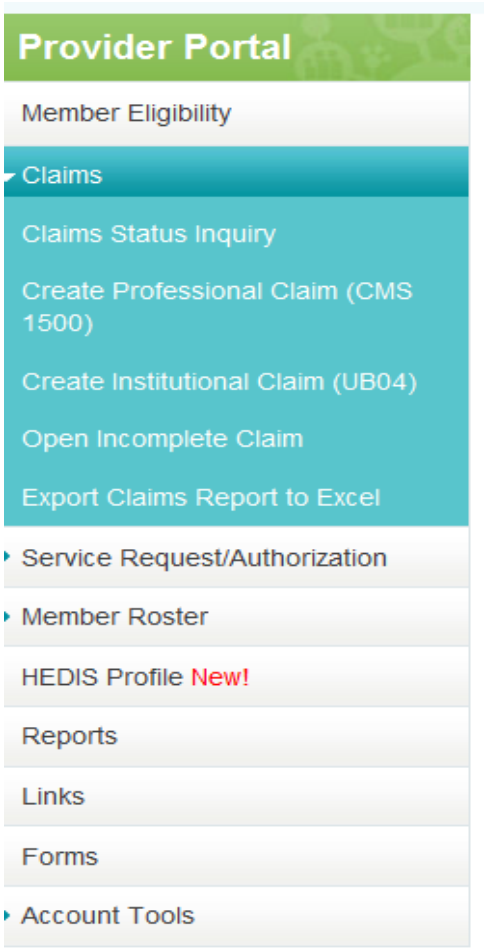
Web Portal



Create new or track previously submitted claims and prior authorizations.

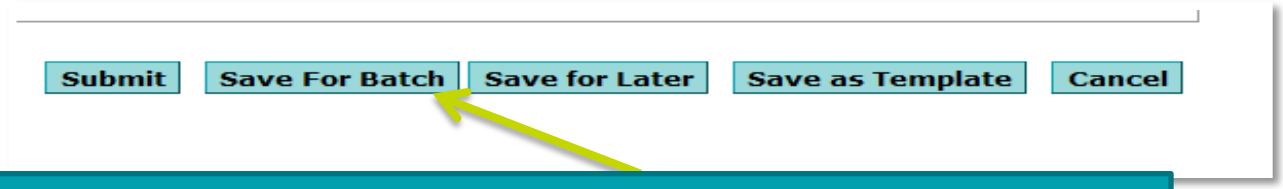
Customize your favorites for quick access.

Web Portal



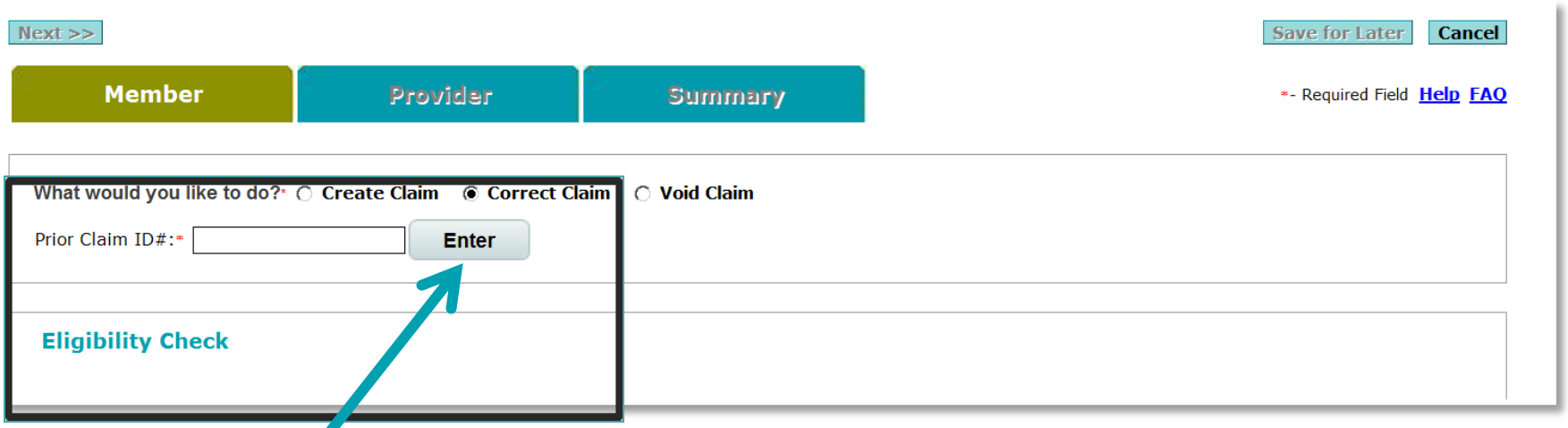
You can also build claims and submit a batch of claims all at once.

- Complete a claim following the normal process.
- Then, instead of submitting, select “Save for Batch.”
- Claims saved for a batch can be found in the “Saved Claims” section in the side menu.
- Ready-to-batch claims need to be selected and then can be submitted all at once.



You will still receive an individual claim number for each claim submitted.

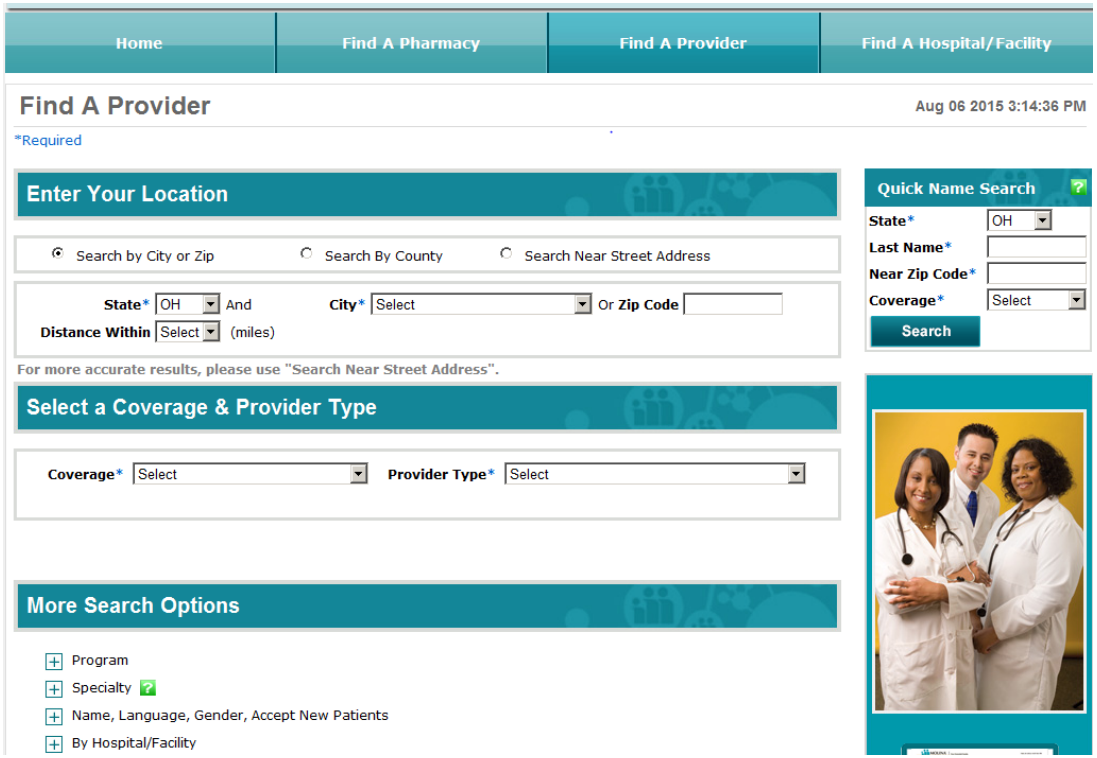
Web Portal



Enter Claim ID number here.

Submit corrected claims or void a claim through the Web Portal. First select "Create Claim," then select the "Correct Claim" or "Void Claim" feature and enter the previously assigned Claim ID number.

Provider Online Directory



Molina Healthcare providers are encouraged to use the Online Provider Directory on our website to find a network provider or specialist.

To find a Molina Healthcare provider, visit our Provider Online Directory **here** and click “Find a Provider".

Claims Submission Options

Clearinghouse

EDI or electronic claims are processed faster than paper claims. Providers may use any clearinghouse. Note that fees may apply. Emdeon is the outside vendor used by Molina.
Use payer ID: 46299
Emdeon phone: (877) 469-3269

Provider Web Portal

Online submission through the Web Portal at MolinaHealthcare.com/provider/login

Paper claims directly to Molina Healthcare

Attn: Molina Marketplace Claims, P.O. Box 22664, Long Beach, CA 90801

Corrected Claims

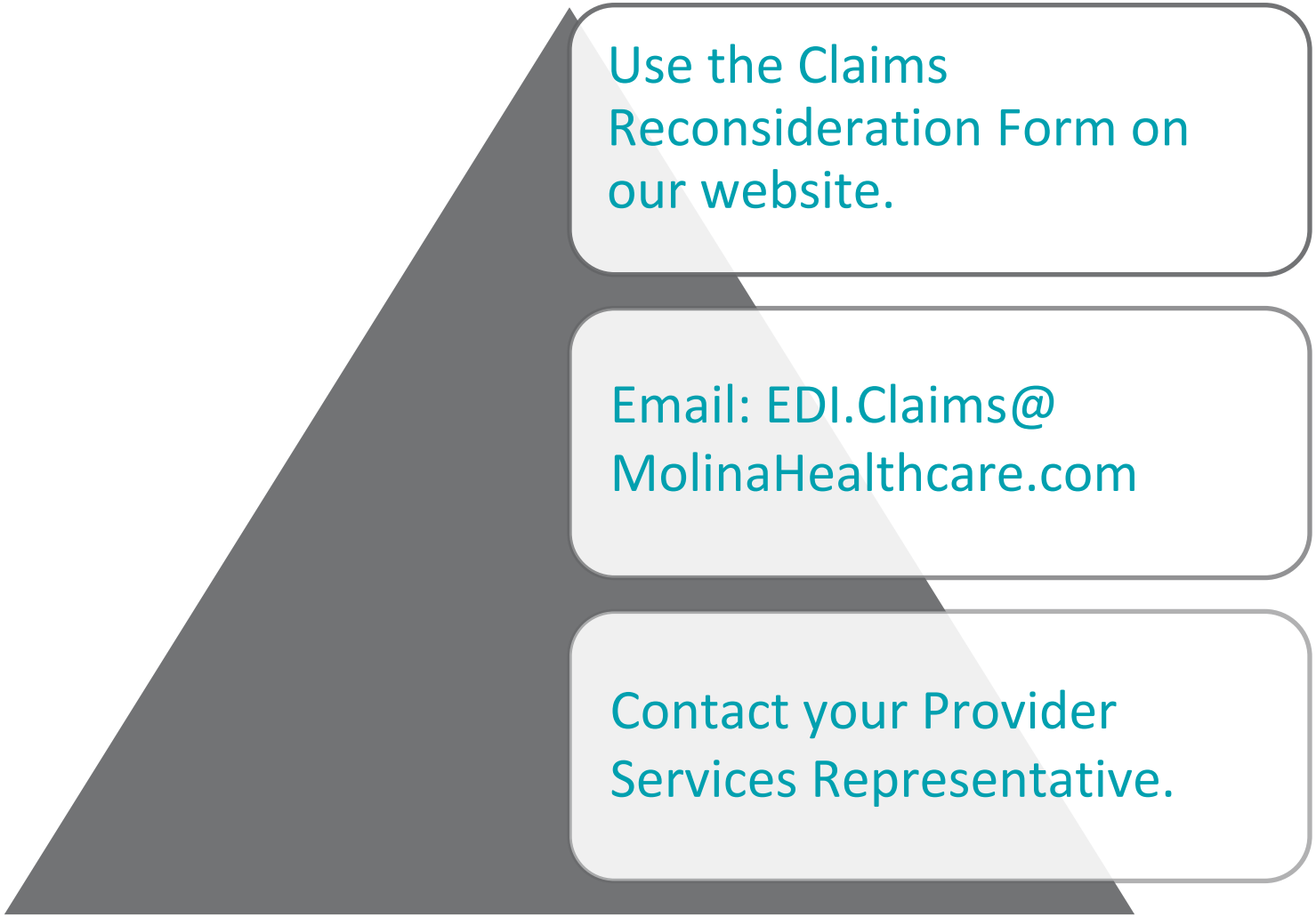
Use the Corrected Claims Form on our website.

Providers have 120 days from the date of original remittance advice.

Mail completed form and corrected claim to:

P.O. Box 22664, Long Beach CA 90801

EDI Submission Issues



Claims Reconsiderations

Call the EDI customer service line at (866) 409-2935.

Requests must be received within 120 days from the date of original remittance advice.

Mail to:
Grievance and Appeals Unit
P.O. Box 40309
North Charleston, SC 29423

For help with any claims related process, contact Provider Services at: (855) 237-6178

Electronic Payments

Molina partners with our payment vendor, **FIS Change Healthcare**, for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Access to Change Healthcare is **FREE** to our providers. Providers are encouraged to register after receiving their first check from Molina. Here's how:

Change Healthcare Access

1. **Register for Change Healthcare online**
2. **Verify your information**
3. **Enter your user account information**
4. **Verify payment information**

Electronic Payment Instructions

- Go to: https://providernet.adminisource.com
- Click “Register”
- Accept the terms

- Select Molina Healthcare from the payers list
- Enter your primary NPI
- Enter your primary tax ID
- Enter recent claim and/or check number

- Use your email address as username
- Strong passwords are enforced (eight or more characters of letters and numbers)

- Bank account and payment address
- Changes to address may interrupt EFT process
- Add additional addresses, accounts, & tax IDs after login

Benefits of Change Healthcare

- Ability to associate new providers within your organization to receive Electronic Fund Transfer (EFT)/835s
- Administrative rights to sign-up/manage your own EFT account
- View/print/save PDF versions of your explanation of payment (EOP)
- Historical EOP search by various methods (i.e. claim number, member name)
- Ability to route files to your file transfer protocol (FTP) and/or clearinghouse

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) requires providers to implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of a member's **protected health information (PHI)**. Providers should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

Molina strongly supports the use of electronic transactions to streamline health care administrative activities. Providers are encouraged to submit claims and other transactions using electronic formats. Certain electronic transactions 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

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with Molina should refer to: HIPAA Transactions

Fraud, Waste and Abuse

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

Do you have suspicions of member or provider fraud? The **Molina Healthcare AlertLine** is available 24 hours a day, seven days a week, and even on holidays at (866) 606-3889. Reports are confidential, but you may choose to report anonymously.

Fraud, Waste and Abuse

Abuse

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

Fraud

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

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

Examples of Fraud, Waste and Abuse

Member

- Lending an ID card to someone who is not entitled to it
- Altering the quantity or number of refills on a prescription
- Making false statements to receive medical or pharmacy services
- Using someone else's insurance card
- Including misleading information on or omitting information from an application for health care coverage or intentionally giving incorrect information to receive benefits
- Pretending to be someone else to receive services
- Falsifying claims

Examples of Fraud, Waste and Abuse

Provider

- Billing for services, procedures or supplies that have not actually been rendered
- Providing services to patients that are not medically necessary
- Balance billing a participating provider balance billing a Marketplace member for covered services
- Double billing or improper coding of medical claims
- Intentional misrepresentation of benefits payable, dates rendered, medical record, condition treated/diagnosed, charges or reimbursement, provider/ patient identity, “unbundling” of procedures, non-covered treatments to receive payment,
  “upcoding,” and billing for services not provided
- Concealing patients misuse of ID card
- Failure to report patient’s forgery/alteration of a prescription