Thank you for joining. We will begin momentarily.

We will send out the presentation after the call. Everyone will be muted. Please feel free to ask questions in the chat and one of our Provider Relations reps will answer you.

If you have a question, please email SCProvider.Services@MolinaHealthcare.com.

MOLINA® HEALTHCARE | You Matter to Molina

Provider Town Hall

Molina Healthcare of South Carolina

MOLINA® HEALTHCARE

You Matter to Molina

Townhall Agenda

- Plan Updates
- Molina Resources and Provider Tools
- Growth and Community Engagement
- Credentialing Reminders and Updates
- Claim and Appeal Reminders
- Prior Authorization
- Medicaid Incentives, Benefits, and Rewards
- Healthcare Effectiveness Data and Information Set (HEDIS) Reminders
- Audits and Medical Record Requests
- Compliance Reminders
- Questions

MOLINA HEALTHCARE

Provider Relations Team

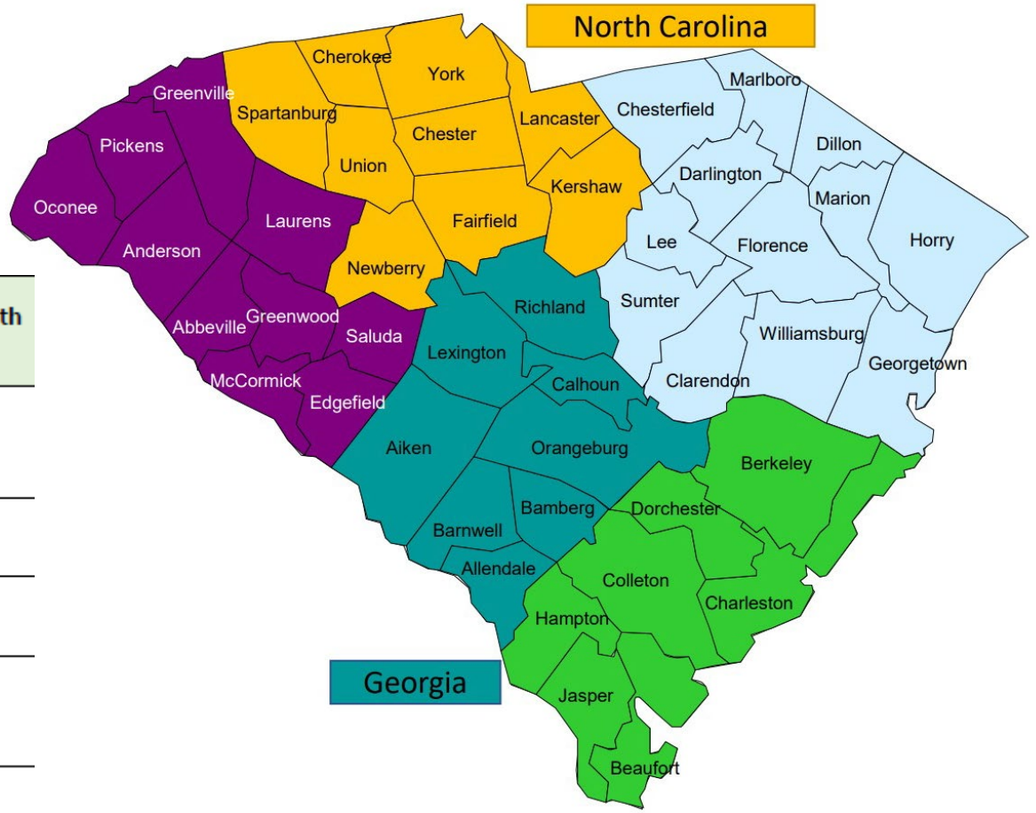
MOLINA® HEALTHCARE

You Matter to Molina

Provider Relations Team: Know Your Representative

- **Tyler Stalvey, Director of Provider Relations**
- Tyler.Stalvey@molinahealthcare.com
- **Jennifer Hamilton, Manager of Provider Relations**
- Jennifer.Hamilton2@molinahealthcare.com

Representative	Contact Information		Designated Specialties/Health Systems
	Email	Telephone	
Talitha Hampton	Talitha.Hampton@molinahealthcare.com	(803) 440-2700	AnMed, Abbeville,, Prisma, Self Regional
Ta'Mequa Durant	Tamequa.Durant@molinahealthcare.com	(803) 508-4468	Bon Secours, Labs, MUSC, Roper
Bethany Cook	Bethany.Cook@molinahealthcare.com	(803) 465-7771	FQHC'S, HCA, Home Health, McLeod, Tidelands
Jen Hamilton	Jennifer.Hamilton2@molinahealthcare.com	(803) 394-1271	Atrium, Newberry, Novant, RHP (Spartanburg Regional), Roper
Kimberly Brown	Kimberly.Brown4@molinahealthcare.com	(803) 673-5039	Aiken, AU/Wellstar, LMC, SNF's, Uniphy



Plan Updates

Reminder to Marketplace Providers

In accordance with CMS guidance, as outlined in Chapter 2, Section 3.ii.b of the 2023 Final Letter to Issuers in the Federally facilitated Exchanges, all Qualified Health Plan (QHP) issuers are required to maintain timely access to care by meeting specific appointment wait time standards. These standards are designed to ensure that members have consistent and equitable access to essential health services within reasonable time frames.

The required wait time standards are as follows:

Service Type - Maximum Wait Time:

Behavioral Health - Within **10 calendar days**

Primary Care (Routine) - Within **15 business days**

Specialty Care (Non Urgent) – Within **30 business days**

QHP issuers must ensure compliance with these standards at least 90% of the time for new patient appointments, reflecting CMS's commitment to improving access, reducing barriers to care, and supporting member well being.

New for Marketplace

Molina is happy to announce a partnership with ProgenyHealth for our Marketplace line of business. ProgenyHealth specializes in Neonatal Care Management Services. ProgenyHealth's care management program will enhance services to our members and support our mission to make a lasting difference in our members' lives by improving their health and well-being. Starting August 4, 2025, ProgenyHealth's neonatologists, pediatricians, and neonatal nurse care managers will collaborate closely with Molina members, as well as with attending physicians and nurses. Their goal is to promote healthy outcomes for Molina's premature and medically complex newborns.

The benefits of this partnership to you:

- The support of a team that understands the complexity and stress of managing infants in the NICU and will work with you to achieve the best possible outcomes
- A collaborative and proactive approach to care management that supports timely and safe discharge to home
- A company that believes in sharing best practices and works with NICU nationwide to improve the health outcomes of the next generation

Families will have a dedicated case manager who will support and educate program members, as well as access to an "on-call" staff member available 24/7. For our hospitals, ProgenyHealth will serve as a liaison for Molina, providing inpatient review services and assisting with the discharge planning process to ensure a smooth transition to the home setting.

Your process for notifying Molina of infants admitted to a NICU or special care nursery will change on August 4, 2025. Please notify ProgenyHealth directly of admissions via fax at (855) 450-1209. Their clinical staff will contact your designated staff to perform utilization management and discharge planning throughout the inpatient stay. If you wish to learn more about ProgenyHealth's programs and services, visit ProgenyHealth.com. Thank you for your partnership in caring for Molina's members.

2025 Medicare & Medicaid Plan Integration

What is changing in 2025 for Medicare and Medicaid plans in South Carolina?

Beginning January 1, 2026, dual-eligible beneficiaries (people with both Medicare and Medicaid) will be required to have both coverage under the same managed care organization (MCO). However, coordination will still be available through D-SNPs for plans that don't participate in the Medicaid MCO space, specifically with companies like United or Aetna. For members who select a Medicare plan from organizations that offer a Medicaid MCO, such as Molina, Centene, Humana, and AmeriHealth Caritas, they will be automatically aligned. Additionally, it's important to note that Healthy Blue operates in the Medicaid MCO market but does not provide a D-SNP.

What is an Integrated Plan?

An Integrated Plan is a health plan that combines Medicare and Medicaid benefits. It simplifies billing, care coordination, and communication by allowing both coverages to be administered by a single MCO.

How will this impact providers?

- Adjust billing processes and workflows for members who transition to Integrated Plans
- Ensure they are in-network with both the Medicare and Medicaid arms of the Integrated Plan
- Be prepared for possible shifts in utilization management, prior authorization, billing, claims, and documentation requirements
- Assist your patients, our members, through the transition, especially those who may not understand the need to choose a new plan

Will provider reimbursement be affected?

Potentially. The 2025 Medicare Physician Fee Schedule includes nearly a three percent reduction in Medicare payment rates. Also, billing codes and care management reimbursements are changing, especially for Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs). Providers should stay informed through the Centers for Medicare and Medicaid, Molina Healthcare of South Carolina, Inc.

Moral and Religious Objections to Specific Services

As per our South Carolina Department of Health and Human Services Medicaid Contract, we are required to identify providers who decline to offer certain services due to moral or religious objections, including family planning services. If you have any objections, please complete this form and return it via email to **SCProvider.Services@MolinaHealthcare.com**.

Molina Resources and Tools

MOLINA® HEALTHCARE

You Matter to Molina

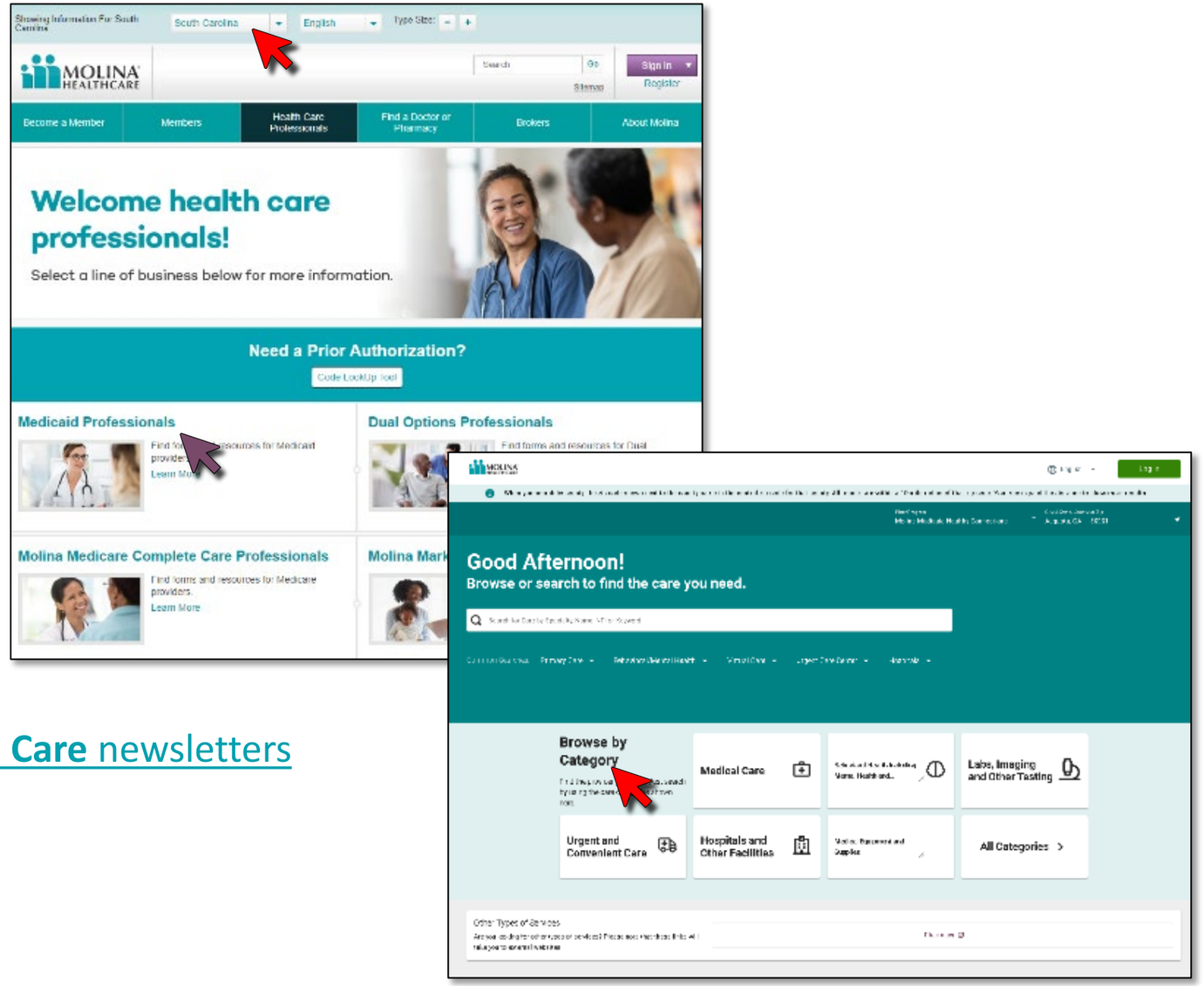
Molina Provider Website

Molina Healthcare Provider Sites

- Select South Carolina
- Select the correct product/network
- Bookmark or save to your favorites

Websites Include:

- Department updates
- Frequently used forms
- Tools and resources
- Provider manual
- Preferred Drug List
- Register for the **Palmetto Partners** and **Partners in Care** newsletters



View the Online Provider Directory

- Search by category
- Report inaccuracies
- Find other network participating providers to refer members

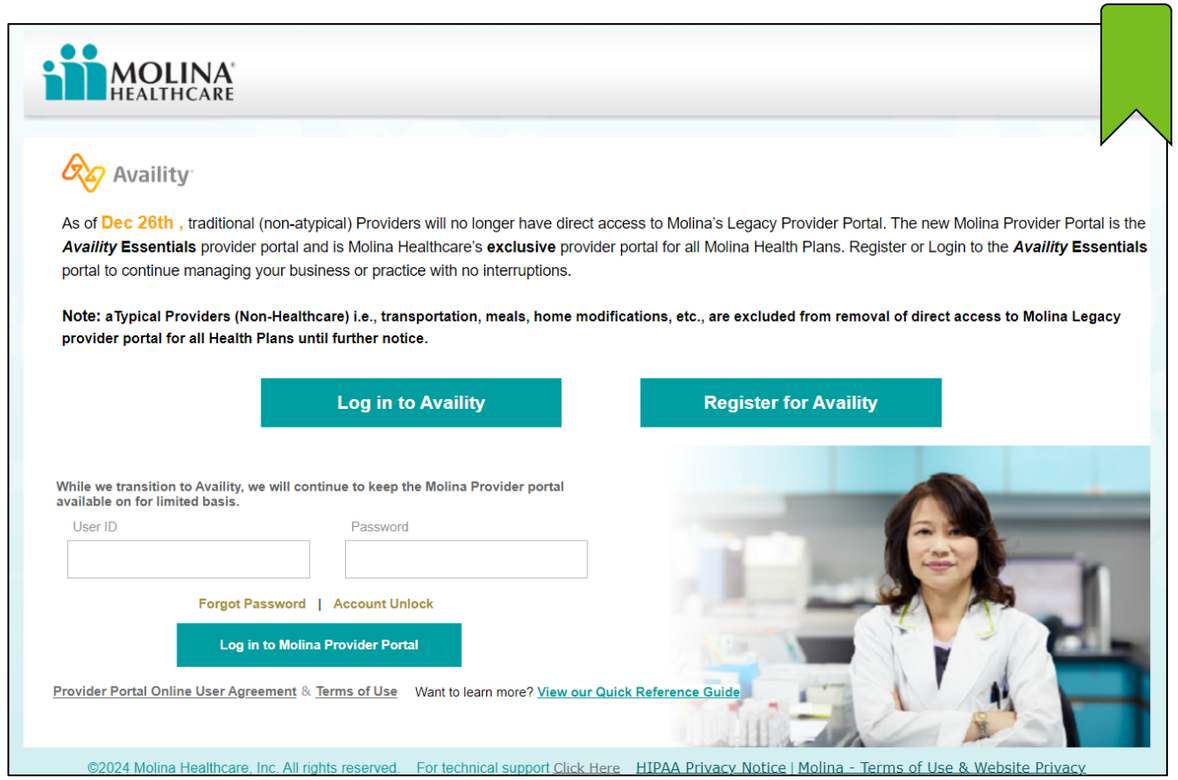
Availity Essentials (Availity) Provider Portal

Core Features

- Verify eligibility and benefits
- Confirm coordination of benefits
- Submit claims (original, correct and void claims)
- Check claim status and ask questions
- Upload medical records, appeals and itemized bills
- Request prior authorization and check the status
- View Electronic Remittance Advice (ERA)

Payer Spaces

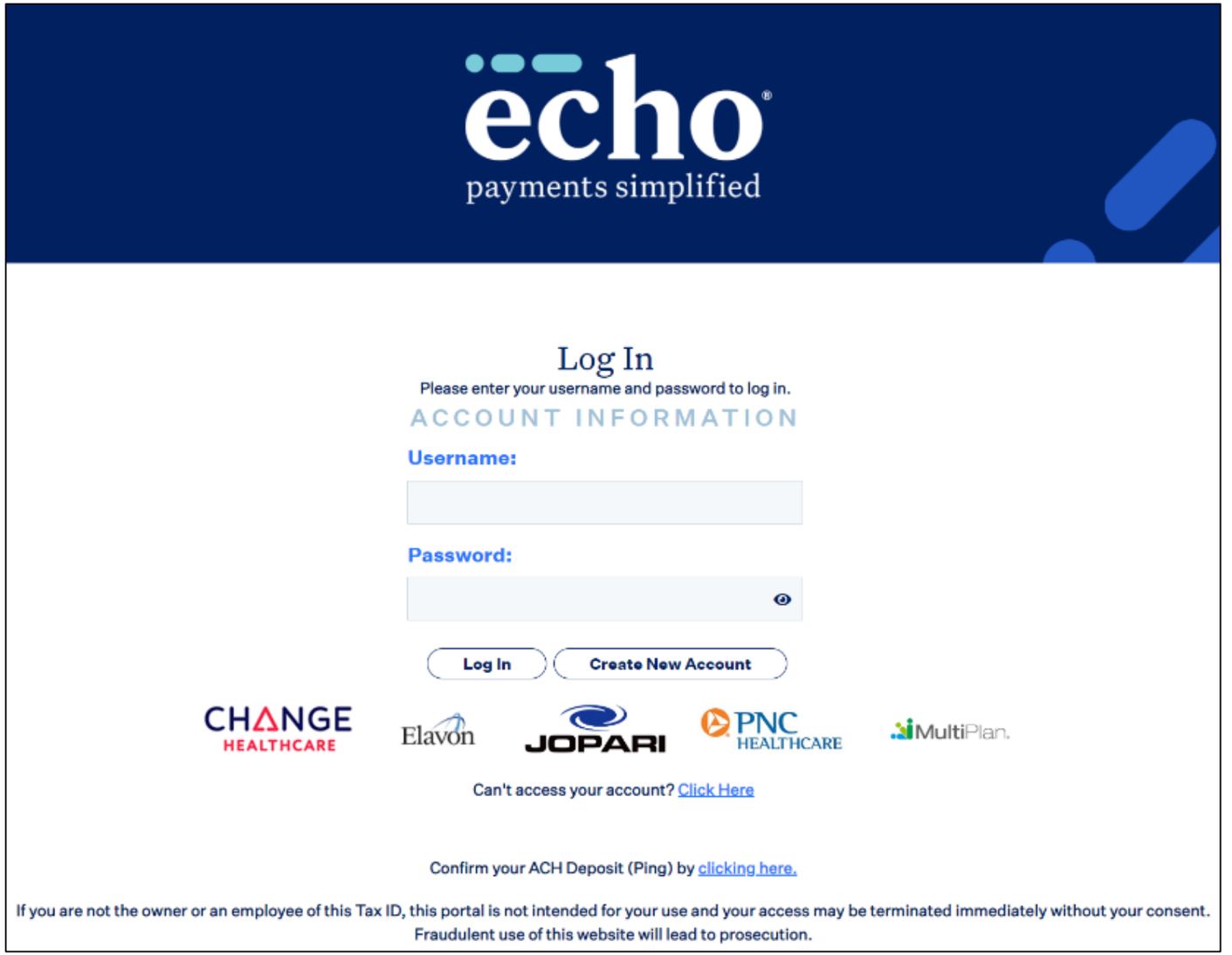
- A Payer Space contains links to payer-specific applications, resources, and announcements.
- Molina's Payer Space is accessed via the single sign-on process through Availity Essentials.



https://www.availity.com/molinahealthcare

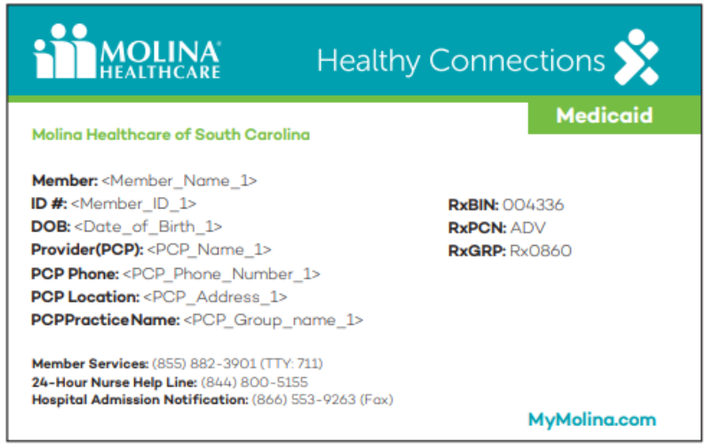
ECHO

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) are now provided through ECHO Healthcare Inc., a partner of Change Healthcare.



Molina Healthcare: Medicaid and Medicare Advantage

Medicaid


MOLINA HEALTHCARE

Healthy Connections

Medicaid

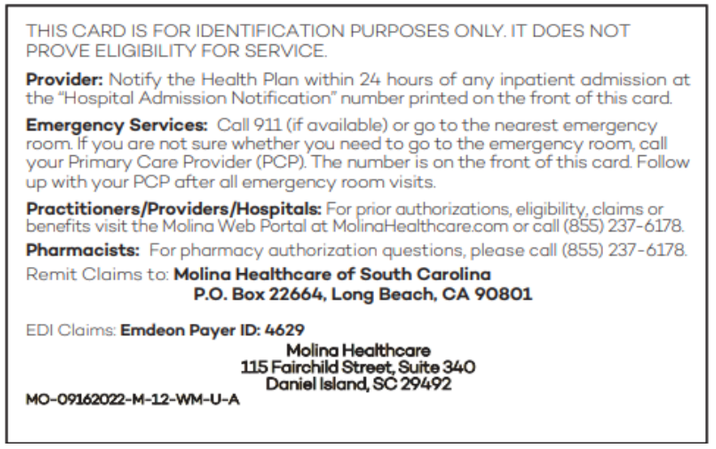
Molina Healthcare of South Carolina

Member: <Member_Name_1>
ID #: <Member_ID_1>
DOB: <Date_of_Birth_1>
Provider(PCP): <PCP_Name_1>
PCP Phone: <PCP_Phone_Number_1>
PCP Location: <PCP_Address_1>
PCPPractice Name: <PCP_Group_name_1>

RxBIN: 004336
RxPCN: ADV
RxGRP: Rx0860

Member Services: (855) 882-3901 (TTY: 711)
24-Hour Nurse Help Line: (844) 800-5155
Hospital Admission Notification: (866) 553-9263 (Fax)

MyMolina.com


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

Provider: Notify the Health Plan within 24 hours of any inpatient admission at the "Hospital Admission Notification" number printed on the front of this card.

Emergency Services: Call 911 (if available) or go to the nearest emergency room. If you are not sure whether you need to go to the emergency room, call your Primary Care Provider (PCP). The number is on the front of this card. Follow up with your PCP after all emergency room visits.

Practitioners/Providers/Hospitals: For prior authorizations, eligibility, claims or benefits visit the Molina Web Portal at MolinaHealthcare.com or call (855) 237-6178.

Pharmacists: For pharmacy authorization questions, please call (855) 237-6178.

Remit Claims to: **Molina Healthcare of South Carolina**
P.O. Box 22664, Long Beach, CA 90801

EDI Claims: **Emdeon Payer ID: 4629**
Molina Healthcare
115 Fairchild Street, Suite 340
Daniel Island, SC 29492

MO-09162022-M-12-WM-U-A

Medicare Advantage


MOLINA HEALTHCARE

Medicare

<LOB>
Member: <MemFIRST> <MemMI> <MemLAST>
Member #: <MemID>

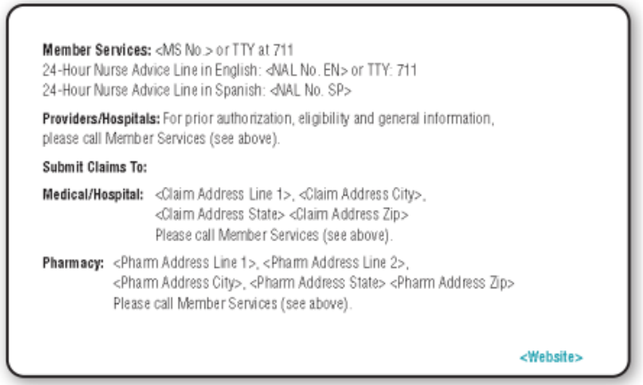
PCP: <PCPNAM>
PCP Tel: <PCPPHN>

RxBIN: <RXBIN>
RxPCN: <RXPCN>
RxGRP: <RXGROUP>
RxID: <MemID>

MedicareRx Prescription Drug Coverage
<ContNum>

Issued Date: <ISSUDAT>

<Website>


Member Services: <MS No > or TTY at 711
24-Hour Nurse Advice Line in English: <NAL No. EN> or TTY: 711
24-Hour Nurse Advice Line in Spanish: <NAL No. SP>

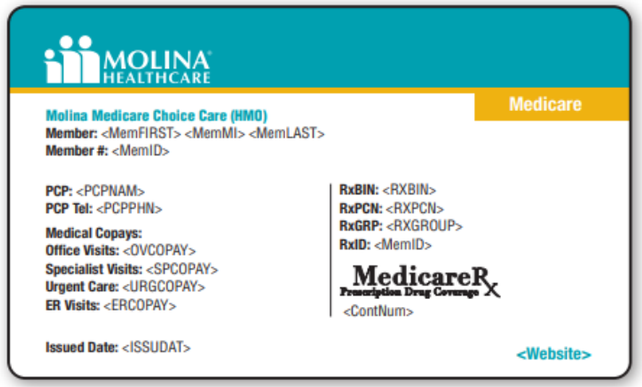
Providers/Hospitals: For prior authorization, eligibility and general information, please call Member Services (see above).

Submit Claims To:

Medical/Hospital: <Claim Address Line 1>, <Claim Address City>, <Claim Address State> <Claim Address Zip>
Please call Member Services (see above).

Pharmacy: <Pharm Address Line 1>, <Pharm Address Line 2>, <Pharm Address City>, <Pharm Address State> <Pharm Address Zip>
Please call Member Services (see above).

<Website>


MOLINA HEALTHCARE

Medicare

Molina Medicare Choice Care (HMO)
Member: <MemFIRST> <MemMI> <MemLAST>
Member #: <MemID>

PCP: <PCPNAM>
PCP Tel: <PCPPHN>

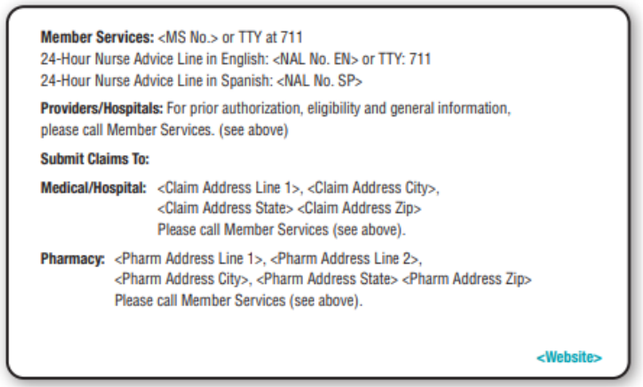
Medical Copays:
Office Visits: <OVCOPAY>
Specialist Visits: <SPCOPAY>
Urgent Care: <URGCOPAY>
ER Visits: <ERCOPAY>

RxBIN: <RXBIN>
RxPCN: <RXPCN>
RxGRP: <RXGROUP>
RxID: <MemID>

MedicareRx Prescription Drug Coverage
<ContNum>

Issued Date: <ISSUDAT>

<Website>


Member Services: <MS No.> or TTY at 711
24-Hour Nurse Advice Line in English: <NAL No. EN> or TTY: 711
24-Hour Nurse Advice Line in Spanish: <NAL No. SP>

Providers/Hospitals: For prior authorization, eligibility and general information, please call Member Services. (see above)

Submit Claims To:

Medical/Hospital: <Claim Address Line 1>, <Claim Address City>, <Claim Address State> <Claim Address Zip>
Please call Member Services (see above).

Pharmacy: <Pharm Address Line 1>, <Pharm Address Line 2>, <Pharm Address City>, <Pharm Address State> <Pharm Address Zip>
Please call Member Services (see above).

<Website>

Molina Healthcare: Dual Option and Marketplace

MMP

MOLINA HEALTHCARE

Healthy Connections PRIME

Molina Dual Options Medicare-Medicaid Plan

MedicareRx Prescription Drug Coverage

Member Name: <Cardholder Name>
Member ID: <Cardholder ID#>

PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

RxBIN: <RxBIN#>
RxPCN: <RxPCN#>
RxGRP: <RxGRP#>
RxID: <RxID#>

MEMBER CANNOT BE CHARGED
Copays: $0 for <doctor visits, hospital stays and prescription drugs>
<H2533> <Plan Benefit Package #>

Carry this card with you at all times and present it each time you receive a service from your doctor, pharmacy, dentist, etc.

Member Services: <(855) 735-5831>TTY: <711>
Behavioral Health: <(888) 275-8750>
Pharmacy Help Desk: <(866) 693-4620>
Nurse Advice Line: <(888) 275-8750>
Website: <MolinaHealthcare.com/Duals>

Send Claims To: <P.O. Box 22664, Long Beach, CA 90801
EDI Submissions: Payer ID 46299>
Claim Inquiry: <(855) 735-5831>

Marketplace members **do not** have out of network benefits, *except* in the event of an emergency.

Members must receive care from in network providers.

Marketplace

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Provider Manual

Provides in-depth guidance across provider operations (enrollment, claims, quality, compliance)
Be sure to select the correct Line of business

- **Contact Information** – for Provider Services, Claims, Credentialing, Alerts, etc.
- **Enrollment & Eligibility** – provider enrollment and Medicaid eligibility details.
- **Healthcare Services** – utilization management, prior authorizations, care coordination.
- **Quality & Behavioral Health** – QI programs, patient safety, clinical guidelines, behavioral health coordination.
- **Compliance & Risk Adjustment** – reporting requirements, fraud/abuse, cybersecurity, coding accuracy.
- **Claims & Compensation** – electronic claims, submission standards, corrections, COB, third-party liability.
- **Grievance & Appeals** – procedures for appeals, grievances, and record retention.
- **Credentialing & Recredentialing** – requirements, provider rights, and timelines.
- **Pharmacy & Benefits** – formulary compliance, pharmacy processes, coverage limits.

(All adapted from content structure in the manual.

Growth and Community Engagement

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Growth & Community Engagement Team

The Growth & Community Engagement team plays a vital role in fostering connections and improving health outcomes.

2025 Mid Year Summary

Events: **125**

Sponsorships: **$111,584**

Lead Cards: **1,818**

Lives Touched: **10,490**

Community Events

- Baby Showers
- Thanksgiving Giveaways
- Winter Coat Giveaways
- Redetermination Events

SC Engagement Team Regions

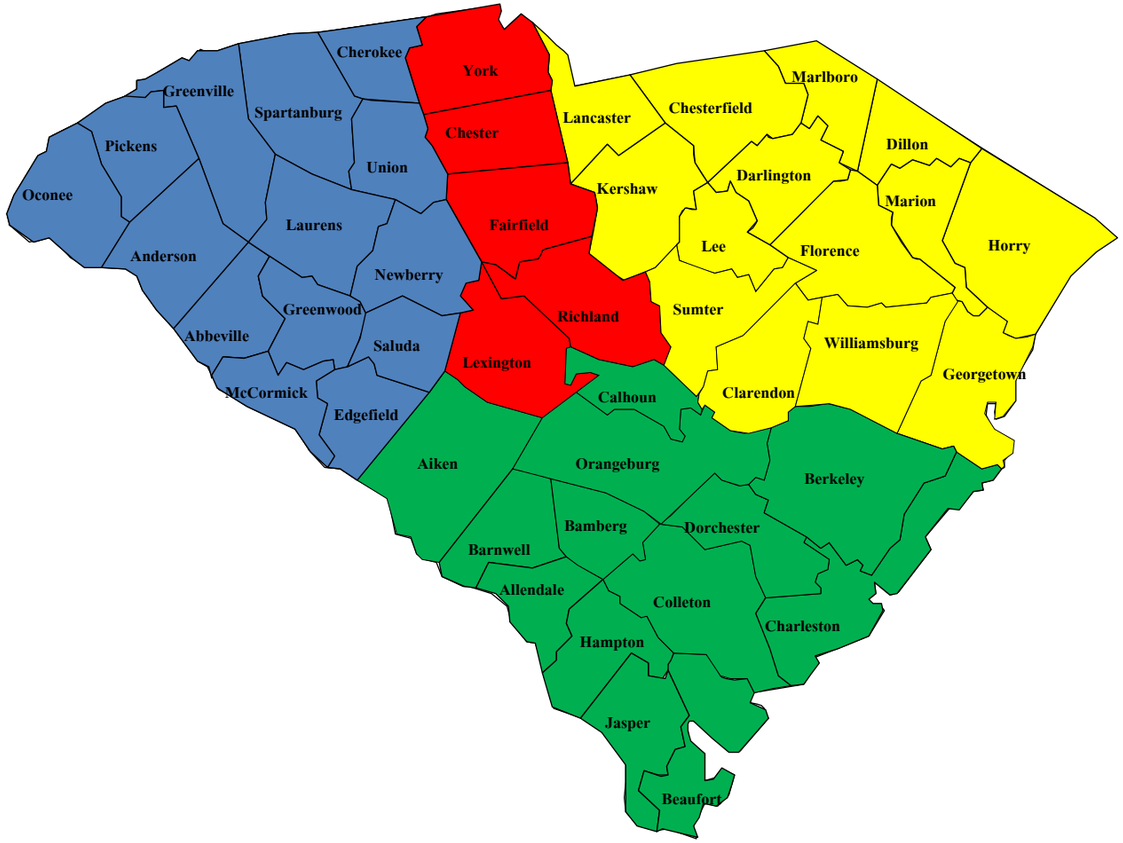
Region	G&CE	Cell Phone	Email
1	Stefania Gutierrez	(864) 807- 0006	Stefania.Gutierrez@Molinahealthcare.com
2	Jay Andrews Jr	(843) 845-3734	Jerome.Andrewsjr@Molinahealthcare.com
3	Allen Tipping	(839) 224-0874	Allen.Tipping@Molinahealthcare.com
4	David Irizarry	(843) 371-4965	David.Irizarry@Molinahealthcare.com

Inese Alvarez	Growth and Community Engagement Internal Specialist
(330) 232-3442	Inese.Alvarez@Molinahealthcare.com

Allen Tipping	Growth and Community Enagagement Manager
(839) 224-0874	Allen.Tipping@Molinahealthcare.com

Johanna Perez	Growth and Community Engagement Director
(864) 288-1399	Johanna.Perez@Molinahealthcare.com

Jennifer Marze	AVP, HP Growth and Engagement
(803) 977-4972	Jennifer Marze@Molinahealthcare.com



Credentialing Reminders and Updates

MOLINA® HEALTHCARE

You Matter to Molina

Credentialing and Provider Updates: New Providers

- Credentialing of new providers often takes up to 60 days from the time a complete application is received.
- Ensuring the application is accurately filled out, whether using CAQH or a paper application, is critical to avoid processing delays. Incomplete applications will be returned for review and correction.
- You must have your SC Medicaid ID before applying to participate with MHSC.
- Attachment C Application can serve multiple purposes including:
  - Initial Credentialing Request , Existing Provider Affiliation, Add New Service Locations
- Once the credentialing process is complete, you will receive a notification letter via email
- The newly credentialed provider will be added to your Tax ID's contract within our claims system **30 days following the date of the date of the letter,** The provider's par/effective date will be **the day after the credentialing date in the letter**
- Please notify Molina when a provider terms. We need the provider's name, NPI, and term date sent to the PSR so we ensure our directory is accurate.

Credentialing and Provider Updates: New Providers

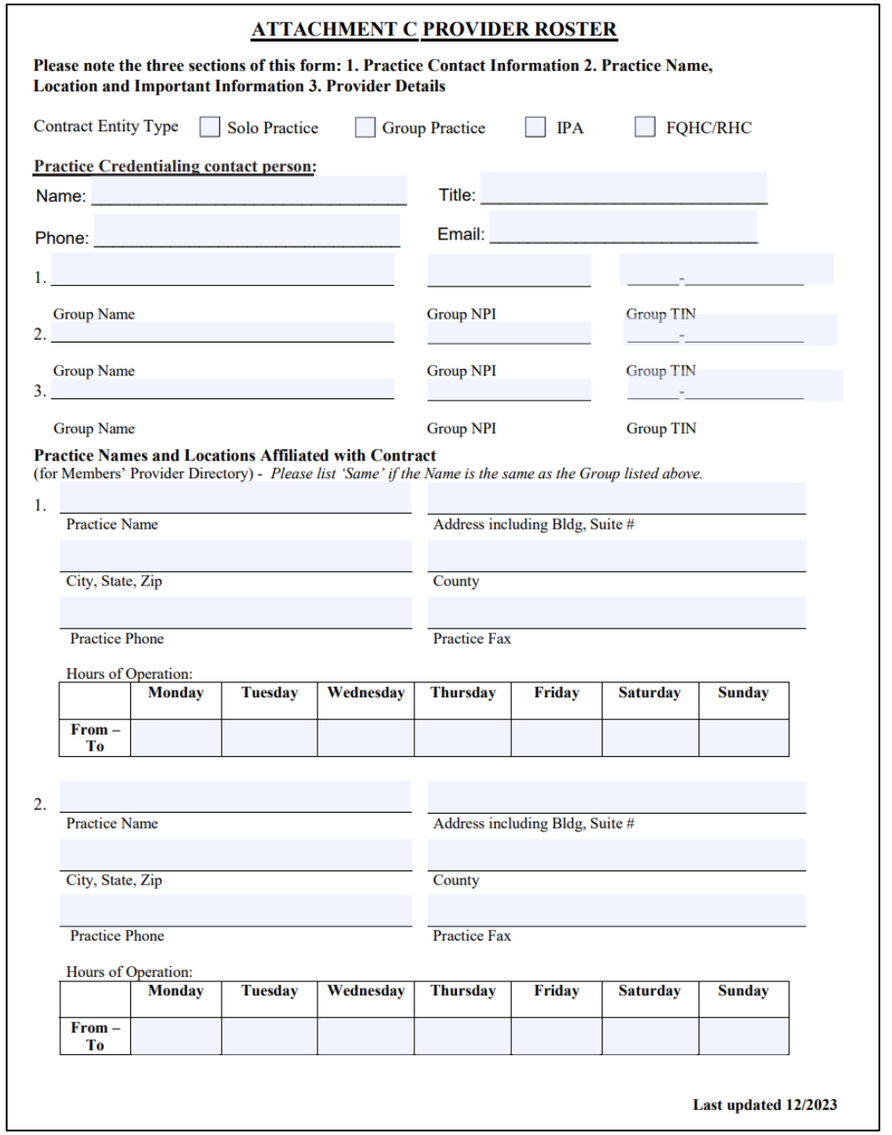
- Important questions on the Attachment C application determine the need for credentialing vs affiliation.
  - Primary care practitioner (PCP) status and desire to see members for member-facing sites and assignments?
  - Is the provider solely seeing members in an inpatient setting (hospital, SNF, etc.)?
  - Is the provider a mid-level such as Nurse Practitioner or PA?
    - Molina is only credentialing new mid-level providers who either qualify to be listed as a PCP or wish to appear in the online provider directories. Mid-level PCPs will have members assigned to them
    - Any mid-level PCP or specialist being credentialed who wishes to be in the directory must also include their full protocols signed and dated within one year both the mid-level and supervising physician.
    - Supervising physicians must also be credentialed and par with Molina Healthcare of South Carolina for the midlevel to be credentialed or affiliated with MHSC.

- If a mid-level is **not** acting as a PCP and does **not** need to appear in the directories, use the Attachment C Form to affiliate the provider and provide the effective date of participation.

Credentialing and Provider Updates: Affiliating Practitioners

Attachment C Provider Roster Practice Information

- Pages one-three provide space to list specific practices where the practitioner routinely sees patients
- Locations listed should be practice locations where potential patients can call and make appointments to see the listed practitioner
- Fields include:
  - Practice name
  - Physical address
  - Telephone
  - Fax
  - Hours of operation



ATTACHMENT C PROVIDER ROSTER

Please note the three sections of this form: 1. Practice Contact Information 2. Practice Name, Location and Important Information 3. Provider Details

Contract Entity Type ☐ Solo Practice ☐ Group Practice ☐ IPA ☐ FQHC/RHC

Practice Credentialing contact person:

Name: _____ Title: _____

Phone: _____ Email: _____

1. _____ _____ _____-_____

Group Name Group NPI Group TIN

2. _____ _____ _____-_____

Group Name Group NPI Group TIN

3. _____ _____ _____-_____

Group Name Group NPI Group TIN

Practice Names and Locations Affiliated with Contract
(for Members' Provider Directory) - *Please list 'Same' if the Name is the same as the Group listed above.*

1. _____ _____
Practice Name Address including Bldg, Suite #
_____ _____
City, State, Zip County
_____ _____
Practice Phone Practice Fax

Hours of Operation:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From – To							

2. _____ _____
Practice Name Address including Bldg, Suite #
_____ _____
City, State, Zip County
_____ _____
Practice Phone Practice Fax

Hours of Operation:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From – To							

Last updated 12/2023

Provider Network and Credentialing Forms

Updates have been made to some of the Molina Provider Network and Credentialing Forms. Please be sure to use the latest forms to prevent delays and ensure accuracy.

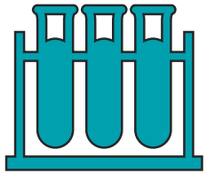
Form Name	Purpose		Where to Send
Credentialing Checklist	Details which documents and forms are required for each provider type		Not applicable
Credentialing Packet	Full credentialing packet; includes guidelines and details which additional documents are required. Required for all new providers who have not been credentialed.		MSC-CREDENTIALING@MolinaHealthcare.com
Practice Demographics Form	Used to provide practice demographics and ensure provider directory accuracy		MHSCPODValidation@MolinaHealthcare.com
Provider Change Form	Used to keep the provider network information current; all notifications are needed within 30 days of the change. Examples of use include practice name or location change, new phone number, a change in office hours.		SCNetworkAdministration@MolinaHealthcare.com
Contract Request Form	Used to request specific contracts and initiate participation with the applicable network		SCProviderContract@MolinaHealthcare.com
Facility HDO Form	Facilities wishing to provide information for all location types: • Atypical Providers • Durable Medical Equipment Suppliers	• Indian Health Clinics • Laboratories • Radiology • Transportation Services	MSC-CREDENTIALING@MolinaHealthcare.com
Attachment C	Used to provide detailed practice information including locations, practitioners, PCP designation, Medicaid and Medicare IDs, etc.		SCNetworkAdministration@MolinaHealthcare.com

Credentialing and Contracting Quick Links

- SCDHHS Provider Enrollment Information
- Molina Frequently Used Forms
- CAQH Provider Data Portal landing page (formerly CAQH ProView)
- Molina Credentialing email address: MSC-Credentialing@MolinaHealthcare.com
- Molina Provider Network email address: SCNetworkAdministration@MolinaHealthcare.com

Refer Members to Network Participating Providers

- **Use the Online Provider Directory**
  - Search by category
  - Report inaccuracies
  - Find other network participating providers to refer members



- Molina is analyzing data on providers who are referring members to non-par labs
  - Moving forward we will be monitoring physicians who are sending work to non-participating providers
  - We will make outreach to these practitioners to better understand why and work on providing education that will help direct services to in-network providers
  - Quest Diagnostics® is Molina's preferred lab; they are a low cost, high quality, laboratory, that provides Molina with lab results that factor into quality measures and calculations

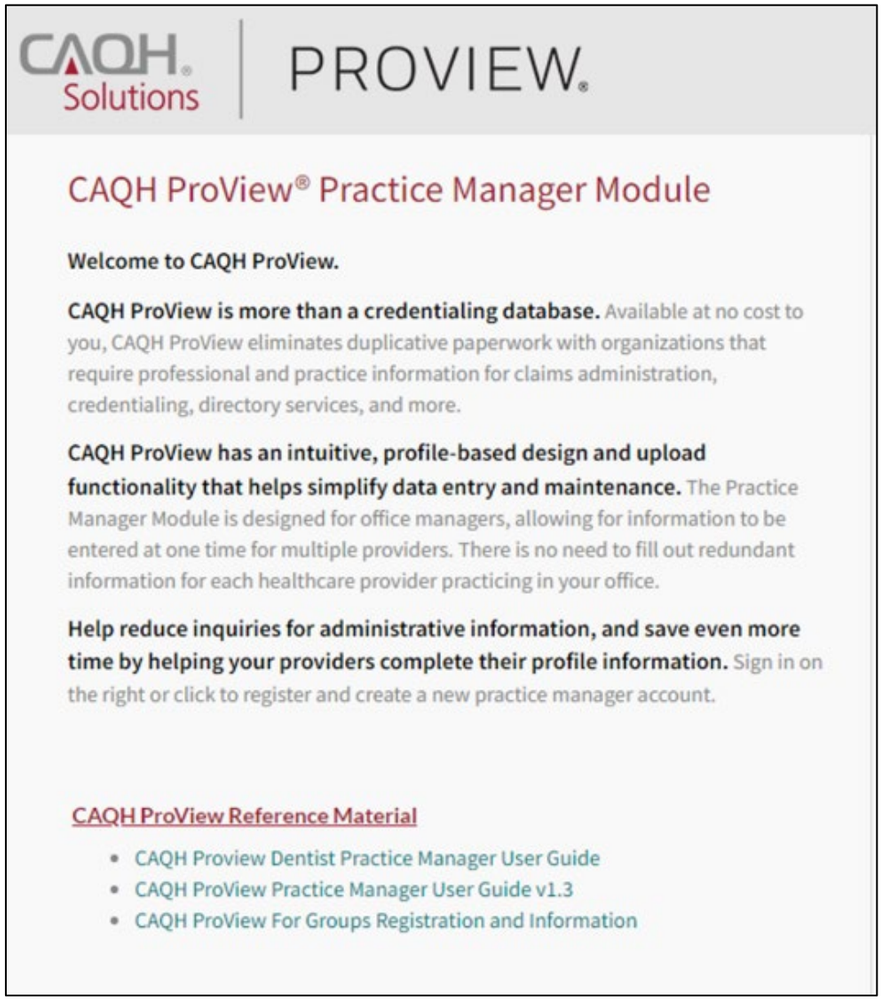
Council for Affordable Quality Healthcare® (CAQH)

Reminders

- Audits run monthly to verify CAQH information vs. what is in our database
- Conflicting info will lead to a term in Molina system

Verify

- Attestation is up to date
- Molina is granted access
- Primary location(s) and group info
- Licensure, certifications, and insurance not expiring within 60 days



Claim and Appeal Reminders

MOLINA® HEALTHCARE | You Matter to Molina

Payment Integrity: High Dollar Claims

- Inpatient charges over $100,000
  - Itemized bills are required
  - Can be attached to the initial claim via Availity, EDI or paper
  - Submit a corrected claim via Availity and attach IZ
- If we do not receive the itemized bill, we will either pay the base rate or deny charges altogether.
- For more details, please refer to PI Payment Policy 01 Hospital Routine Supplies Services Reimbursement.

You may receive medical records requests from Molina or a third party on our behalf to conduct payment integrity activities. Please respond to these requests to ensure prompt, accurate adjudication.

Payment Integrity: Sepsis Diagnosis

- Molina performs a pre-payment and post-payment review of all Sepsis-related claims across all product lines.
- Molina uses Sepsis 3 Criteria and the Sequential Organ Failure Assessment (SOFA) scoring.
- If the clinical documentation reviewed ***does not*** support Sepsis definitions, the Sepsis diagnosis will be removed, and payment will be adjusted accordingly.
- Providers will have standard Appeal timelines via the Claims Appeal Process for MHSC to review the additional documentation from providers, please ensure you clearly indicate you are appealing the Sepsis decision.

Review PI Payment Policy 26 Sepsis for additional information

Claim Submission Timelines

	Medicaid	Medicare	MMP (Dual)	Marketplace
Timely Filing Limit	**12 months/365 days** after the discharge for inpatient services or the date of service for outpatient services	**365 calendar days** after the discharge for inpatient services or the date of service for outpatient services	**365 calendar days** after the discharge for inpatient services or the date of service for outpatient services	**365 days** from the date of service
Corrected Claims	**365 calendar days** from the date of service	**365 calendar days** from the date of service or most recent adjudicated date of the claim	**365 calendar days** from the date of service	**365 days** from the date of service
Third Party Liability (TPL)/Coordination of Benefits (COB)	**12 months/365 days** from date of service after final determination by the primary payer	**365 calendar days** after final determination by the primary payer	**365 calendar days** after final determination by the primary payer	**120 calendar days** after final determination by the primary payer
Claim Disputes/ Appeals	Requests must be made within **90 calendar days** of Molina's original remittance advice date	Requests must be made within **120 calendar days** of Molina's original remittance advice date or longer as stated in the Provider Agreement.	Requests must be made within **120 calendar days** of Molina's original remittance advice date or longer as stated in the Provider Agreement.	Requests must be made within **90 days** of Molina's original remittance advice date.

Refer to the respective Provider Manual for additional information and details regarding claim submission and reconsiderations.

Claim Disputes and Appeal Steps

1. File a Corrected Claim

- Submit a corrected claim ***when appropriate***
- Include the original claim number in the appropriate box or loop segment

2. Submit Medical Records

- Records may be requested from Molina or one of our business partners
- Respond to record requests as soon as possible and send them to the appropriate requestor

3. Contact Molina

- Inform Molina when you disagree with the adjudication of a claim
- Ask specific questions using Availity
- Call Provider Services

4. File a Formal Appeal

- Upload through Availity
- Include an explanation of what is being appealed (a specific denial, payment discrepancy, etc.)
- Attach relevant medical records

5. Contact Your Provider Relations Representative

Email your representative and include details:

- Member ID
- Member name
- Claim number
- Issue
- Steps taken
- Expected outcome

Instructions for submitting formal appeals can be found in the corresponding product manual.

Appeals and Grievances: Balance Billing

Balance billing Molina members for covered services is prohibited. Members may be billed for the applicable copayment, coinsurance, and deductible.

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

Examples of balance billing include:

- Requiring Molina members to pay the difference between the discounted and negotiated fee and the provider's usual and customary fees
- Charging Molina members fees for covered services beyond copayment, coinsurance, and deductible.

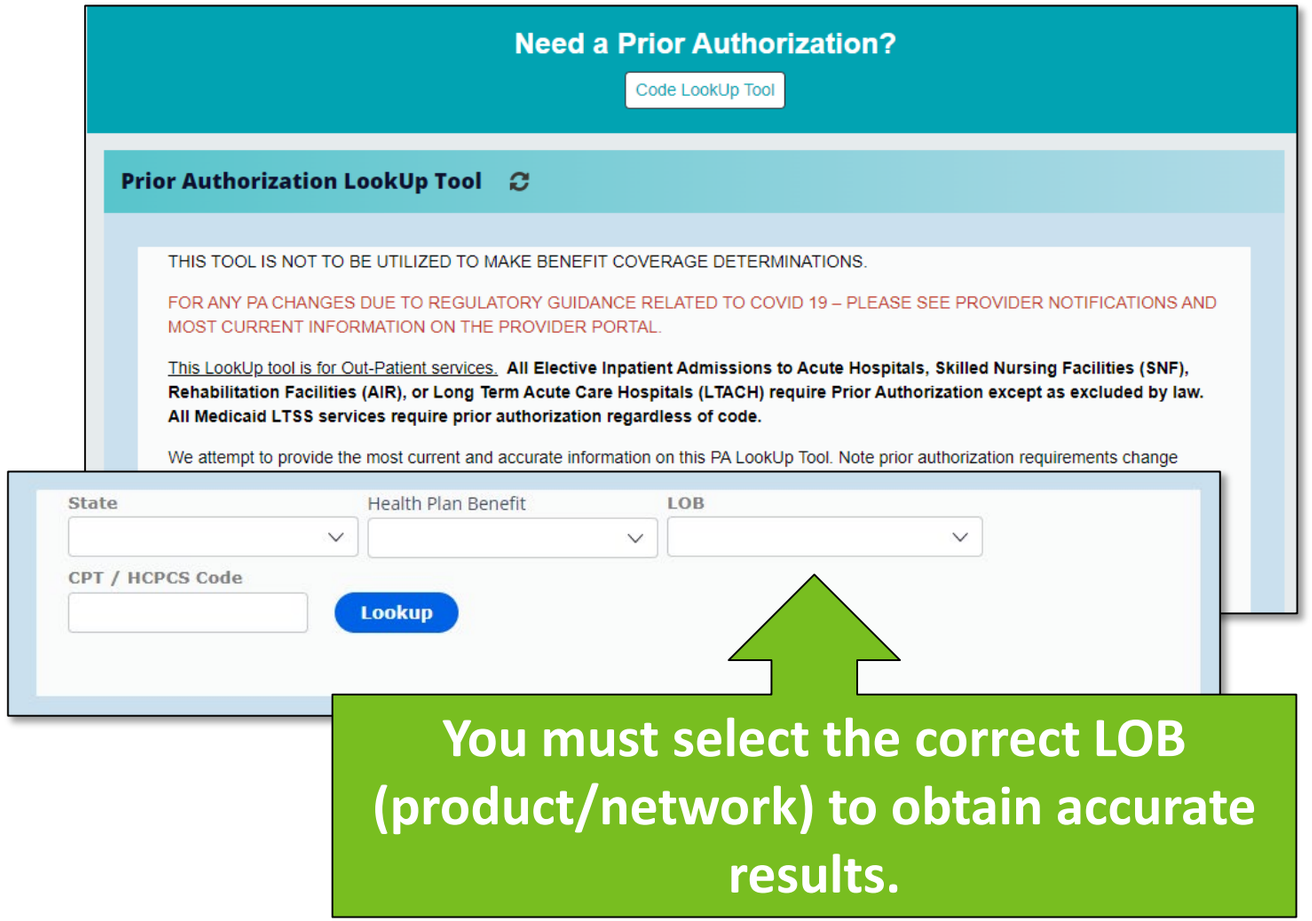
Prior Authorization

MOLINA® HEALTHCARE | You Matter to Molina

Prior Authorization (PA) LookUp Tool

PA LookUp

- Tools is a located on the Molina Healthcare Provider landing page
- Scroll down and select South Carolina from the State box
- Select the applicable product/network
- Enter CPT/HCPC code



Prior Authorizations are required for all non-par offices/providers/facilities visits, surgical procedures, labs, diagnostic studies, and inpatient stays except for ER services.

Prior Authorization Approval

Standard Prior Authorization

- Authorization requests for elective services and procedures
- Decisions are made and notification is provided within **14 calendar days**
- For approved services, the provider will receive an authorization number, by phone or fax.
- For denied services, the provider will receive a faxed letter. The member will receive a letter by mail. The letter will explain the reason for the denial and additional information regarding the grievance and appeals process.

Expedited Prior Authorizations

- Decisions where the member's life or health may be jeopardized; or could jeopardize the member's ability to regain maximum function.
- Providers must provide supporting documentation to justify an expedited authorization request. Without sufficient justification the authorization request may be downgraded and processed as a standard request.
- Decisions are made and notification is provided within **seventy-two hours or three calendar days** from receipt of the request
- When services are approved, the provider will receive an authorization number, by phone or fax.
- Denied services, the provider will receive a faxed letter. The member will receive a letter by mail. The letter will explain the reason for the denial and additional information regarding the grievance and appeals process.

HCS and Prior Authorizations

HCS decision making is based only on appropriateness of care and service and existence of coverage. The provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Prior authorizations may be submitted by fax to **(866) 423-3889** or through Availity. Availity can be used to check the status of all prior authorization requests, regardless of how the request was submitted.

Common reasons for delays or denial of the request:

- Insufficient or missing clinical information to provide for making the decision
- Lack of or missing progress notes or illegible documentation
- Request for an urgent review when there is no medical urgency

Prior Authorizations: When Other Insurance as Primary

Members with Other Health Insurance as Primary

If the primary will authorize or cover the service (i.e., payment is made) then authorization is **not required by Molina**.

If the Service is *Non-covered* by the Primary Carrier:

- Initiate a PA and send notes from the primary
- Pull the official stance on the service from their website
- If you have already performed the service, you can submit the EOB showing it is not covered or exhausted, however, if it doesn't meet medical necessity then we will deny the PA and claim.

Prior Authorizations: ProgenyHealth

Progeny for NICU Babies (Medicaid)

We have an ongoing partnership with ProgenyHealth, a company that specializes in neonatal care management services. This is an exciting opportunity. ProgenyHealth's care management program will enhance services to our members and support our mission to make a lasting difference in our members' lives by improving their health and well-being.

ProgenyHealth's Neonatologists, Pediatricians, and Neonatal Nurse Care Managers will work closely with Molina members, as well as attending physicians and nurses, to promote healthy outcomes for Molina premature and medically complex newborns.

The benefit of this partnership to you:

- The support of a team that understands the complexity and stress of managing infants in the NICU and will work with you to achieve the best possible outcomes
- A collaborative and proactive approach to care management that supports timely and safe discharge to home
- A company that believes in sharing best practices and works with NICUs nationwide to improve the health outcomes of our next-generation

The fax number for ProgenyHealth is **(888) 250-8468**.

Prior Authorizations: MCG Cite AutoAuth

Molina has also partnered with MCG Health, to extend our Cite AutoAuth self-service method for all lines of business to submit advanced imaging PA requests, from MRIs to PET scans

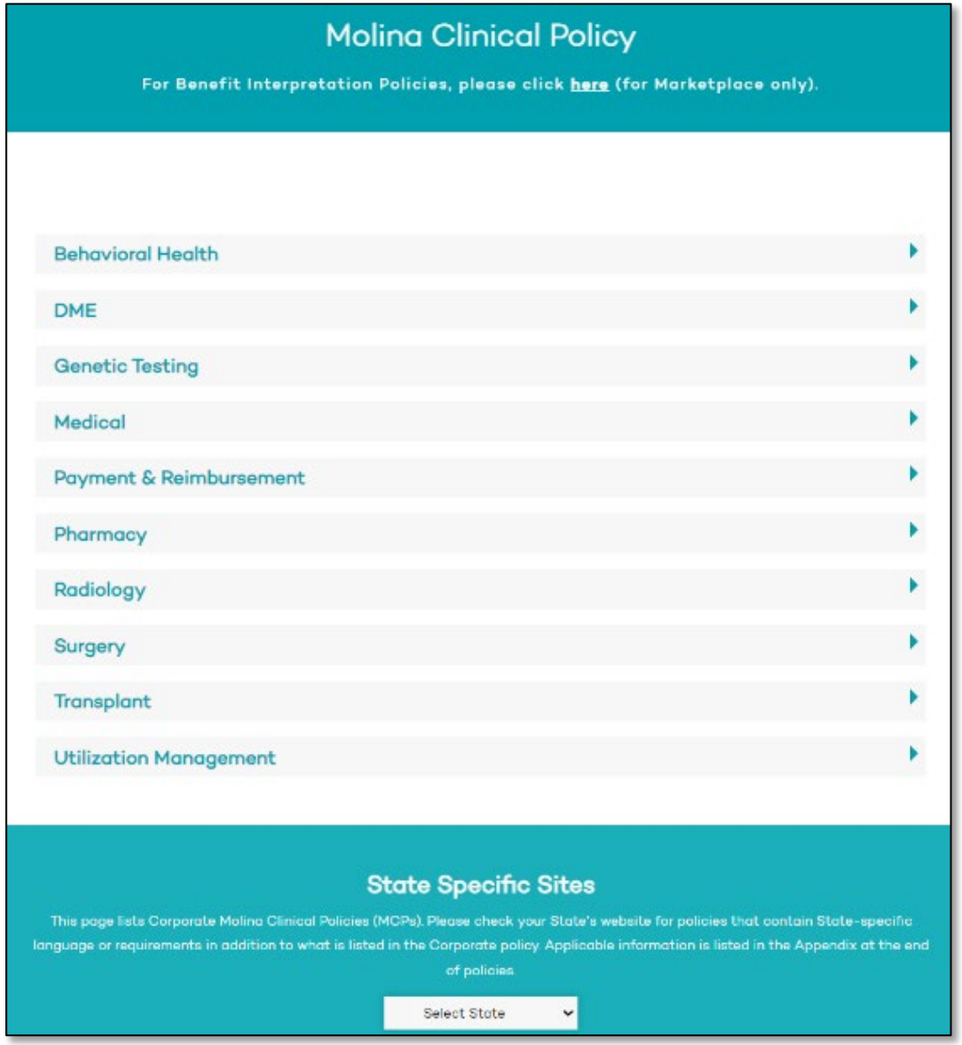
Through a customized rules engine, Cite AutoAuth compares Molina's specific criteria to the clinical information and attached guideline content to the procedure to determine the potential for auto authorization.

- Accessed via Availity and is available 24 hours per day, seven days per week.
- Used as a primary submission route although the existing fax, phone, and email methods of submission are still available.
- Quicker and more efficient processing of your authorization request and the status of the authorization will be available immediately upon completion of your submission.

Prior Authorizations: Clinical Policies

Molina Clinical Policy

- Lists Corporate Molina Clinical Policies (MCPs)
- Includes a link to view state specific policies
- Set of guidelines for coverage decisions and necessity determinations.



Prior Authorizations: Peer to Peer

Peer to Peer:

- You have **five business days** from a denial notification to schedule a Peer to Peer (P2P)
- Requests to discuss any medical necessity determinations with Medical Director can be made by:
  - Telephone: **(855) 237-6178**
  - Fax: **(866) 423-3889**
  - Email: mhscpriorauth@MolinaHealthcare.com
- When requesting a peer-to-peer discussion, please be prepared with the following information:
  - Member name and Molina ID number
  - Authorization number
  - Requesting provider name, contact number, the best times to call and provide more than one option for the Molina Medical Director to contact the provider (best times are Monday through Friday, between 10:00 AM EST-4:00 PM EST)
  - Updated clinicals if available
- An appeal may still be required if applicable
- You have up to **60 days** from the date of denial to file an appeal on behalf of the member.

HCS: Care Management

Molina offers programs to help our members, and their families manage a diagnosed health condition with Health Education, Disease Management, Care Management, and Complex Case Management.

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.

Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Cardiovascular Disease (CVD) management/Congestive Heart Disease
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management

For more information about our programs, please call Provider Services at (855) 237-6178 (TTY: 711).

Case Management (CM) – Overview

- **Voluntary, no-cost program** for members with complex needs
- **Whole-person, member-centered approach** – addressing medical, behavioral, and social needs
- **Care coordination** across providers and community resources to ensure right care, right time
- **Key functions:**
- Comprehensive assessment & individualized care planning
- Care coordination & advocacy across the continuum
- Member education & self-management support
- Ongoing monitoring of progress and adjusting care plans
- Collaboration through Interdisciplinary Care Teams (ICTs)
- **Eligibility/Referrals:** high-risk or special needs members, frequent hospital/ED use, serious illness, high-risk pregnancies, or provider/member requests

Molina SC Transition of Care Overview

- **Goal:** Ensure safe, seamless transitions after hospital stays or health plan changes
- **Dedicated team:** Transition Coordinator + TOC Coaches (RNs, social workers)
- **Core functions:**
- Hospital outreach & discharge planning
- Post-discharge follow-up (within 5 business days)
- Medication review & reconciliation
- Scheduling follow-up appointments (PCP/specialists within 7 days)
- Coaching members on discharge instructions & symptom monitoring
- **Short-term intensive support (≈30 days)** – stabilizing members and preventing readmissions
- **Strong collaboration** with providers, case managers, pharmacists, community resources, and behavioral health teams
- **Common triggers:** hospital/facility discharge, ED visits, new member transitions, provider terminations/changes

Medicaid Incentives, Rewards and Benefits

MOLINA® HEALTHCARE

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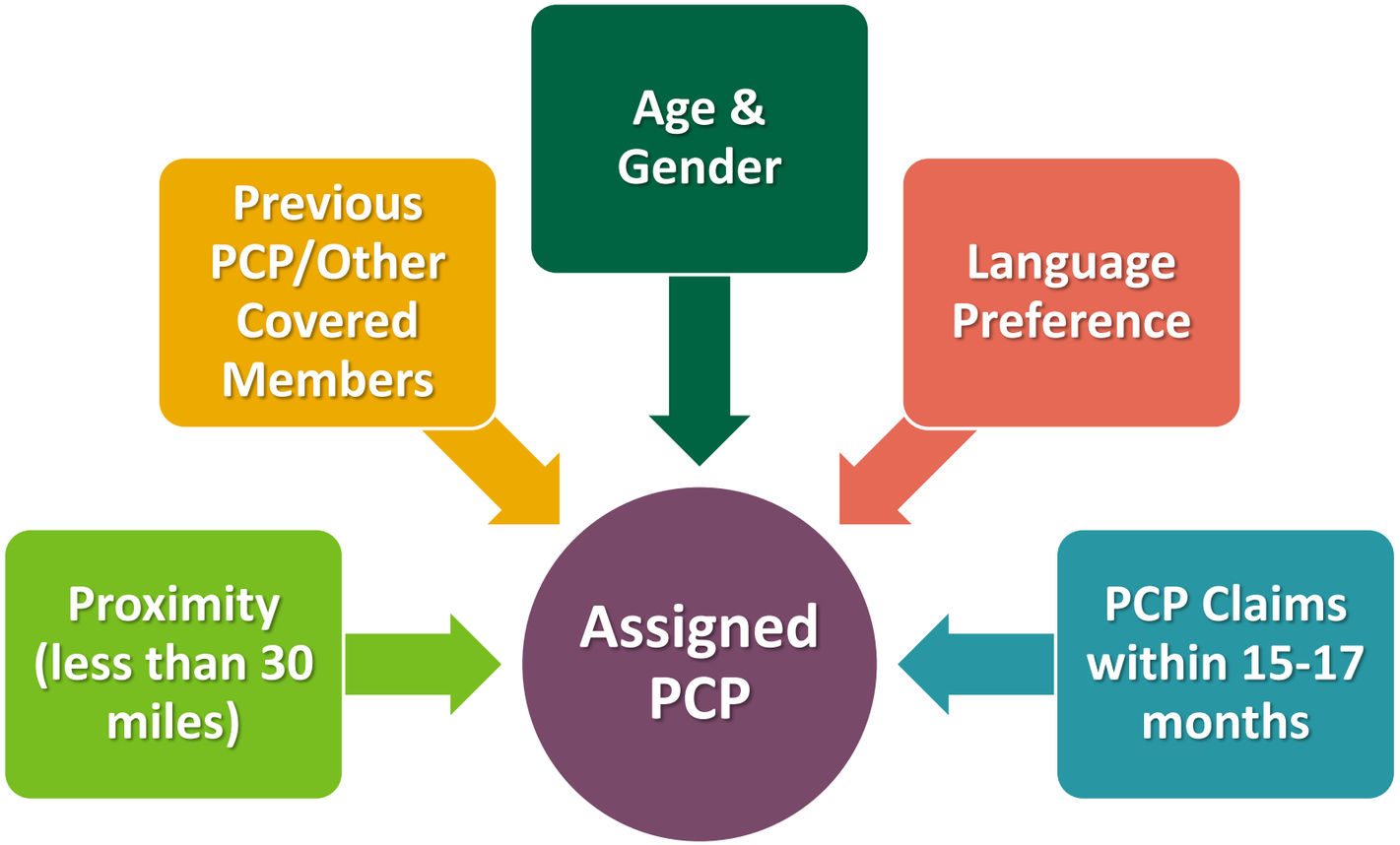
Benefits Reminder: Member PCP Assignment

PCP Assignment – Members have the right to choose their PCP. If the member or his/her designated representative does not choose a PCP, one will be assigned using:



How to Change Primary Care Practitioner (PCPs)

Call Member Services

- (855) 882-3901 – 8 a.m. to 6 p.m.
- Monday-Friday For hearing impaired TTY/TDD 711

Provider Change Form

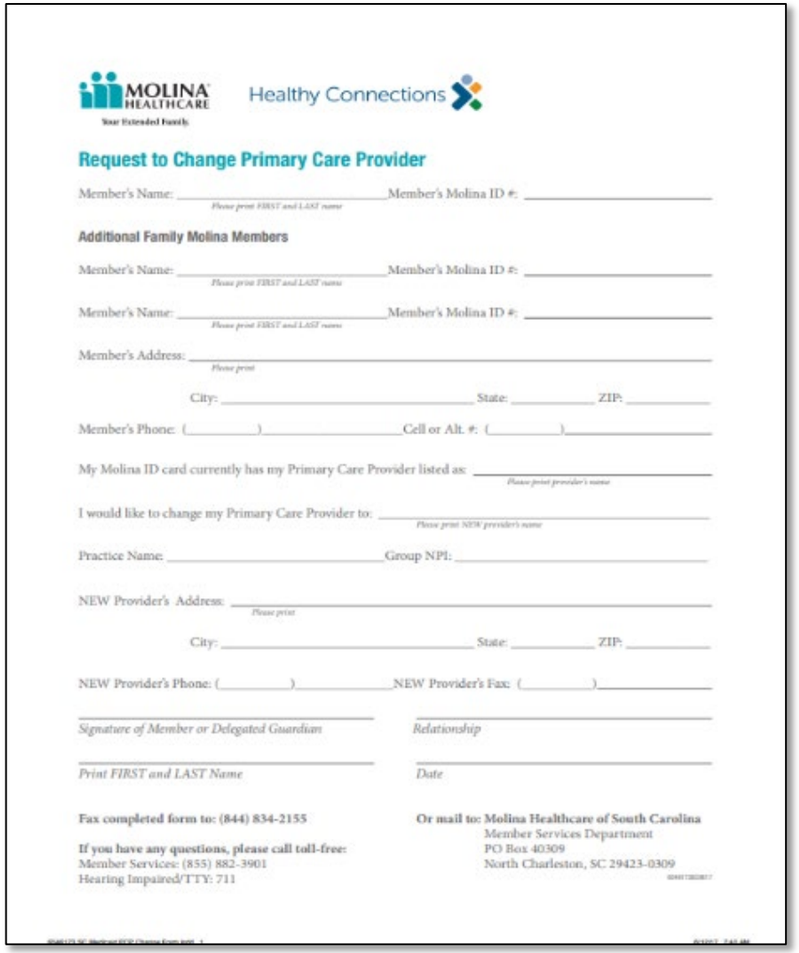
Can be completed in the providers office and faxed back to Molina. PCP reassignment should be complete within 30 days.

New Member Re-assignment Configuration

Two or more claims to another PCP will get member automatically reassigned to the provider they are seeing.

My Molina App

SCAN ME



MOLINA HEALTHCARE
Your Extended Family

Healthy Connections

Request to Change Primary Care Provider

Member's Name: _____ Member's Molina ID #: _____
Please print FIRST and LAST name

Additional Family Molina Members

Member's Name: _____ Member's Molina ID #: _____
Please print FIRST and LAST name

Member's Name: _____ Member's Molina ID #: _____
Please print FIRST and LAST name

Member's Address: _____
Please print

City: _____ State: _____ ZIP: _____

Member's Phone: (_____)_____ Cell or Alt. #: (_____)_____

My Molina ID card currently has my Primary Care Provider listed as: _____
Please print provider's name

I would like to change my Primary Care Provider to: _____
Please print NEW provider's name

Practice Name: _____ Group NPI: _____

NEW Provider's Address: _____
Please print

City: _____ State: _____ ZIP: _____

NEW Provider's Phone: (_____)_____ NEW Provider's Fax: (_____)_____

_____ _____
Signature of Member or Delegated Guardian *Relationship*

_____ _____
Print FIRST and LAST Name *Date*

Fax completed form to: (844) 834-2155

If you have any questions, please call toll-free:
Member Services: (855) 882-3901
Hearing Impaired/TTY: 711

Or mail to: Molina Healthcare of South Carolina
Member Services Department
PO Box 40309
North Charleston, SC 29423-0309

Well Visits

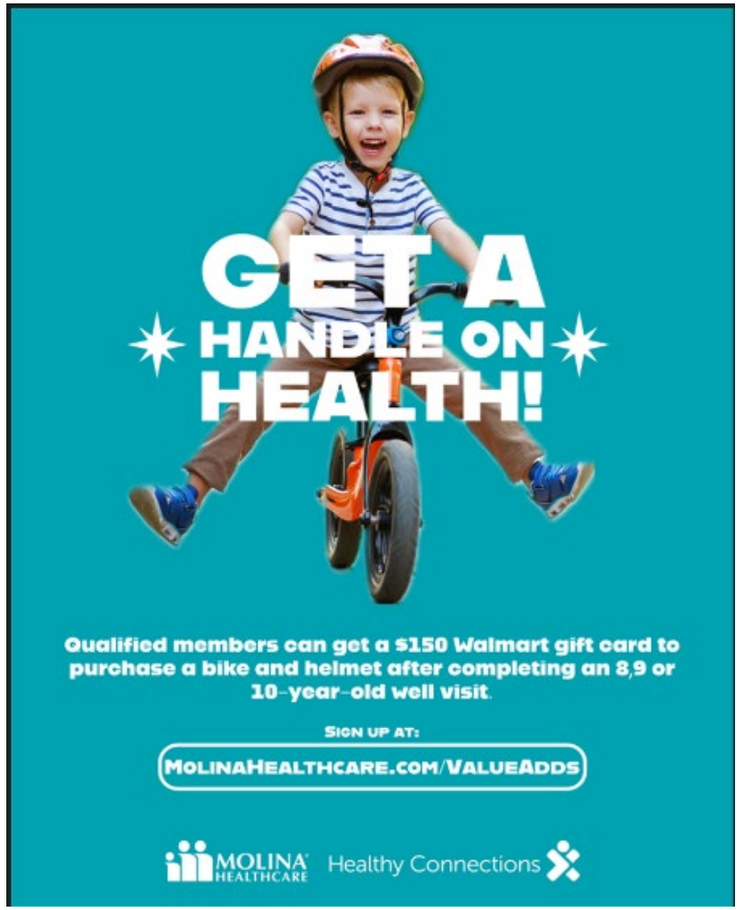
- Molina will reimburse any PCP provider for completing a well visit. Member does not have to be assigned to PCP for well visit reimbursement.
- Convert sick visit to well visit with use of the appropriate modifier: 25 indicating a significant, separately identifiable E/M service was provided by the same physician on the same day as the preventive medicine service.
- Free Sports Physicals – Offer a well child check in lieu of a Sports Physicals. Sports Physicals are not a covered service for Medicaid. Diagnoses Z02.5 and Z71.82 will meet Counseling for Physical Activity – WCC sub measure only

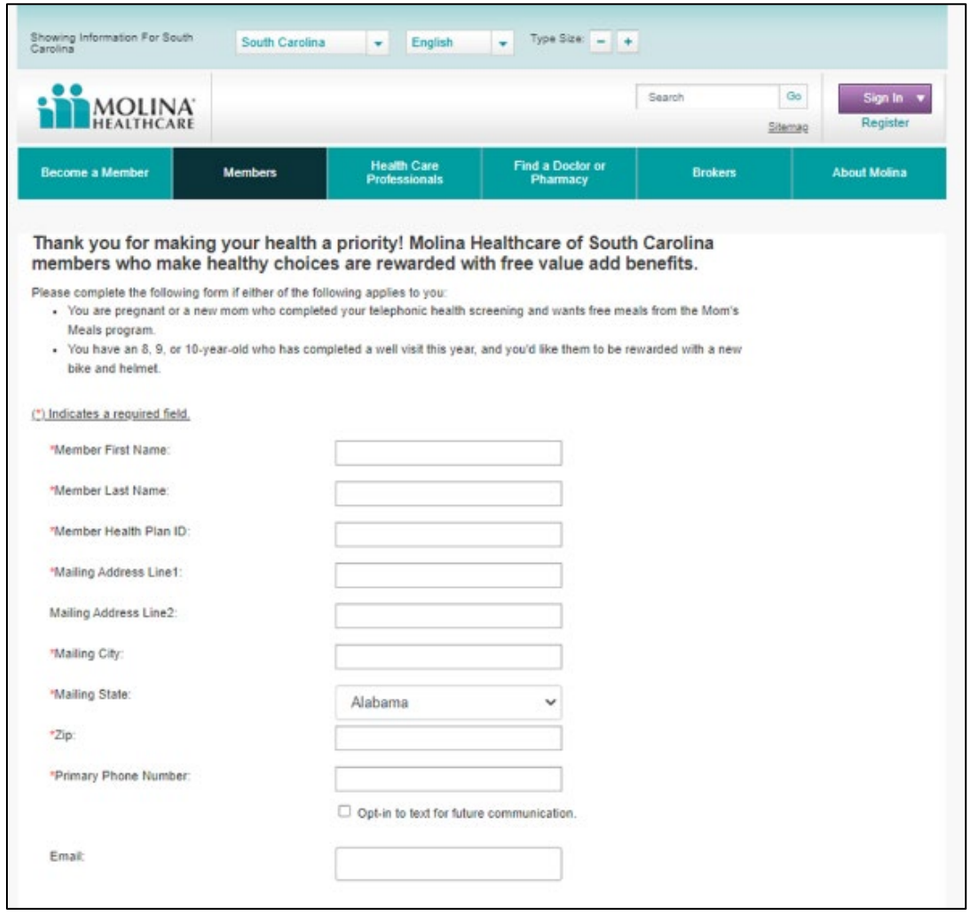
The well visit benefit for ages 3-21 are **no longer based on birthdate, well visit anniversary date, rolling year or 365+1 days from prior year well visit**.

Well visits may be performed at **anytime** during a calendar year.

Molina Value Add: Free Bike and Helmet

https://www.MolinaHealthcare.com/members/sc/en-us/mem/medicaid/scvalueadds





Or Member /parent can register for bike @ Member Customer Service Benefits/Eligibility: Phone: (855) 882-3901

Weight Assessment and Counseling for Nutrition and Physical Activity (WCC)

HEDIS® Tips:

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)

MEASURE DESCRIPTION

The percentage of patients 3-17 years of age who had an outpatient visit with a PCP or OB/GYN provider and who had evidence of the following during the measurement year.

- BMI percentile documentation. *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.*
- Counseling for nutrition or referral for nutrition education.
- Counseling for physical activity or referral for physical activity.

CODES INCLUDED IN THE CURRENT HEDIS® MEASURE

Description	Code
BMI Percentile <5% for age	**ICD-10:** Z68.51
BMI Percentile 5% to <85% for age	**ICD-10:** Z68.52
BMI Percentile 85% to <95% for age	**ICD-10:** Z68.53
BMI Percentile ≥95% for age	**ICD-10:** Z68.54
Counseling for Nutrition	**CPT®:** 97802-97804 **ICD-10:** Z71.3 **HCPCS:** G0270, G0271, G0447, S9449, S9452, S9470
Counseling for Physical Activity	**ICD-10:** Z02.5, Z71.82 **HCPCS:** S9451, G0447
Telephone Visits	**CPT®:** 98966-98968, 99441-99443
Telehealth Modifier	95, GT ***with*** **POS:** 02
Online Assessments (E-visits or Virtual Check-in)	**CPT®:** 98969-98972, 99421-99423, 99444, 99457 **HCPCS:** G0071, G2010, G2012, G2061-G2063

52%

of Well Visits are not compliant for the 3 WCC sub measures below

- ❑ **Weight Assessment (BMI)**
- ❑ **Counseling for Nutrition**
- ❑ **Physical Activity**

New Mom Benefits

Molina provides continued Coverage for mom for **12 months** after the baby's birth.

- Well Visit PCP (yearly)
- Sick Visits (PCP/ or Urgent Care)
- Women's Health Visits (PPC or OBGYN)
- Behavioral Health Visits (24 visits w/o PA)
- MOM’s Meals
- Eye Exams & Glasses – March Vision
- Dental- Dentaquest
- Prescriptions /Pharmacy

Additional Benefits for New Moms and Babies

Mom’s Meals

Mom's Meals are Home-delivered meals for pregnant and postpartum mothers who complete a telephonic health screening. Up to three weeks of meals offered.

Sign up for Mom's Meals at MolinaHealthcare.com/ValueAdds, or call **(866) 891-2320** and press 1 for questions.

Free Breast Pumps

Free electric breast pump for qualifying pregnant members. Breast pumps are provided by Aeroflow. To get a breast pump:

1. Molina must be your primary insurance
2. You must not have received a breast pump from Medicaid before.

Visit the Rewards with Molina Healthcare of South Carolina page for more information

Well Baby Incentives

Members can earn up to $200 for pediatric well visits and immunizations combined!

Free Car Seat

To qualify for a free car seat, complete six prenatal visits with your provider. Then email the following information to Molina's Member Engagement team at **Molina_sc_car_seat@MolinaHealthcare.com**

- Member first and last name
- Member physical mailing address
- Member phone number
- Member Molina ID #
- Be sure to use "Car Seat" as your email subject line.
- You must be a Molina member during the time of your prenatal visits. Car seat type may vary.

Medicaid Vision Care

Coverage includes:

- One routine vision exam every year
- For members 21 and over: Glasses every two years, if needed
- For members under 21: Glasses once per year, if needed

If you have diabetes, protect your health with an annual dilated eye exam for diabetic retinopathy.

How do I find a doctor? Choose from two ways:

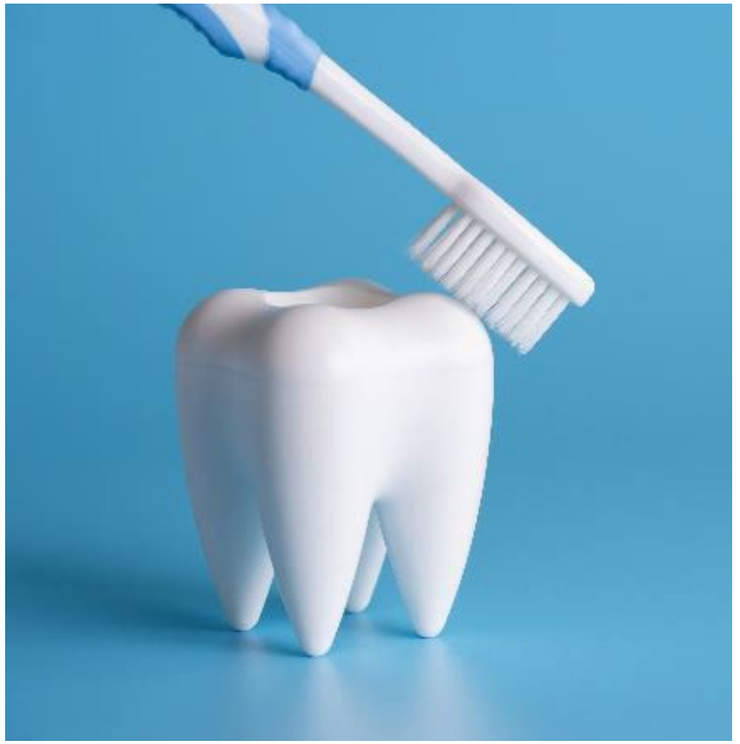
1. Visit marchvisioncare.com/find.aspx to use MVC's provider directory
2. Call an MVC representative toll-free at (844) 946-2724 or TTY/TDD (877) 627-2456

Medicaid Dental Care

Dental is covered and offered through DentaQuest as part of your Healthy Connections coverage and is separate from the benefits covered by Molina Healthcare of South Carolina.

How do Members Get Dental Care?

For complete information on what is covered and how to use your dental benefits, please call DentaQuest toll-free at (888) 307-6552. For more information visit dentaquest.com.



Healthcare Effectiveness and Data Information Set (HEDIS) Reminders

MOLINA® HEALTHCARE

You Matter to Molina

Quality Meetings

2025 Quality Meetings Available

Monthly or Bi-monthly

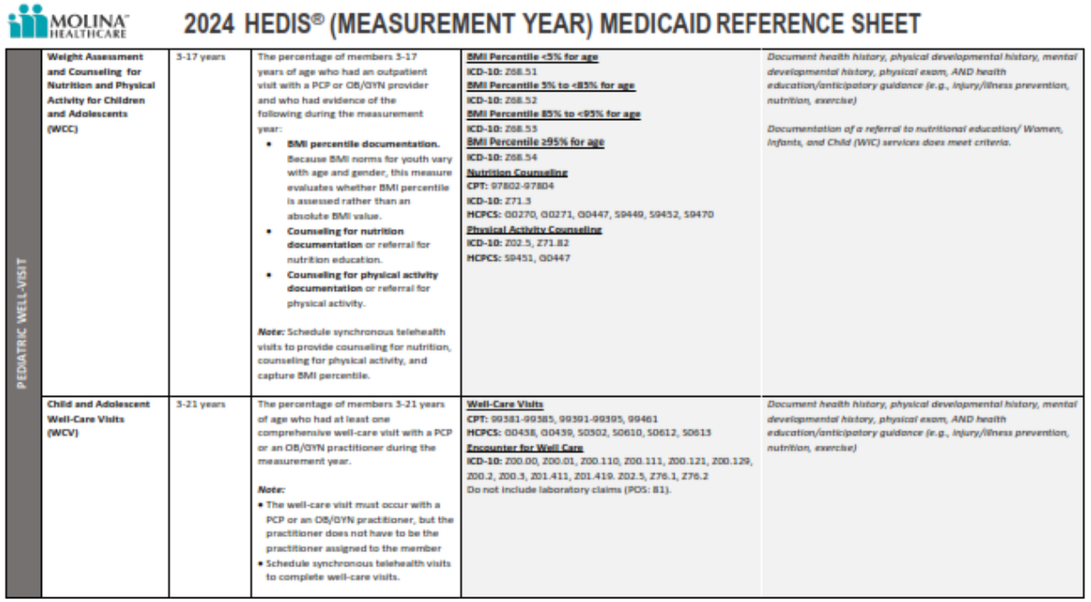
- Provider and Clinic Level Detail
- Gap In Care Report
- Call Center/Direct Scheduling
- On Site Gift Cards/Goodies
- Billing Analysis

Contact Lisa A. Collins,
Director of Provider Engagement

Email: Lisa.Collins@Molinahealthcare.com

HEDIS Tip Sheets in Availity

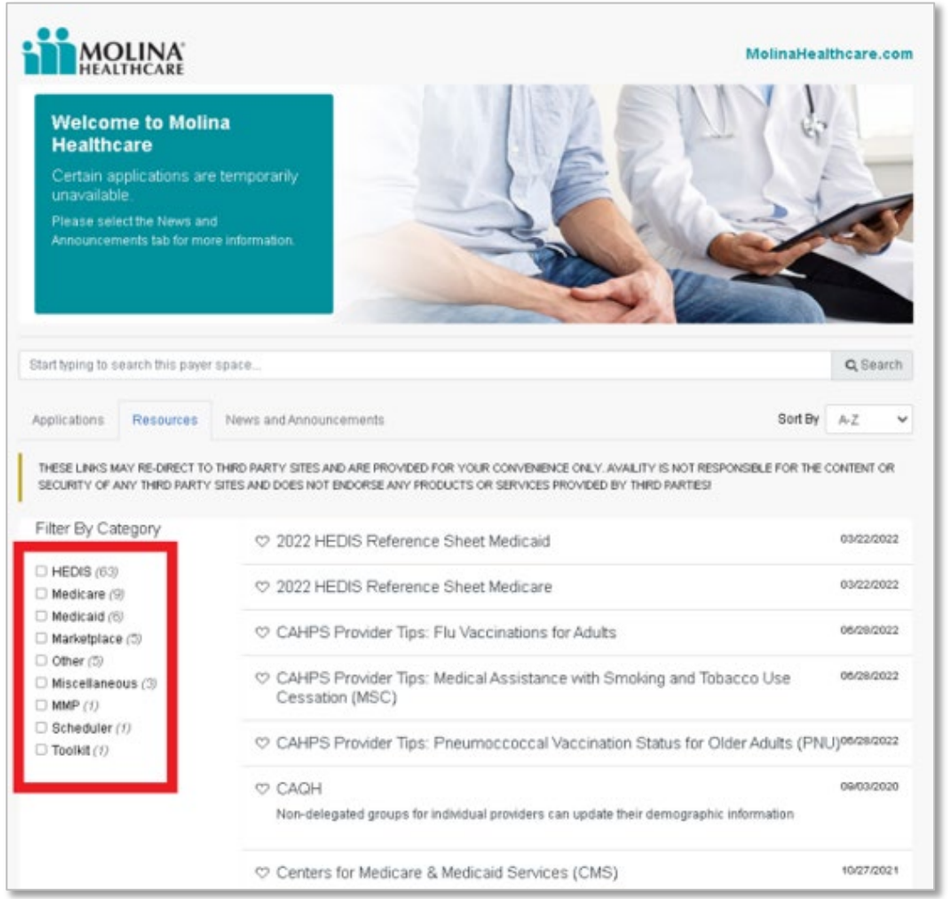
Tips sheets are located under the Resources Tab of the Molina Payor Space page.



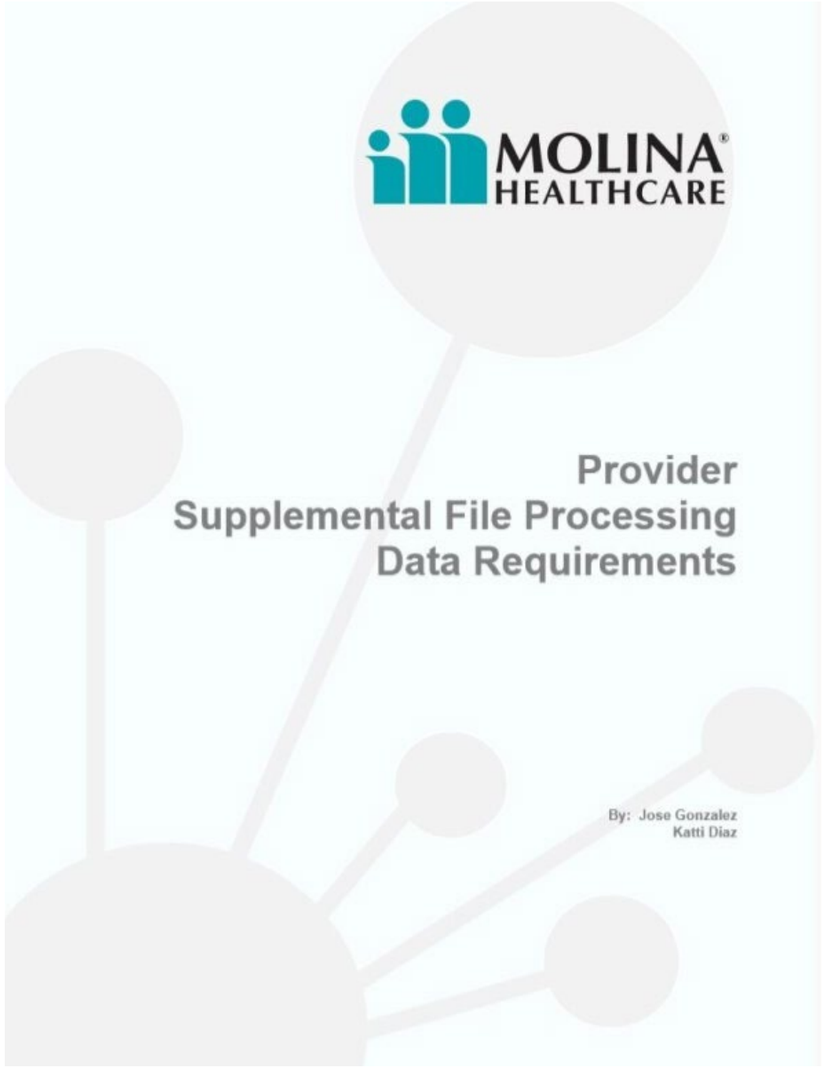
MOLINA HEALTHCARE

2024 HEDIS® (MEASUREMENT YEAR) MEDICAID REFERENCE SHEET

PEDIATRIC WELL-VISIT	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)**	3-17 years	The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN provider and who had evidence of the following during the measurement year: • **BMI percentile documentation.** Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value. • **Counseling for nutrition documentation** or referral for nutrition education. • **Counseling for physical activity documentation** or referral for physical activity. ***Note:*** Schedule synchronous telehealth visits to provide counseling for nutrition, counseling for physical activity, and capture BMI percentile.	**BMI Percentile <5% for age** **ICD-10:** Z68.51 **BMI Percentile 5% to <85% for age** **ICD-10:** Z68.52 **BMI Percentile 85% to <95% for age** **ICD-10:** Z68.53 **BMI Percentile ≥95% for age** **ICD-10:** Z68.54 **Nutrition Counseling** **CPT:** 97802-97804 **ICD-10:** Z71.3 **HCPCS:** G0270, G0271, G0447, S9449, S9452, S9470 **Physical Activity Counseling** **ICD-10:** Z02.5, Z71.82 **HCPCS:** S9451, G0447	*Document health history, physical developmental history, mental developmental history, physical exam, AND health education/anticipatory guidance (e.g., injury/illness prevention, nutrition, exercise)* *Documentation of a referral to nutritional education/ Women, Infants, and Child (WIC) services does meet criteria.*
	Child and Adolescent Well-Care Visits (WCV)	3-21 years	The percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. ***Note:*** • The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member • Schedule synchronous telehealth visits to complete well-care visits.	**Well-Care Visits** **CPT:** 99381-99385, 99391-99395, 99461 **HCPCS:** G0438, G0439, S0302, S0610, S0612, S0613 **Encounter for Well Care** **ICD-10:** Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2 Do not include laboratory claims (POS: 81).	*Document health history, physical developmental history, mental developmental history, physical exam, AND health education/anticipatory guidance (e.g., injury/illness prevention, nutrition, exercise)*



Supplemental Data: The Provider “Safety Net”



Race	Patient's Race	Optional
Ethnicity	Patient's Ethnicity	Optional
SSN	Patients Social Security Number	Optional
Provider NPI	Type 1 National Provider Identifier (NPI) if appropriate OR Type 2 National Provider Identifier (NPI) and 10 characte	Required
Claim Number	Number referring to office visit	Optional
Date of Service	Date service was rendered	Required
CPTCode	Multiple CPT codes need to be reported as separate rows with no modifier code attached	Required
BPSYSTOLIC VALUE	If CPTII Blood Pressure codes are not being captured	Conditionally Required - See description
BPDIASTOLIC VALUE	If CPTII Blood Pressure codes are not being captured	Conditionally Required - See description
BMI Value	BMI Value	Optional
DIAGNOSISCODE1	Applicable diagnosis code with decimal point	Required
DIAGNOSISCODE2	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE3	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE4	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE5	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE6	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE7	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE8	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE9	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE10	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE11	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE12	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE13	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE14	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE15	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE16	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE17	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE18	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE19	Applicable diagnosis code with decimal point	Optional
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DIAGNOSISCODE21	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE22	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE23	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE24	Applicable diagnosis code with decimal point	Optional
DIAGNOSISCODE25	Applicable diagnosis code with decimal point	Optional
RevenueCode	If institutional or Hospital: Required	Conditionally Required - See description
PROCEDURECODE1	Applicable procedure codes	Optional
PROCEDURECODE2	Applicable procedure codes	Optional
PROCEDURECODE3	Applicable procedure codes	Optional
PROCEDURECODE4	Applicable procedure codes	Optional
PROCEDURECODE5	Applicable procedure codes	Optional
PROCEDURECODE6	Applicable procedure codes	Optional
PROCEDURECODE7	Applicable procedure codes	Optional
PROCEDURECODE8	Applicable procedure codes	Optional
PROCEDURECODE9	Applicable procedure codes	Optional
PROCEDURECODE10	Applicable procedure codes	Optional
PROCEDURECODE11	Applicable procedure codes	Optional
PROCEDURECODE12	Applicable procedure codes	Optional
PROCEDURECODE13	Applicable procedure codes	Optional
PROCEDURECODE14	Applicable procedure codes	Optional
PROCEDURECODE15	Applicable procedure codes	Optional
PROCEDURECODE16	Applicable procedure codes	Optional

The Advantage of Molina's Provider Resources

Scheduling Assistance

Email: Lisa.Collins@molinahealthcare.com

- Keonna Health Direct Scheduling
- Block Scheduling
- Molina Contact Center Outreach

Community Engagement

Email: SCCommunityEngagement.com

- Coat Giveaways
- Spring/ Summer Extravaganza
- Back to School Events

Targeted Campaigns

Email: Lisa.Collins@Molinahealthcare.com

- Well Visit Days
- Vaccine Clinics
- Handle on Health

Health Educator / Case Management

Email: MHIHealthEducationMailbox@MolinaHealthCare.Com

- Asthma (2+ years old)
- Sickle Cell
- Catastrophic/complex diagnosis

Audits and Medical Record Requests

MOLINA® HEALTHCARE

You Matter to Molina

Medical Record Review Audits

Ongoing Audits

- HEDIS 2025– Gaps In Care
- Risk Adjustment
- PMRR
- EQRO AUDIT – Reviewing Standards for Medical Record Documentation

Let Us Do the Heavy Lifting

- Grant Remote Access to your EMR
- Notification of Audit Window
- Access only used during audit
- Fact: We see a 45% greater compliance rate for providers when remote access is being used

Payment Integrity: Pre-payment Audits and Optum

The purpose of conducting pre-pay reviews is to ensure that services billed are consistent with medical record documentation

What is the remark code?	What is the remit message?	How do I submit medical records? What should I include?
Remit Remark Code M127	“Optum requesting Medical Records on Molina’s behalf. The allowed timeframe for Medical Record submission and any disputes is based on timely filing requirements. Please direct questions regarding this Medical Record request to Optum at (877) 244-0403.”	If you receive a request for medical records from Optum, please follow the instructions in the letter. The letter will provide details of how and where to submit your medical records and what to include with your submission. Submission options vary, depending on market requirements. A URL Upload and fax option are available for all markets.

Review the Pre-Pay Audit Frequently Asked Questions and PI Payment Policy 29 Optum Pause and Pay resources for more information.

Molina Special Investigations Unit (SIU)

The SIU analyzes providers by using software that identifies issues such as:

- Questionable coding and/or billing patterns
- Compliance with the terms of the Provider Agreement
- Fraud, waste and abuse involving medical necessity
- Selections are random

If your practice receives a notice from the SIU:

- Cooperate with the notice and any instructions, provide requested medical records and all supporting documentation.
- Any questions, please contact your Provider Services Representative.

You may receive medical records requests from Molina or a third party on our behalf to conduct payment integrity activities. Please respond to these requests to ensure prompt, accurate adjudication.

Compliance Reminders

MOLINA® HEALTHCARE

You Matter to Molina

Model of Care Training

Molina Model of Care is the plan for delivering coordinated care and management to special needs members and provide the basic framework under which we meet the regulatory requirements as defined by CMS

- Molina Healthcare requires compliance with provider education and training programs.
- All contracted Medicare PCPs and key high-volume specialists are required to complete Model of Care training annually.

Access the 2025 training here

Complete the attestation here

CAHPS: Improving Patient Satisfaction

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an industry standard survey tool used to evaluate patient satisfaction. Improving patient satisfaction has many benefits. It not only helps to increase patient retention but can also help increase compliance with physician recommendations and improve patient outcomes.

Related CAHPS® Questions:

- When you needed care right away, how often did you get care as soon as you needed?
- When you made an appointment for a check-up or routine care at a doctor's office or clinic, how often did you get an appointment as soon as you needed?
- How often was it easy to get the care, tests treatment you needed?
- How often did your personal doctor listen carefully to you?
- How often did your personal doctor spend enough time with you?
- How often did your personal doctor explain things in a way that was easy for you to understand?
- How often did you and your personal doctor talk about all the prescription medicines you were taking?
- How would you rate your personal doctor?
- How would you rate the specialist you saw most often in the last six months?
- Have you had a flu shot since July 1 (of previous year)?

Access to Care Standards: Medicaid

Provider Type	Routine Visit Availability	Urgent / Non-Emergent Availability	Emergent Availability	Other Requirements
Primary Care Providers	Available within 15 business days	Available within 48 hours	Available immediately upon presentation at a service delivery site	Walk-in patients must be seen if possible or scheduled per written procedures; wait times ≤ 45 min
OB/GYN	Available within 15 business days	Available within 48 hours	Available immediately upon presentation at a service delivery site	Same as above
Autism Therapy	Available within 15 business days	Available within 48 hours	Available immediately upon presentation at a service delivery site	Same as above
Specialist Providers	Available within four weeks	Available within 48 hours of referral or PCP notification	Available immediately upon referral	Same as above
Behavioral Health Providers	Available within 10 business days	Follow-up routine care: within 15 days of initial visitUrgent: Available within 48 hours of request	Emergent (non-life threatening): Available immediately upon presentation at a service delivery site	Same as above

Access to Care Standards: Medicare

Medical appointment

Appointment Type	Standard
Primary Care: Routine and Preventive Care	Within 30 calendar days
Primary Care: Urgently needed services or Emergency; services that are not emergency or urgently needed but require medical attention	Within 7 calendar days
Urgently needed services or emergency	Immediately
Urgent Care	Within 24 hours
After Hours Care	24 hours/day; 7 days/week availability

Specialist provider care

Appointment Type	Standard
Specialty Care (High Volume)	Within 12 weeks
Specialty Care (High Impact)	Within 12 weeks
Urgent Specialty Care	Within 24 hours

Access to Care Standards: Medicare Con

Behavioral health appointment

Appointment Type	Standard
Life-threatening Emergency: Urgently needed services or emergency	Immediately
Non-life-threatening emergency	Within 6 hours
Urgent Care	Within 48 hours
Services that are not emergency or urgently needed but require medical attention	Within 7 calendar days
Follow-up Routine Care	Within 30 calendar days

Additional information on appointment access standards is available from your local Molina Quality department.

Office wait time

The wait time in offices for scheduled appointments should not exceed 45 minutes. All PCPs are required to monitor waiting times and adhere to this standard.

Marketplace Access to Care

<u>Service Type – Maximum Wait Time:</u>

Behavioral Health – Within **10 calendar days**

Primary Care (Routine) – Within **15 business days**

Specialty Care (Non Urgent) – Within **30 business days**

Health Insurance Portability and Accountability Act (HIPAA)

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 identify 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 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 advice

Molina is committed to complying with all HIPAA Transactions and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with Molina should refer to the HIPAA Transactions on our provider website.

Fraud, Waste, and Abuse (FWA)

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

Fraud	Waste	Abuse
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 spending that can be eliminated without reducing the quality of care. Quality waste includes overuse, under use, and ineffective use. Inefficiency waste includes redundancy, delays, and unnecessary process complexity.	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)

Do you have suspicions of member or provider fraud? The **Molina HealthcareAlertLine** 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.

FWA

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. Molina maintains a comprehensive plan, which addresses how Molina will uphold and follow state and federal statues, and regulations.

For more information, read the “Fraud, Waste, and Abuse section of our provider manuals at MolinaHealthcare.com. Information includes:

- Introduction and Mission Statement
- Definitions
- Regulatory Requirements
- Examples of FWA by a Provider
- Examples of FWA by a Member
- Review of Provider Claims and Claims Systems
- Prepayment FWA Detection Activities
- Post-payment Recovery Activities

Do you have suspicions of member or provider fraud? The **MolinaAlertLine** is available 24-hours a day, 7 days a week, and even on holidays at **(866) 606-3889**. Reports are confidential, but you may choose to report anonymously.

Americans with Disabilities Act (ADA)

The Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities, including discrimination that may affect employment, public accommodations (including health care), activities of state and local government, transportation, and telecommunications. The ADA is based on three underlying values:

Compliance with the ADA extends, expands, and enhances the experience for **all** Americans accessing health care and ensures that people with disabilities will receive health and preventive care that offers the same full and equal access as is provided to others.

For more information, view the Molina Provider Education Series on the Culturally and Linguistically Appropriate Resources/Disability Resources page.

Cultural and Linguistic Competency

Molina is required to provide annual Cultural Competency (CC) training to our participating provider network. Providers are required to attest to Molina the completion of CC training.

Molina offers educational opportunities in CC concepts for providers, their staff, and Community-Based Organizations.

Providers have the option to:

Utilize Molina's CC training, located on the Culturally and Linguistically Appropriate Resources/Disability Resources page of the Molina website and attest.

Utilize their own CC training that meets the federal requirement and attest to Molina.

View the Provider Training Attestation Form

Please note: Molina does not review and assess providers' training programs. Providers are mandated to complete training in compliance with the federal requirement ***and then attest to its completion***.

Questions and Comments

Please submit questions in the chat.

If you have questions following the conclusion of the Town Hall, please reach out to your Provider Relations Representative or email SCProvider.Services@MolinaHealthcare.com.

A copy of the presentation will be sent via email to you at the end of the week.

Thank you for joining us!