Molina Marketplace Provider Orientation

Our Marketplace Presence

Molina Marketplace currently offers benefit plans in every county except: Oconee, Pickens, and Anderson.

Currently, Molina offers Marketplace product in an additional 12 states:

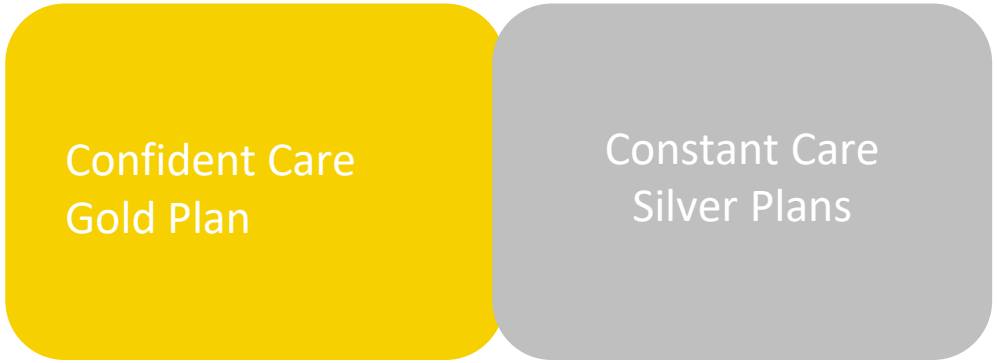
- California
- Florida
- Idaho
- Illinois
- Kentucky
- Mississippi
- New Mexico
- Ohio
- Texas
- Utah
- Washington
- Wisconsin

Introduction to Health Insurance Exchange

The Health Insurance Marketplace (also known as the Exchange/HIX) 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 13 states.
- The Marketplace is an outcome of the Affordable Care Act – more commonly known as 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 and Silver 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.

Confident Care Gold Plan	• Ideal for mid- to high-earners • Closely resembles employer-sponsored benefits
Constant Care 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

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 and 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 Period

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. Click here for more information.

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

MOLINA HEALTHCARE

Marketplace

Subscriber: [redacted]
Subscriber ID: [redacted]
Plan: Constant Care Silver 7 100

Member: [redacted]
Member ID: [redacted]
Effective Date: 08/01/2022

MWK00079898062229334-A00001-X

Cost Share
PCP: $0
Specialist: $10
Urgent Care: $0
ER Visit: $250
Tier-1 Rx: $0
Tier-2 Rx: $10

Deductibles
Medical Indv Deductible: $0
RX Indv Deductible: $0

Annual Out of Pocket Maximum (OOPM)
Indv OOPM: $1,200

RxBIN: 004336 RxPCN: ADV RxGRP: RX0856
HMO Molina Healthcare of South Carolina, Inc.

CVS caremark

Member Numbers

Member Services: (855) 885-3176
TTY/TTD: 711
24/7 Nurse Advice: (844) 800-5155
24/7 Línea de Consejos de Enfermeras: (844) 800-5155

Billing and Payments:
(800) 400-7957

Cost Shares are a summary only.
Visit MyMolina.com for plan details.

Notice: Covered Services must be received from Participating Providers. Refer to your Agreement for exceptions.

Provider Numbers

CVS Caremark Help desk: (888) 407-6425

Prior Authorization/Notification of Hospital Admission: (855) 237-6178

Medical Claims:
Molina Healthcare
PO BOX 22664
Long Beach, CA 90801

Inpatient Admissions: Provider to notify plan within 24 hours of admission.

MyMolina.com This card is for identification purposes only and does not prove eligibility for service.

Member Cost Sharing

Cost sharing is the **deductible, copayment, or coinsurance** that members must pay for covered services provided under their Molina Marketplace plan. Click here for Benefits at a Glance.

- 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 co-payment 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, their coverage will not be effective.
- There will be a binder restriction placed on every Marketplace member record until the binder payment is received and coverage is effectuated.
- 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.

Member: An individual, including any dependents, enrolled in Molina Marketplace. This term includes both APTC Members and Non-APTC Members.

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 as well as information about how authorizations and claims will be processed when a member is in a grace period.
- 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.

Grace Period Differences

Non-Advanced premium tax credit grace period (APTC) members

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.

If the Non-APTC member's full past-due premium is not paid by the end of the one month grace period, the member will be retroactively terminated to the previous month.

The advanced premium tax credit members

APTC members who receive a subsidy 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.

Primary Care Assignment

- Molina will offer each patient a choice of Primary Care Provider (PCP).
- Molina will assign a PCP to those members who did not choose a PCP at the time of enrollment.
- The member's last PCP will be taken into consideration for all PCP assignments.
- Patients can change their PCP at any time. All changes completed by the 25th of the month will be in effect on the first day of the following calendar month.
- Any changes requested on or after the 26th of the month will be in effect on the first day of the second calendar month.

Prior Authorizations (PA)

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.

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.

Prior Authorizations

Medical Services:

- Routine Prior Authorization Requests: Will be processed within 5 business days from receipt of all information reasonably necessary and requested by Molina to make the determination. The period of time may be shorter if required by law.

- Expedited Prior Authorization Requests: Medical conditions (that are not Emergency Medical Conditions) that a Member's Provider believes may cause a serious threat to a Member's health are processed within 72 hours from receipt of all reasonably necessary information requested by Molina to make the determination. The period of time may be shorter if required by law.

- Emergency Medical Conditions: Do not require Prior Authorization.

Prescription Drugs and Medications: Prior Authorization decisions and notifications for access to medications not listed on the Molina Formulary will be provided as described in the section of this Agreement titled "Access to Non-Formulary Drugs."

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**.

You can submit PAs in two different ways:

- Submit Online: Via our Provider Web Portal here.
- Or fax: (833) 322-1061

Hospital Requirements

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.

For a full link to hospital requirements, click here.

Provider Standard Appointment Timeframes

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

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 Molina Marketplace 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.

Provider Online Resources

- Provider Marketplace Main Page
- Policies
- 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

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

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

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

Mail directly to Molina Healthcare

Attn: Molina Marketplace Claims
PO Box 22664 Long Beach, CA 90801

Corrected Claims

- Use the Corrected Claims Form on our website. Providers have 365 days from the date of service.

Mail completed form and corrected claim to:
PO Box 22664
Long Beach CA, 90801

EDI Submission Issues

- Use the Claims Reconsideration Form on our website.
- Contact your Provider Services Representative.
- Email: EDI.Claims@MolinaHealthcare.com

Claims Reconsiderations

- Requests must be received within 90 days from the date of original remittance advice.
- Call the EDI customer service line at (866) 409-2935.

Mail to:
Grievance and Appeals Unit
PO Box 40309
North Charleston, SC 29423

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

Electronic Payments

Please click **here** for more information on ERA and EFT. Training can be found for the Echo Provider Payments portal **here**.

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 HIP!!'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.

If you suspect cases of fraud, waste, or abuse, you must report it to Molina. You may do so by contacting the Molina AlertLine or submit an electronic complaint using the website listed below.

Confidential
Compliance Official
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
Online: MolinaHealthcare.AlertLine.com

For definitions of fraud, waste and abuse, and more information on this, please refer to the Provider Manual here.