2023 Annual Provider Training

October 2023

Presenters

HHS

Maria James
- Desiree Smith
- Towera Chilongo
- Peter Crane
- Dionisia Johnson

Iowa Total Care

- Ben Badgley
- Lina Fareel
- Ashley Woods
- Dave Smith
- Julie Anderson
- Cort Brown
- Eric Esser
- Rhonda Jones
- Sheri Siemen
- Heath Hill
- Toni Mineras

Amerigroup

- Patty Bucklin
- Robin Lank
- Lisa Barton
- Sheree Smith-Martinez
- Maria Wilson
- Donna Wendt

Molina Healthcare

- Maria Markham
- Theresa Ellis
- Jordan Kohlmeyer
- Adrian Cain
- Veronica Smith
- Elizabeth Erickson
- Kendra Abel
- Amber Meador

Agenda

- Health and Human Services (HHS) NEW Dashboard
- Electronic Visit Verification (EVV)
- Revalidation, Enrollment & Reenrollment
- Electronic Data Interchange Support System (EDISS)
- Medicare Savings Program
  - Qualified Medicare Beneficiary (QMB)
  - Specified Low Income Medicare Beneficiary (SLMB)
  - Expanded Specified Low Income Medicare Beneficiary (E-SLMB)
- Presumptive Eligibility

New Health And Human Services Dashboard

The new dashboard presents many new opportunities for Iowa Medicaid. The digital reporting will enhance communication, streamline processes, provide clarity, and better serve our Medicaid members.

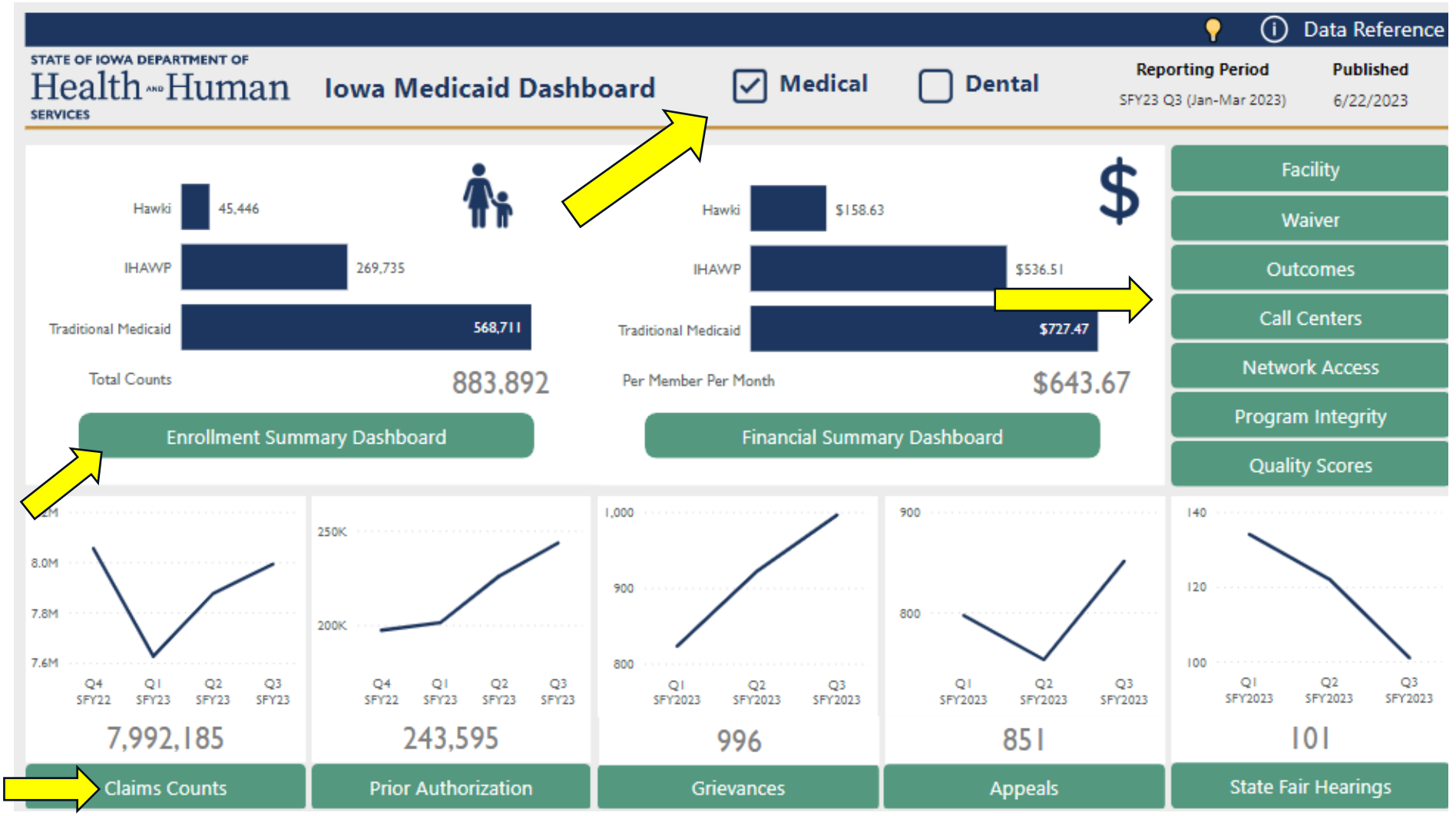
View the dashboard on the HHS website:

https://hhs.iowa.gov/Iowa-Medicaid-dashboard

Informational Letter (IL) 2501-MC-FFS

Iowa Medicaid Health Dashboard

https://hhs.iowa.gov/Iowa-Medicaid-dashboard



New Health and Human Services Dashboard

https://hhs.iowa.gov/Iowa-Medicaid-dashboard

Facility

- Captures the total number of members enrolled in a facility, per member per month costs and a pie chart comparison of waiver versus facility members by percentage.

Grievance and Appeals

- Shows the total grievances or appeals received, information on status and service type. It files reasons using Centers for Medicare and Medicaid Services (CMS) Managed Care Program Annual Report (MCPAR) data definitions. Data can also be filtered by standard or expedited status.

New Health and Human Services Dashboard

https://hhs.iowa.gov/Iowa-Medicaid-dashboard

Call Center

- Shows total calls received, service levels and abandonment rates for 10 different helplines between all MCOs, dental plans and Iowa Medicaid.

Program Integrity

- Identifies overpayments, member concerns referred to Iowa Medicaid, investigations opened and cases referred to the Medicaid Fraud Control Unit (MFCU).

Network Access:

- Captures the average distance, the counts of members with access and total provider counts.

New Health and Human Services Dashboard

https://hhs.iowa.gov/Iowa-Medicaid-dashboard

Outcomes

- Shows child outcomes for wellness and prevention measures for:
  - Substance use disorder (SUD)
  - Serious emotional disturbance (SED) and mental health treatment and services
- In addition, the outcomes page captures value added services offered by the Managed Care Programs (MCPs) and waiver plan service activity for:
  - Meals
  - Respite
  - Consumer Directed Attendant Care (CDAC)
- Not all sections are available for dental.

New Health and Human Services Dashboard

https://hhs.iowa.gov/Iowa-Medicaid-dashboard

Quality Scores

- This section captures measures for the annual National Committee for:
  - Quality Assurance (NCQA) Health Plan Ratings
  - CMS CORE Set Measures
  - the Iowa Medicaid Scorecard
  - Healthcare Effectiveness Data and Information (HEDIS)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Not all sections are available for dental.

New Health and Human Services Dashboard: Contacts

If you have any questions or concerns, please contact:

Kurt Behrens

- Quality Improvement Analyst
- kbehren@dhs.state.ia.us

Joanne Bush

- Managed Care & Oversight Bureau Chief
- jbush@dhs.state.ia.us

Electronic Visit Verification (EVV) Implementation

What is EVV?

Electronic Visit Verification (EVV): A technological solution used to electronically verify that personal care providers and home health providers delivered or rendered services as billed.

EVV systems must verify the:

- Type of service performed
- Individual receiving the service
- Date of service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

EVV is Used as a Tool

Ensures financial accountability of the program

- ✓Reduction in unauthorized services
- ✓Improvement in quality of services to individuals
- ✓Reduction in Fraud, Waste, and Abuse

Frequently Asked Questions:
https://hhs.iowa.gov/ime/providers/evv/faqs

Iowa's Model

Iowa implemented EVV through a managed care choice implementation model.

Iowa's managed care organizations (MCOs) work with CareBridge for EVV implementation.

Providers have the option to utilize another EVV vendor.

Federal Guidance and State Requirements

21st Century Cures Act requires states to implement EVV for all Medicaid Personal Care Service (PCS) and Home Health Care Services (HHCS) requiring an in-home visit by a provider.

- EVV for PCS was implemented January 1, 2021
- HHCS will begin implementation on October 1, 2023
- Full compliance being required by January 1, 2024

In 2021, Iowa Medicaid implemented rule changes that were applied to Iowa Administrative Code: https://www.legis.iowa.gov/law

Provider Attestation

Assisted Living Facility (ALF) and Residential Care Facility (RCF) are able to opt out of EVV for shift workers.

ALF and RCF providers must complete an attestation to be identified as exempt and then annually by June 30th thereafter.

If a provider does not have an exemption on file claims must be submitted through EVV or the provider will face denial of the claim.

Home Health Care Services

- EVV applies to all home health services requiring an in-home visit that are described in section 1905(a)(7) of the Social Security Act and provided under the state plan or under a waiver of the state plan.
  - Home Health services will be required by January 1, 2024

The Medicaid home health benefit includes:

Nursing Services

Health Home Aide Services

Physical Therapy

Speech Therapy

Occupational Therapy

Third Party Liability (TPL)

When an individual receives **both Medicare and Medicaid** HHCS, EVV requirements them to apply to the home health services claimed as a Medicaid home health benefit.

Resources

Please visit the EVV Webpage for information and future updates:

https://hhs.iowa.gov/ime/providers/EVV

To contact the EVV Team, the following email should be used:

evv@dhs.state.ia.us

Revalidation

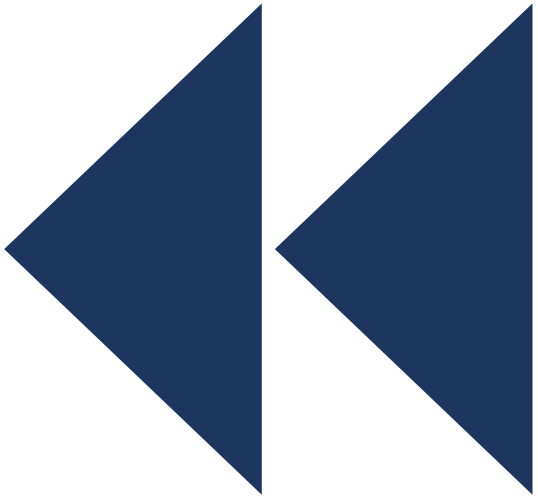
Learning Objectives

Which providers will need to go through the revalidation process?

When is revalidation due?

How to revalidate?

Provider Revalidation



In response to the COVID-19 PHE ending, May 11, 2023, Provider Enrollment will be requiring providers to revalidate their enrollment.

Revalidation is normally required every five years; therefore, providers enrolled during the PHE will not be subject to revalidation at this time.

Provider Revalidation

All providers complete enrollment renewal every 5 years.

Your enrollment revalidation date is based on the date you signed their provider agreement.

After you've completed revalidation for the first time, your **next** revalidation date is based on the date you have completed your last revalidation.

Providers that do **NOT** have to revalidate their enrollment with HHS:

If you were a new provider who enrolled with Iowa Medicaid during the PHE.

OR

Providers who chose to complete the revalidation of their enrollment during PHE.

Provider Revalidation - Initial Step

To start the revalidation process simply print and compete the DCP, form 470-5112 found on our website at: **https://hhs.iowa.gov/ime/providers/forms**

return the form to:

Iowa Medicaid Provider Enrollment

PO Box 36450

Des Moines, Iowa 50315

Or scan and email to: IMEProviderEnrollment@dhs.state.ia.us

If you are already set up as the Designated Contact Person (DCP), you can skip this step.

With exception for individual CDAC providers, revalidation is completed electronically on the IMPA system.

To access the portal, use the following link:

https://secureapp.dhs.state.ia.us/impa/Default.aspx

The provider must do the following:

- ❑ Review and agree to the new Provider Agreement.
- ❑ Verify professional and institutional components of the provider organization and structure.
- ❑ Complete the Ownership and Control Disclosure (OCD); and
- ❑ Provide individual Social Security Number(s) where indicated.

Provider Revalidation – IMPA

With exception for individual CDAC providers, revalidation is completed electronically on the IMPA system.

To access the portal, use the following link:

https://secureapp.dhs.state.ia.us/impa/Default.aspx

The provider must do the following:

- Review and agree to the new Provider Agreement.
- Verify professional and institutional components of the provider organization and structure.
- Complete the Ownership and Control Disclosure (OCD); and
- Provide individual Social Security Number(s) where indicated.

Provider Revalidation - Individual CDAC

To stay active in the Iowa Medicaid program revalidation is required.

Providers who fail to complete revalidation will have their Medicaid provider number terminated and claims will no longer be paid.

To revalidate a provider agreement and ICDAC disclosure forms must be signed:

- Provider Agreement: 470-2965 Iowa Medicaid Provider Agreement General Terms.
- Disclosure Form: 470-4612 Individual Consumer-Directed Attendant (CDAC) Disclosure (iowa.gov)

Enrollment Information

Both ICDAC forms can be found on our website at: https://hhs.iowa.gov/ime/Providers/enrollment/WaiverEnrollment

- CDAC Disclosure (470-4612)
- Iowa Medicaid Provider Agreement (470-2965)

Return form to:

Provider Enrollment-Renewal
- PO Box 36450
- Des Moines, Iowa 50315
- Or scan and email to: IMEProviderEnrollment@dhs.state.ia.us

Please note, each provider must be enrolled with Iowa Medicaid to credential with the Managed Care Plans (MCPs). Providers must also credential with each MCP individually.

Electronic Data Interchange Support Services (EDISS)

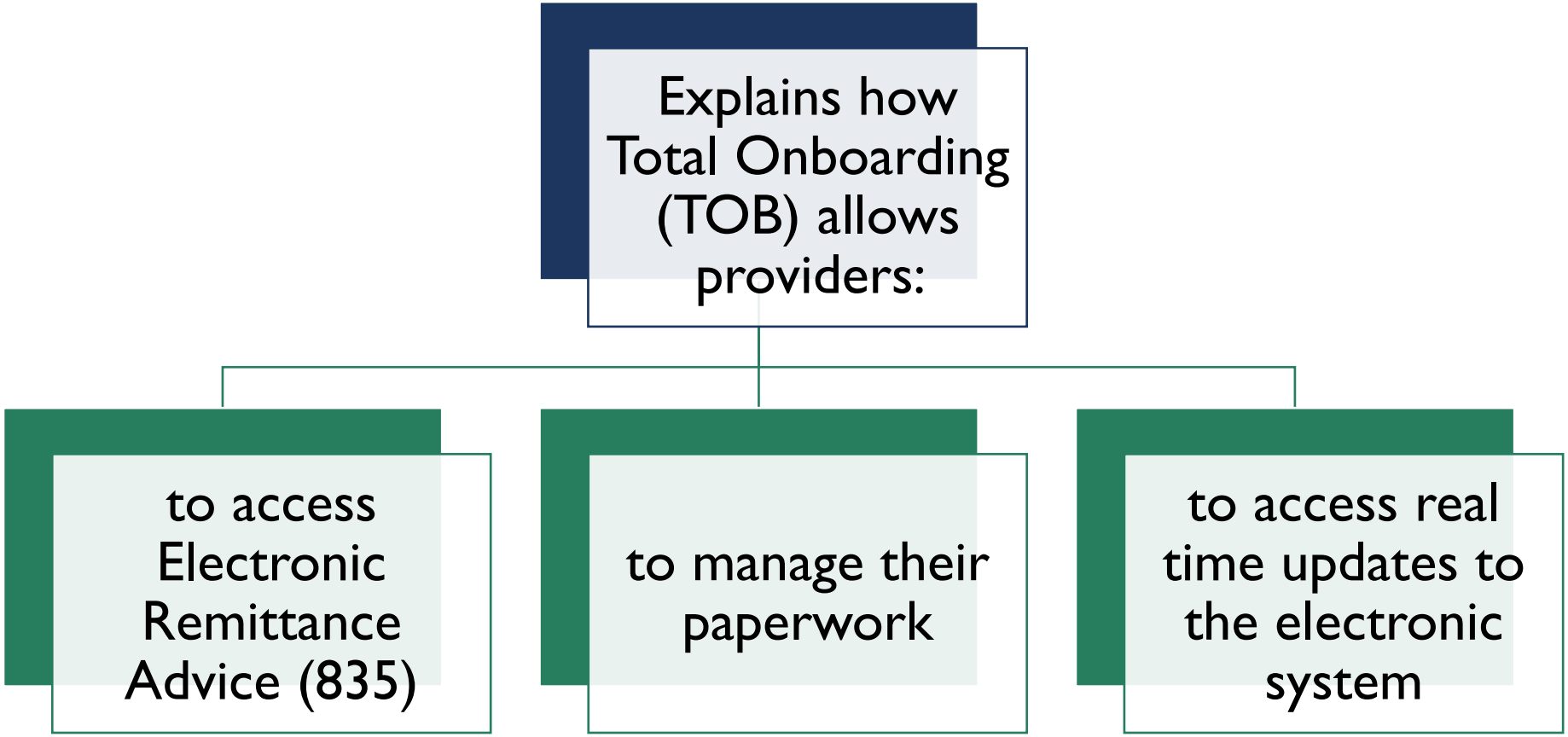
EDISS Explained

Iowa HHS is contracted with an electronic vendor, Electronic Data Interchange Support Services (EDISS).

This company provides free software for providers to electronically file claims, PC-ACE pro32, as well as a web-based application "EDISS Connect."

EDISS Connect

A wide range of education regarding Total Onboarding (TOB) along with electronic billing is also available on www.edissweb.com.



Eligibility and Verification Information System (ELVS)

ELVS is the software utilized by EDISS.

Read more about the ELVS web portal and the procedure for logging in for providers 24/7.

This can be used to pick up and drop off batch files and submit real-time requests for Eligibility, Claim Status, Prior Authorizations and Provider Summary.

Electronic Data Interchange Support Services (EDISS)

All providers need to ensure their registration with EDISS, which is located within EDISS Connect, is accurate and up to date to avoid issues with their electronic transactions.

Providers are responsible for creating their EDISS Connect profile and entering all demographic information, as well as creating their EDISS Connect user account so they can log into their account.

EDISS

After registration, providers can control the transactions they will be using and who will be submitting those transactions as their administrator.

If a clearinghouse is selected by a provider to be the administrator of their account, it means the provider has selected that they **do not** manage their transactions, or their ability submit them.

EDISS

If a provider wants the ability to submit a transaction themselves, they need to ensure they have selected themselves as the one that will be conducting the transaction in their EDISS Connect account.

This means they need to check the "I will and/or" box associated to the appropriate transaction. Once approved by EDISS, a provider will be issued credentials via fax. (These credentials are different from the EDISS Connect user credentials mentioned above.)

EDISS

If a provider had credentials issued previously and they are no longer aware of what they are, they can contact EDISS about having the credentials resent to them.

Once the provider has their credentials, they can use them to connect to the EDI Gateway or log into the Iowa Medicaid Web Portal to submit transactions.

EDISS

If a provider has forgotten their EDISS Connect username, let their EDISS Connect password expire, or let their EDISS Connect user account go inactive for 90 or more days, they can utilize the appropriate link available on the EDISS Connect login page to self-remedy the situation.

Providers can also contact EDISS at 800-967-7902 if they wish to speak to a Customer Service Representative instead of using the available links.

EDISS

- EDISS Connect documentation and FAQs can be found at https://connect.edissweb.com/web/guest/help

Medicare Savings Program

Qualified Medicare Beneficiary (QMB)

Specified Low Income Medicare Beneficiary (SLMB)

Expanded Specified Low Income Medicare Beneficiary (E-SLMB)

Medicare Savings Program

Medicaid is a joint Federal and State program that helps pay medical costs for individuals with limited income and resources.

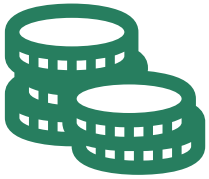
Individuals with Medicare Part A and/or Part B, who have limited income and resources, may get help paying for their out-of-pocket medical expenses from their State Medicaid Program

Qualified Medicare Beneficiary (QMB)

Under the QMB program, Medicaid only pays Medicare premiums, deductibles, and coinsurance for persons who are qualified Medicare beneficiaries.

Qualifications include:

Are 65 or older, blind or disabled and eligible to get Medicare Part A benefits.



Have resources less than $9,090 for a single person or $13,630 for a couple.

Have income at or below 100% of the federal poverty level

QMB and Specified Low Income Medicare Beneficiary

If the total countable income or resources are higher than the QMB limits, they may qualify for other programs:

- Medically Needy: This member is eligible if the member has a lot of medical bills and not enough money to pay the bills. If they qualify for Medically Needy, they will need to pay their medical bills up to the spenddown or deductible.

Qualified Medicare Beneficiary (QMB) – Covered Services

- Under the QMB program, they can get limited Medicaid coverage.
- This means Medicaid will pay only for the Medicare premiums, deductibles, and co-insurance for medical services covered by Medicare.

They should not be charged an additional cost, unless they get medical services that are not covered by Medicare.

All medical providers who accept Medicaid are required to accept payments made through the program as payment in full for services covered by Medicaid.

QMB - Covered Services

- If you get medical services that are not covered by Medicare, then Medicaid will **not** pay for them.

QMB - Next Steps

After they qualify for the QMB program, they will receive a Medical Assistance Eligibility Card.

If they lose their card, contact their local HHS office or Member Services at 1-800-338-8366 (If they live in the Des Moines area, call 515-256-4606).

1

This card may not be used by people other than the individual listed on the card.

2

The medical provider will bill the Medicaid program. Payment for Medicare deductibles and co-insurance will be sent directly to the provider.

3

Medicaid will pay for Medicare Part A and Part B premiums.

Specified Low Income Medicare Beneficiary (SLMB) or Expanded Specified Low Income Medicare Beneficiary (E-SLMB)

- With SLMB and E-SLMB only the Medicare Part B premium is paid by HHS.
- Medicare copayments, deductibles and Part A premiums **<u>are not covered</u>**.

SLMB status will also automatically qualify a member for:

Medicare part D financial Extra Help program.

Prescription drug plan premiums.

Lower Rx co-payments and remove the donut hold or coverage gap from the drug coverage.

Presumptive Eligibility (PE)

PowerPoint Presentation (iowa.gov)

Presumptive Eligibility (PE)

Presumptive Eligibility Resources

Affordable Care Act (ACA)

AFFORDABLE CARE ACT (ACA)

- **The Patient Protection and Affordable Care Act**
  - The "Patient's Bill of Rights" gives stability and flexibility to Americans that need to make informed choices about their health.
  - The ACA has impacted health care availability and eligibility determination, including presumptive eligibility.
  - Acronyms used: Presumptive Eligibility (PE), Presumptive Provider (PP) and Qualified Entity (QE).

Presumptive Eligibility

Presumptive Eligibility and Programs

- PE refers to a government program that offers immediate health services access by providing **temporary** health insurance through Medicaid or Children's Health Insurance Program (CHIP).

Presumptive Provider

- Organization that approves PE determinations.
- Authorized by state agency.
- Only employees of PP have authority to make PE determinations.
- May not delegate PE authority to another entity, subcontractor, or agent.

Qualified Entity

- Individual authorized to determine Presumptive Eligibility.
- Under the supervision and authority of a Presumptive Provider.

PE Determination:
Based on the Modified Adjusted Gross Income (MAGI) Rules

Tax Rules

- Determine the income to be counted for eligibility.

Household Size

- Based on the tax-filing unit.

Household Taxpayer's Family Size

- Includes all claimed dependents.

MAGI

- Defines HH size to use when no taxes are filed.

Different MAGI Households

- Different people the same household may have different MAGI.

Child support

- Excluded from taxable income.

PE Determination:
Based on the Modified Adjusted Gross Income (MAGI) Rules

State Residency

- Must be an Iowa resident.

Citizenship

- Must be US citizen or qualified alien.
- **Exceptions:** Pregnant Women and Breast and Cervical Cancer Treatment (BCCT) Applicants.

Applicants' Statements

- PE based on the applicant statements regarding circumstances and income and self-attestation.

Presumptive Eligibility

- Is not retroactive.

12-Month Rule

- Applicant may **not** have received PE in past 12 months.
- **Exceptions:** Pregnant Women and BCCT Applicants

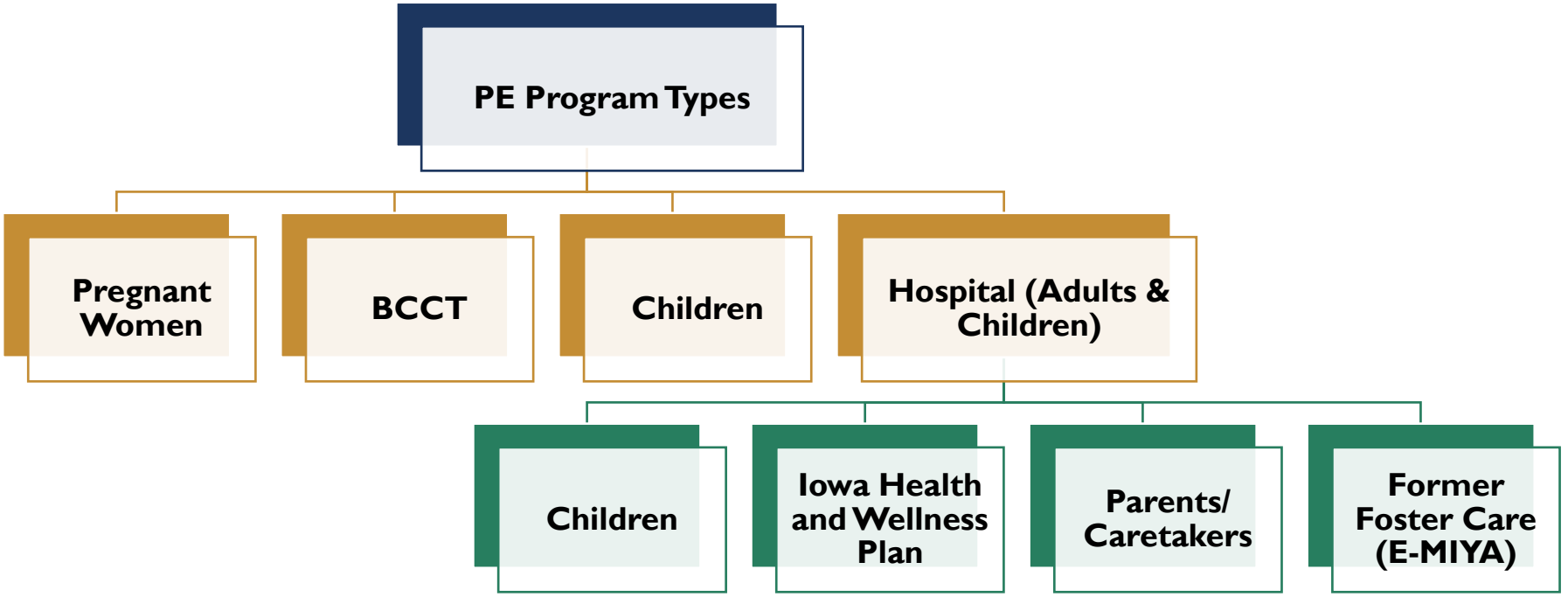
Presumptive Eligibility Rules

PE is granted on a **daily basis**, rather than monthly basis

Coverage through end of month after application month

- PE may end earlier, if the ongoing Medicaid eligibility determination is made
- PE may continue longer, if the ongoing Medicaid application is in a pending status

Presumptive Eligibility: Program Types



Presumptive Eligibility: Breast & Cervical Cancer Treatment (BCCT)

Citizenship/Qualified Alien status is not an eligibility factor.

The applicant must meet the income limit of 375% Federal Poverty Level for MAGI household size.

If under age 65 the individual is screened and diagnosed with Breast/Cervical pre-cancer/cancer results in and need for treatment, which also has no creditable insurance coverage.

- Only BCCEDP providers can determine BCCT PE
- Medicare Part A or Part B are considered credible coverage for BCCT.

Presumptive Eligibility: Pregnancy

Citizenship/Qualified Alien status is not an eligibility factor.

The applicant must meet the income limit of 375% Federal Poverty Level for MAGI HH size.

Ambulatory prenatal care qualify for Medicaid-covered services except inpatient hospital or institutional care and charges associated with delivery of baby.

- This includes miscarriage or pregnancy termination.

Presumptive Eligibility: Children

Under age 19

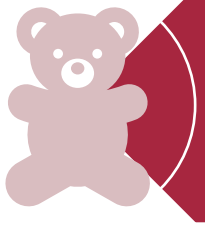
Family income limit is 302% of Federal Poverty Level (FPL) for children ages 1-18 years of age.

Family income limit is 375% of Federal Poverty Level (FPL) for infants under 1 year of age.

Presumptive Eligibility: Expanded Medicaid for Independent Young Adults (E-MIYA)

Age 18 though 25

No income test for Expanded Medicaid for Youth Aging Out of Foster Care (E-MIYA)



At the age of 18 or older was concurrently enrolled in Foster Care and Medicaid in any state

Presumptive Eligibility

Providers may process five (5) types of PE programs for patients and non-patients.

Hospital/Adults & Children

- QE: Are the only ones allowed to do PE determinations for Iowa Health and Wellness Plan (IHAWP), Parents/Caretakers, and Expanded Medicaid for Youth Aging Out of Foster Care (E-MIYA).
- Only BCCEDP hospitals may do all six (6) types of PE.

Presumptive Eligibility

IHAWP

- Ages 19 through 6
- Not pregnant
- Not eligible for Medicare or Medicaid
- Dependents in home have, or are applying for, insurance
- Income limit is 133% Federal Poverty Level (FPL)

Parent/caretaker of child under age 18 or 18 and still in high school

- Income limit is $1033 for HH of four
- Income limit varies by HH size

Immigration Status

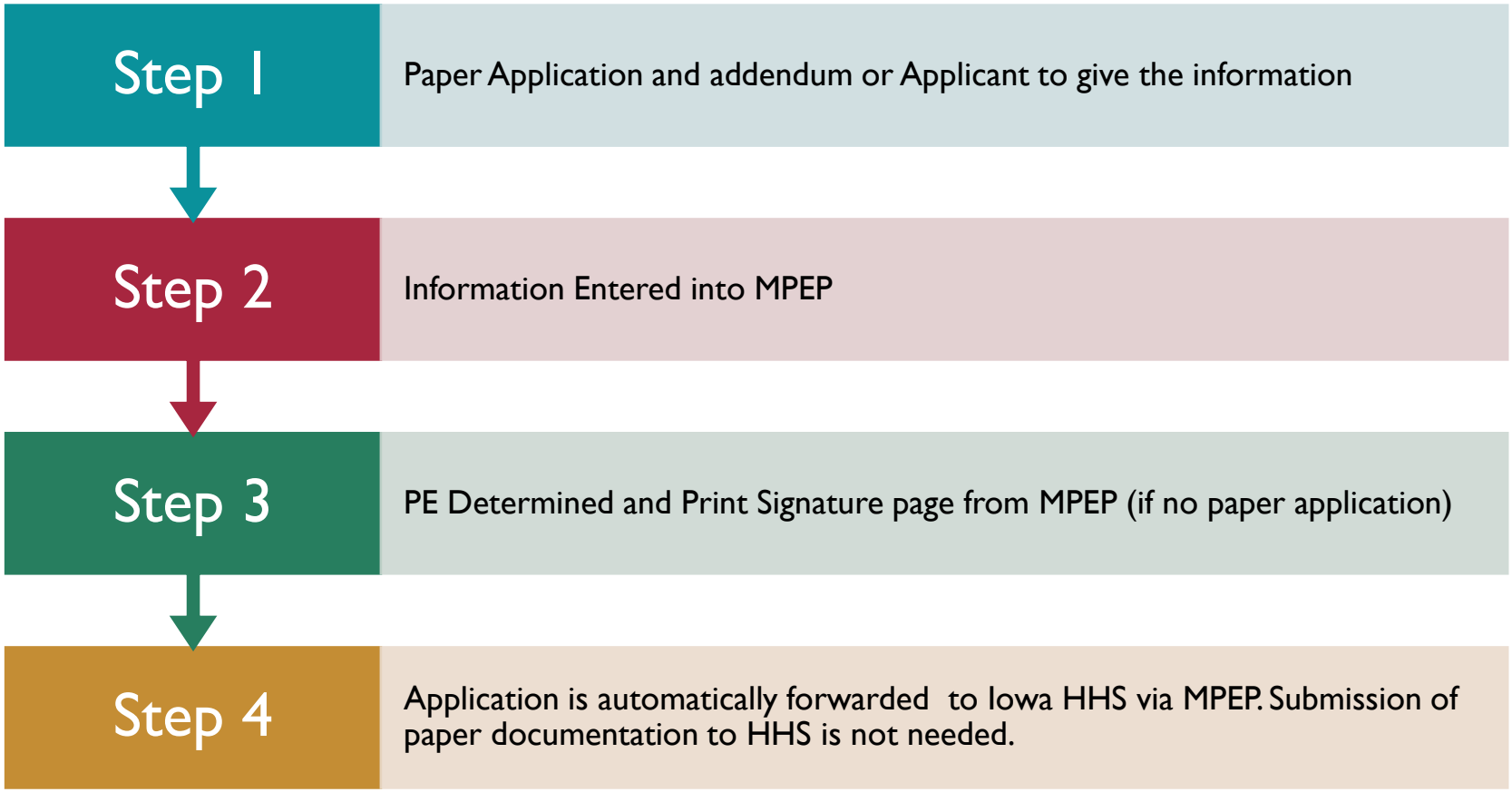
The PE applicant must attest to being a citizen or having an eligible immigration status.

The QE needs to help the applicant understand how to answer the immigration question, but the QE does not need to verify or make the determination of the immigration status.

Immigration Status

- **For Adults**
  - See the list under the heading 'Immigrants and Medicaid & CHIP' at https://www.healthcare.gov/immigrants/lawfully-present-immigrants/
- **For Children**
  - See the list under the heading 'Immigrants with the following statuses qualify to use the Marketplace' at https://www.healthcare.gov/immigrants/immigration-status/

Qualified Entity (QE) Application Process



Qualified Entity (QE) Responsibilities

Application is valid and must be date stamped on the date submitted to QE with applicant's name, address, and signature under penalty of perjury at the bottom of page 16 of Application for Health Coverage and Help Paying Costs.

All necessary information must be obtained from applicant before application can be entered and completed in the Medicaid Presumptive Eligibility Portal (MPEP).

All valid applications must be submitted for processing in MPEP. Contact MPEP Support desk if unable to enter application in MPEP.

Qualified Entity (QE) Responsibilities

QE who fails to ensure that complete and accurate information is obtained from the applicant and entered into MPEP may lose the certification to act as QE and process PE applications.

Eligibility cannot begin prior to entry into MPEP

Qualified Entity (QE) Responsibilities

Print and Maintain Documentation

1. Print the Notice of Action (NOA) and Right and Responsibilities (R&R) Comm. 233.
2. Provide the applicant with the printed NOA and R&R as soon as possible but no later than two (2) working days after the date of determination.
3. Print a PDF of the PE application and NOA for the QE file.
4. QE must provide the client with a printed copy of the application, NOA and R&R.
5. Date stamp the application upon receipt
6. Maintain PE records for five (5) years

Qualified Entity (QE) Responsibilities for BCCEDP

The QE must complete all actions listed and in a separate document provide HHS the items listed below:

Person's Name and Date of Birth

Verification the person has been screened under the breast and cervical cancer early detection program (BCCEDP)

Need for treatment for breast or cervical cancer

Qualified Entity (QE) Responsibilities for BCCEDP

Anticipated initial length of treatment

Does not have other creditable coverage

Name of approved BCCEDP provider:

- Example: **Holly Jones, RN,BSN, Care For Yourself, Iowa Breast and Cervical Cancer Program Coordinator**
- This is only required when a PE BCCT applicant is *also applying for ongoing* Medicaid.

Qualified Entity (QE) Responsibilities: BCCEDP Uploading Documents

- The previous information must be sent to HHS using the Upload Documents feature within MPEP, using Medicaid Treatment Option Eligibility Verification form.

- If unable to upload the documents using the Upload Documents feature in MPEP due to an error, then the BCCEDP provider may email the required information to: IMEMPEPSupport@dhs.state.ia.us

Incarceration Eligibility

Incarcerated individuals are only eligible for Medicaid when they are admitted to a noncorrectional facility medical institution, such as a hospital.

Payment is limited to inpatient hospital services only. Inpatient defines stays for a period of 24 hours or longer.

After 30 days Medicaid is suspended with coverage for hospital and emergency only.

Incarceration Eligibility

Assisting incarcerated individuals with obtaining Medicaid coverage prior to release:

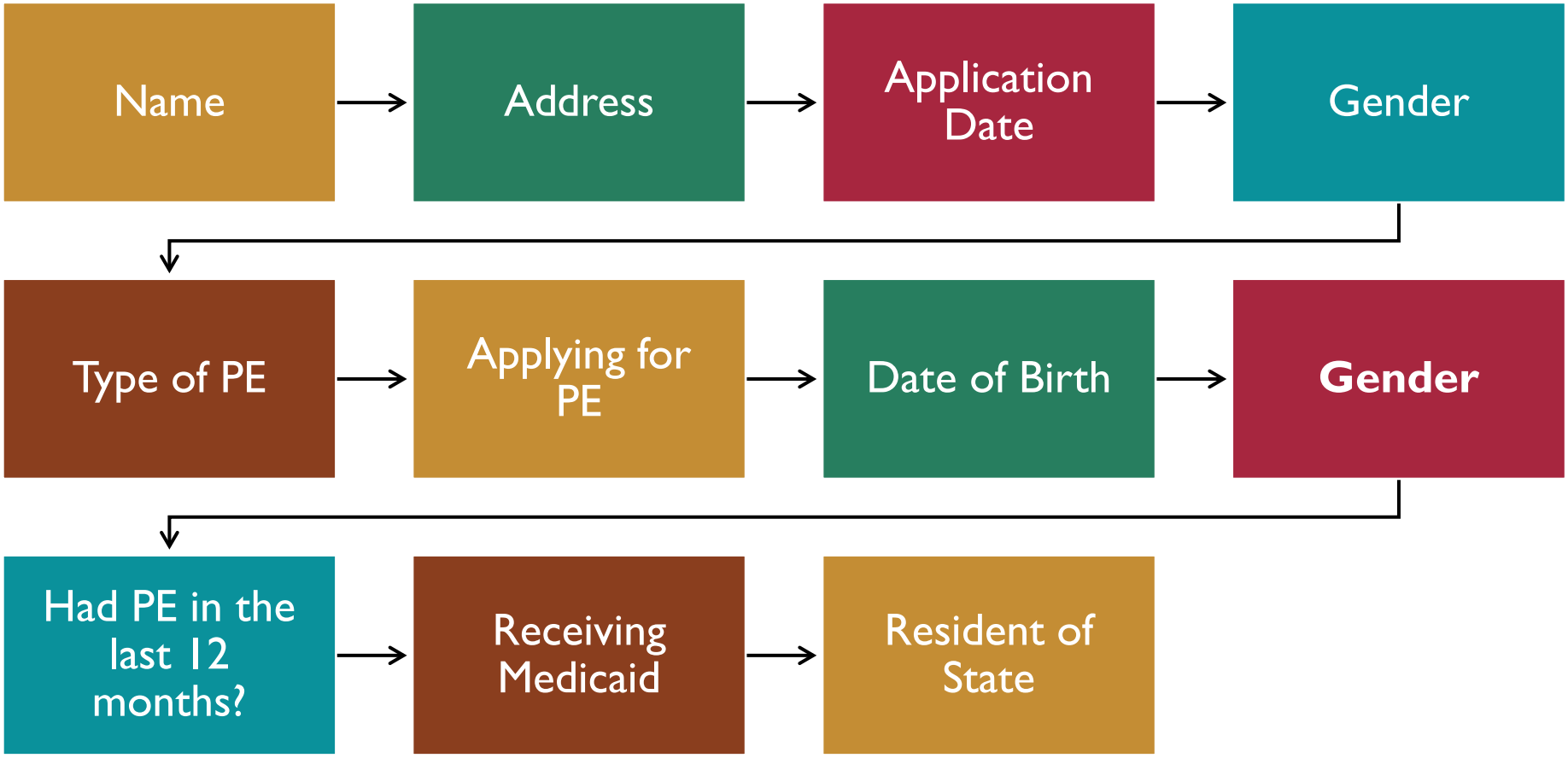
If the individual was previously receiving Medicaid, they should call the Income Maintenance Customer Service Center at (877) 347-5678.

If the individual was not previously receiving Medicaid, they can complete a Medicaid application by visiting Self Service Portal Home Page (iowa.gov)

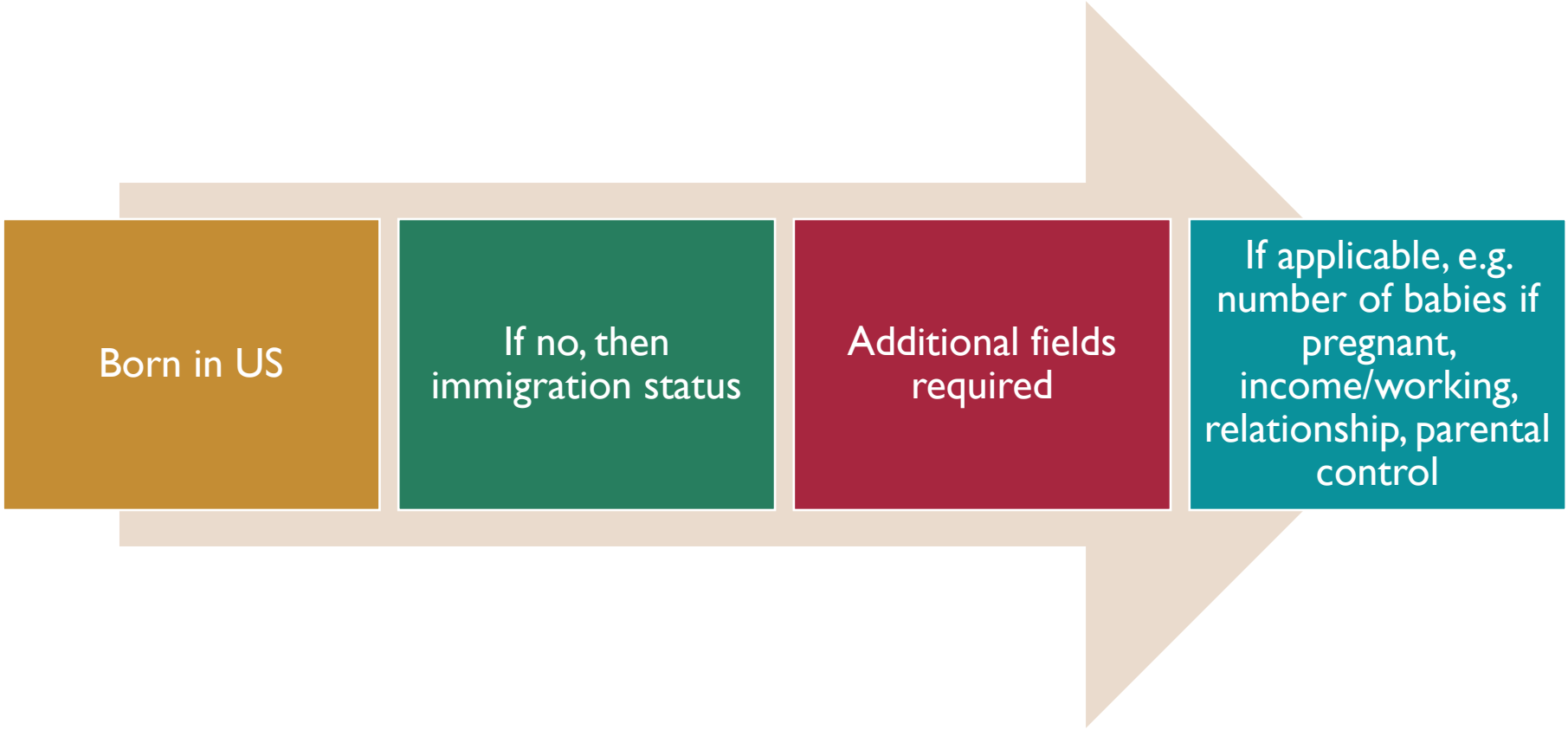
https://hhs.iowagov/ime/providers/tools-trainings-and-services/Medicaid-initiatives/pe

1. Used by Presumptive Providers to enter PE Applicant information
2. Run Eligibility Determination
3. Create Notice of Actions

MEP System Requirements



MEP System Requirements: Required to Run Eligibility



Estate Recovery Program

- QEs are required to make ALL applicants aware of the Estate Recovery program.
- A QE is responsible to declare they have made the applicant aware of the Estate Recovery Program.
- Federal law requires Iowa to have an estate recovery program.
- If you get Medicaid, you may be subject to estate recovery.

Estate Recovery Program

This means any Medicaid funds used to pay for your healthcare, including the monthly fee paid to a Managed Care Organization (MCO), will need to be paid back from your estate after your death.

Estate recovery applies if you get Medicaid and are:

- Age 55 or older, or
- Are under age 55 and live in a medical facility and cannot reasonably be expected to return home.

Estate Recovery Program

For more information, call the Iowa Medicaid Estate Recovery Program at 1-877-463-7887 or go online to: http://hhs.iowa.gov/sites/default/files/Comm123.pdf.

Health and Human Services (HHS) Contact Center

855-889-7985

M-F 8 am–5 pm

IMEMPEPSupport@dhs.state.ia.us

Presumptive Eligibility | Iowa Department of Health and Human Services

QE Support: PE Policy and MPEP Technical

Health and Human Services (HHS) Contact Center

- Monday – Friday , 8 am–5 pm
- Phone: 855-889-7985
- Email: IMEMPEPSupport@dhs.state.ia.us
- Link: https://hhs.iowa.gov/ime/providers/tools-trainings-and-services/medicaid-initiatives/pe

Resources

Iowa Medicaid Provider Services

- **Phone:** 1-800-338-7909
- **Email:** IMEProviderServices@dhs.state.ia.us
- **Website:** https://hhs.iowa.gov/ime/providers

Amerigroup Provider Services

- **Phone:** 1-800-454-3730
- **Email:** iowamedicaid@amerigroup.com
- **Website:** https://providers.amerigroup.com/ia

Resources

Iowa Total Care Provider Services

- **Phone:** 1-833-404-1061
- **Email:** providerrelations@iowatotalcare.com
- **Website:** https://www.iowatotalcare.com

Molina Healthcare of Iowa Provider Services

- **Phone:** 1-844-236-1464
- **Email:** iaproviderrelations@molinahealthcare.com
- **Website:** www.molinahealthcare.com/IA
- **Provider portal:** provider.MolinaHealthcare.com

"Alone we can do so little; together we can do so much." Helen Keller

- We wanted to **THANK all of you, as providers** for always delivering the best healthcare for all our members. You all have been through a lot during the pandemic and your commitment for excellence has not gone unnoticed!
- We also wanted to thank everyone that assisted in developing this Annual Provider Training.