Alaska

2026 Provider Workshop



moda HEALTH

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Welcome

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Agenda

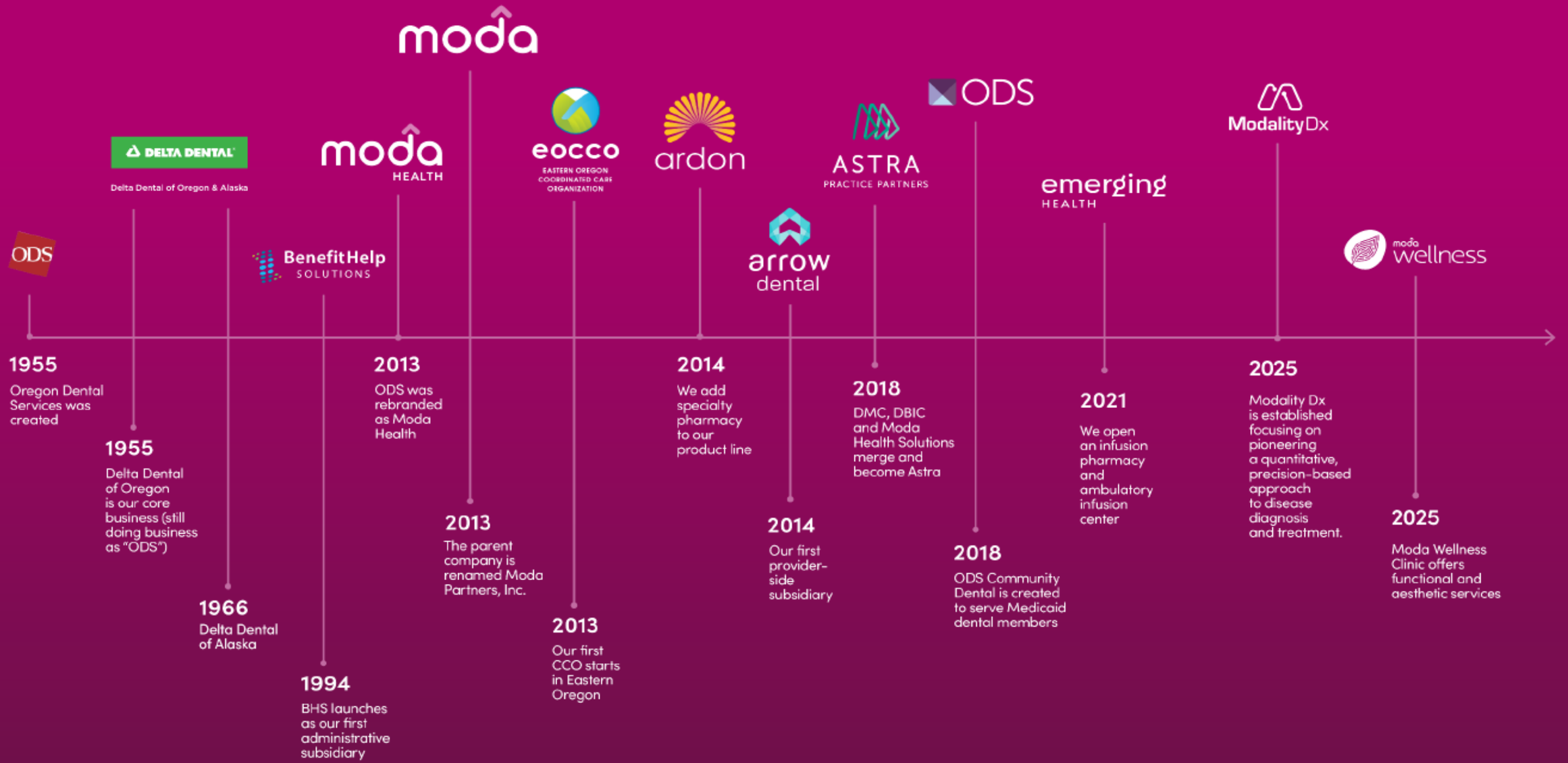
- Diversity, equity and inclusion (DEI)
- Credentialing vs. Contracting
- Data accuracy & Better Doctor
- Commercial network updates
- Claims & billing updates
- Prior authorizations
- Appeals
- Healthcare services
- HEDIS, Quality Measures & Population Health
- Provider information/resources



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Trusted partner since **1955**

The Moda Family of companies: Strength in diversification



Diversity, equity and inclusion (DEI) survey

Diversity

We value, respect and celebrate people of all backgrounds, identities and abilities. And we actively seek to identify how uniqueness makes us better.

Equity

We strive to understand the underlying causes of outcome disparities and actively work to increase justice and fairness in our processes, procedures and systems. We do this within our company and within our communities.

Inclusion

We are committed to creating environments where every individual has an equal opportunity to belong and can be recognized for their inherent worth and dignity.



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DEI survey

Currently, diversity among physicians is limited. Mounting evidence suggests that when physicians and patients share the same race or ethnicity, it improves:

- Time spent together
- Shared decision-making
- Wait times for treatment
- Screening adherence
- Patient understanding of health risks
- Patient perceptions
- Treatment decisions

We invite you to share your demographic information with us.

Moda Companies - Provider Data for Diversity, Equity and Inclusion

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Credentialing vs. Contracting



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Credentialing vs. Contracting

Credentialing:
This process allows Moda to vet the providers education, licensure, insurance and specialty. Verifying that the information is accurate and up to date.

Contracting:
This process allows our Provider Configuration and Update teams to add the contracted participating networks to the provider's profile, which drives claims processing.

Our Join the Moda network page lays out how to begin the process of joining Moda as a participating provider
Join the Moda Health medical provider network

Our Credentialing page lays out how to begin the process of credentialing with Moda
Moda Health Medical providers | Credentialing overview

Join our network | Moda Health - Alaska Providers

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Data Accuracy & Better Doctor



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Data Accuracy/Rosters/Better Doctor

Provider Directory Data Accuracy-

In accordance with The Consolidated Appropriations Act (CAA), 2021, Moda Health requires participating providers to update provider directory information every 90 days. All participating providers are required to comply with our policies and procedures to supply the necessary information ensuring Moda's provider directory remains accurate and up to date.

Moda's Find Care tool allows members to locate you, receive timely access to care, and ensures payment for services rendered.

Moda Find Care | Search as a guest

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Data Accuracy/Rosters/Better Doctor Cont.

Process Overview-

- BetterDoctor will contact you quarterly by email, fax, telephone and/or US mail. Their outreach will indicate Moda Health as a participating health plan.
- You'll be asked to visit betterdoctor.com/validate and enter the access code given to you by BetterDoctor. (It is an eight-character alphanumeric code and is not case sensitive.)
- Verify and update your information using the online tool via the BetterDoctor portal.
    - BetterDoctor verifies information for each practicing location and providers, so you may receive more than one verification request. Access codes provided on communications are specific to the providers and locations listed.
    - Please respond and attest that your information is correct or provide changes when you receive outreach. Providers are required to validate the accuracy of their information every 90 days, even if there are no changes to the information.

- Updates captured by BetterDoctor will be passed on to Moda Health for system updates.

BetterDoctor® Exchange - Practitioner Validation

Questions?
844-668-2543
support@BetterDoctor.com

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Data Accuracy/Rosters/Better Doctor Cont.

How it works

BetterDoctor contacts providers every **90 days** via email, fax, phone, or mail on behalf of **Moda Health**.

Providers with multiple locations may receive separate requests, as each provider and practice location is validated individually.

Providers use the unique access code provided in the outreach to log in to betterdoctor.com/validate to verify and attest the information is accurate and submit updates as needed.

Attestation is required every 90 days, even if there are no changes.

Updates submitted through BetterDoctor are shared with Moda Health and updated in our systems.

FAQs
Roster Attestation Agreement (RAA)

Large Group Validation with Quarterly Rosters

For organizations with **20+ practitioners** or **5+ facility locations;** to simplify your submissions utilize the roster template below-

- Large Group Roster template

The finalized roster is required to be submitted to both rosterupdates@modahealth.com and rosters@questanalytics.com simultaneously.

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Commercial networks

2026 -2027

Commercial networks



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2026-2027 Commercial networks

Pioneer (Moda Select)	• Individual, small and large group PPO plan • Tiered benefits • Offered in Anchorage, Mat-Su, and Kenai Peninsula Borough
Endeavor Select (Connexus)	• Small and large group PPO plan • Health systems included: Central Peninsula Hospital, Alaska Regional Hospital, Mat-Su Regional, Fairbanks Memorial, PeaceHealth Ketchikan, Bartlett Regional, South Peninsula Hospital
Endeavor Providence (Connexus)	• Large group PPO plan-fully insured • All boroughs in Alaska
Connexus PeaceHealth	• ZoomCare Caregivers & PeaceHealth plans • Tiered benefits • Provider participation determined by PeaceHealth & ZoomCare

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Membership numbers

Alaska Individual: 4,773
Alaska Group: 5,808

Total Commercial Alaska members:

10,581



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Claims and billing



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Scope of license – Evaluation & management

Our clinical edit system includes edits to ensure procedure codes with specific requirements are reported by appropriate providers. There are edits to address a variety of procedure codes to determine if the billing provider's scope of license does or does not encompass the key responsibilities required for the billed services.

Qualifying provider types for E/M services include:

- Physicians
- Physician assistant (PA)
- Advanced practice nurses
- Pharmacists for Oregon Commercial and Medicaid plans only

Scope of License for Evaluation & Management Codes

NPPES NPI Registry

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Drugs and biologicals discard and waste

CMS requires providers and suppliers use the JW modifier on all claims for separately payable drugs with discarded drug amounts from single-use containers separately payable under Part B.

When submitting claims, providers must indicate the units of the drug that were discarded using the JW modifier on a unique line.

Use of the JZ modifier is required on claims for drugs from single-dose containers when there are no discarded amounts.

*Please note that medical records must support drug wastage when billed. Documentation requirements are outlined in Moda Reimbursement Policy RPM015 “Modifiers JW & JZ – Drugs and Biologicals, Wastage and/or Discarded Amounts.”

Modifiers JW & JZ – Drugs and Biologicals, Wastage and/or Discarded Amounts **(Moda Policy)**

Discarded Drugs and Biologicals – JW Modifier and JZ Modifier Policy **(CMS Policy)**

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Time-based codes

Procedure codes with descriptions that specify an increment of time such as minutes or hours are “time-based procedure codes.” For all time-based services, the duration of the service must be clearly documented in the medical record with either a) begin- and end-times listed or b) the specific total number of minutes and hours the service was performed.

If more than one time-based service/procedure code is billed for the same date of service, the medical record must separately document the time for each distinct time-based service. Documenting the total time spent with the patient is not sufficient to support the multiple time-based codes billed. Please ensure documentation is complete for each service billed to avoid issues if the claim is reviewed to validate the billed procedure codes.

https://www.modahealth.com/-/media/modahealth/shared/Provider/Policies/RPM039.pdf

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Common time-based code examples

Multiple physical medicine (PT) modalities
Neurobehavioral status exam (96116, Psychological or neuropsychological test administration/scoring (96136/96137) and Neuropsychological testing evaluation (96132/96133).

https://www.modahealth.com/-/media/modahealth/shared/Provider/Policies/RPM039.pdf
(see section E, Time-based services)

https://www.apaservices.org/practice/reimbursement/health-codes/testing-code-faq.pdf
(see page 2)

https://www.apaservices.org/practice/reimbursement/health-codes/testing/billing-coding-addendum.pdf

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Unlisted procedure codes

Selecting procedure codes, unlisted codes-

Report the most specific code that accurately represents the service, procedure or item provided. Do not select a code that merely approximates the service or item provided. Unlisted codes should only be used when there isn't an established code to describe the service, procedure or item provided. If an unlisted code must be used, select the most specific unlisted code available.

When unlisted codes are reported, a description must be included on the claim. Supporting documentation and explanations should be attached as appropriate. The absence of a description for an unlisted code is a billing error.

https://med.noridianmedicare.com/web/jfb/topics/claim-submission/submission-errors-solutions/unlisted-procedure-and-noc-codes

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c26pdf.pdf

Moda-Health-Commercial-Provider-Manual.pdf

(see page 41)

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Unlisted code examples

For electronic claims:
The description can be placed in the Line Level Procedure Code Descriptions field.

Comparable code information can be included in the Claim Notes Additional Information field.

Alternatively, all information may be able to fit in the Line Level Procedure Code Descriptions field.

Line Level Procedure Code Descriptions

Line 1	Code and Mods: **31299**	Description:	**PR ENDSB RESECT MCF PARASELLAR EXTRADURAL**

Claim Notes

:

Line 1	Additional Information:	**ENDOSCOPIC MIDDLE CRANIAL FOSSA RESECTION EXTRADURAL 61607**

Line Level Procedure Code Descriptions

Line 1	Code and Mods: **31599 51**	Description:	**ADAM'S APPLE REDUCTION - UNLISTED 31599 - COMPARABLE TO CPT 31400 WITH EQUAL COM**

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Claims

Clinical edits — clinical editing systems

- Professional claims — professional clinical edits, Procedure-to-Procedure (PTP) edits and Medically Unlikely Edits (MUE)
  - Practitioner PTP edits apply to ASCs
- Facility claims — outpatient hospital CCI, PTP and MUE edits
- Claims exempt from Outpatient Prospective Payment System (OPPS) edits, status indicators and rules
  - Critical Access Hospitals (CAH) – Type of Bill 085x
  - Rural Health Clinic (RHC) – Type of Bill 071x
  - Federally Qualified Health Center (FQHC) – Type of Bill 077x

Clinical Editing

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Claims

National Correct Coding Initiative (NCCI) links

- MUE information: cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE
- PTP coding edit information: cms.gov/medicare/coding/ncci-edits/procedure-procedure
- NCCI FAQ: cms.gov/medicare/national-correct-coding-initiative-edits/ncci-faqs
- Medicare NCCI Correspondence Language Manual | CMS

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Claims

ED leveling

Moda Health reimburses emergency department (ED) professional evaluation and management (E/M) services based on the level of acuity, complexity and severity.

Reimbursement determinations are based on:

- Medical necessity/utilization criteria
- The patient's primary discharge diagnosis
- The patient's age

ED-Leveling-MHMNC.pdf (modahealth.com)

Emergency Department Visit Leveling

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G2211 Visit Complexity Policy

Beginning November 1, 2026, procedure code G2211 is not eligible for separate reimbursement for commercial plans.

Should CMS implement their proposed plan to delete G2211 and replace it with two new visit complexity modifiers effective for January 1, 2027, those visit complexity modifiers will also not be eligible for separate, additional reimbursement for Commercial plans.

G2211 Visit Complexity

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Reference Lab Policy

Upcoming changes to reimbursement for reference laboratory services billed by hospitals or facilities as non-patient laboratory services using type of bill 014X.

Beginning January 1, 2026, hospitals acting as a reference laboratory or conducting diagnostic testing for non-patients must have a rate for Reference Lab services in their Agreement for reference lab services to be payable under your current Agreement.

A letter regarding these changes was sent via a letter on September 23, 2026.

Further questions need to be directed to your assigned Contractor

Modifier 90 - Reference (Outside) Laboratory and Hospital Reference Lab Services (TOB 014X)

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Claims

Corrected claims

When billing corrected claims to add additional services, include the original services that may have already paid. The entire bill including corrections must be submitted.

Example: Changing modifiers, procedural codes, diagnosis, dates, units or other information.

Claims must be clearly identified in one of the following ways:

Submit a corrected claim electronically via a clearinghouse.

a. Facility Claims (UB): Box 4 (7 = replacement or corrected; 8 = voided or cancelled) Original Claim Number

b. Professional Claims (CMS): Box 22 on CMS 1500 (7 = replacement or corrected; 8 = voided or cancelled)

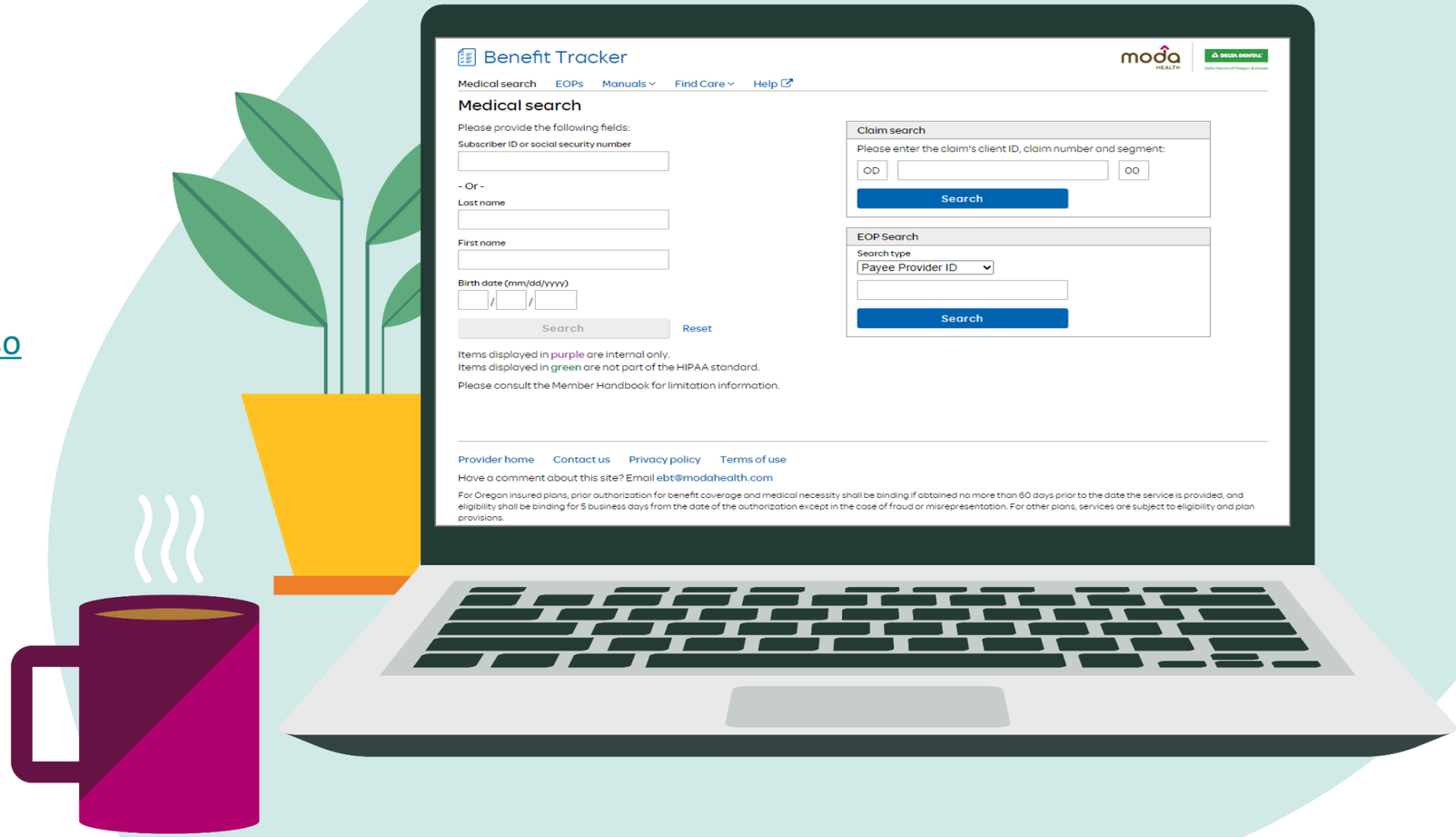
Submit a corrected paper claim to:

Moda Health
P.O. Box 40384 Portland
OR 97240
Fax #: 855-522-9810
Attention:
Corrected Medical Claims

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Claims
Benefit Tracker

- Access Benefit Tracker from two platforms:
  - Moda Health — modahealth.com/medical/mbt.shtml
  - OneHealthPort — onehealthport.com/sso
- Access to detailed patient benefit information
- Search by Member ID#, SSN, first or last name and DOB
- Our website has additional information that OneHealthPort may not capture
- Login required for each site
- Information and questions, email or call ebt@modahealth.com or 877-277-7270



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Contacting Medical Customer Service



Medical Customer Service will always be your first point of contact for any claim issues or inquiries.

Provide the following information:

- Customer Service Tracking (CST) number
- Claim numbers or member ID and date of service
- Any supporting documentation or correspondence

503-243-3962
medical@modahealth.com

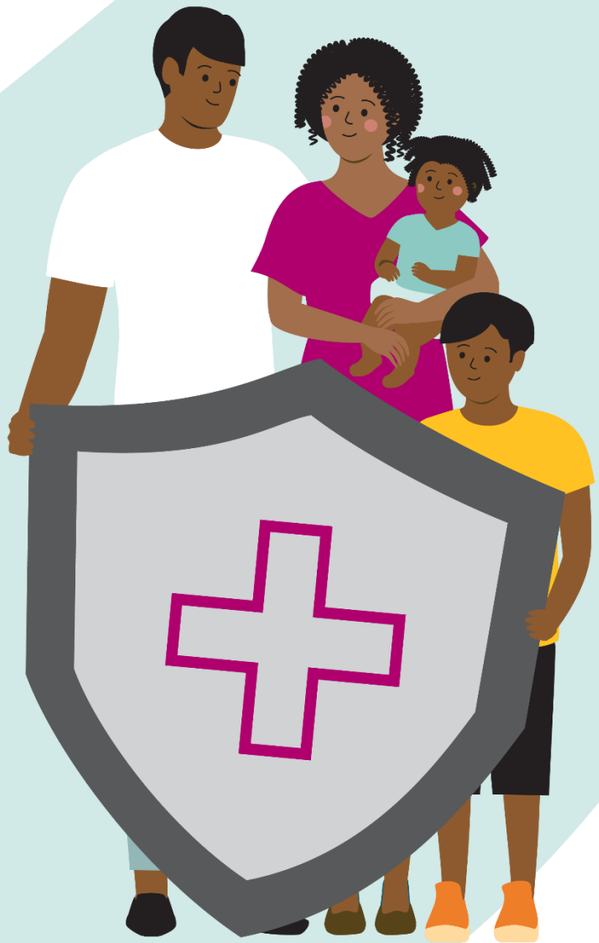
Contact us | Moda Health - Alaska Provider

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Prior authorizations



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Prior authorizations

How to determine that a service requires prior authorization:

- Review referral and authorization guidelines based on the line of business
- Review “Always Not Covered” list
- Access prior authorization forms

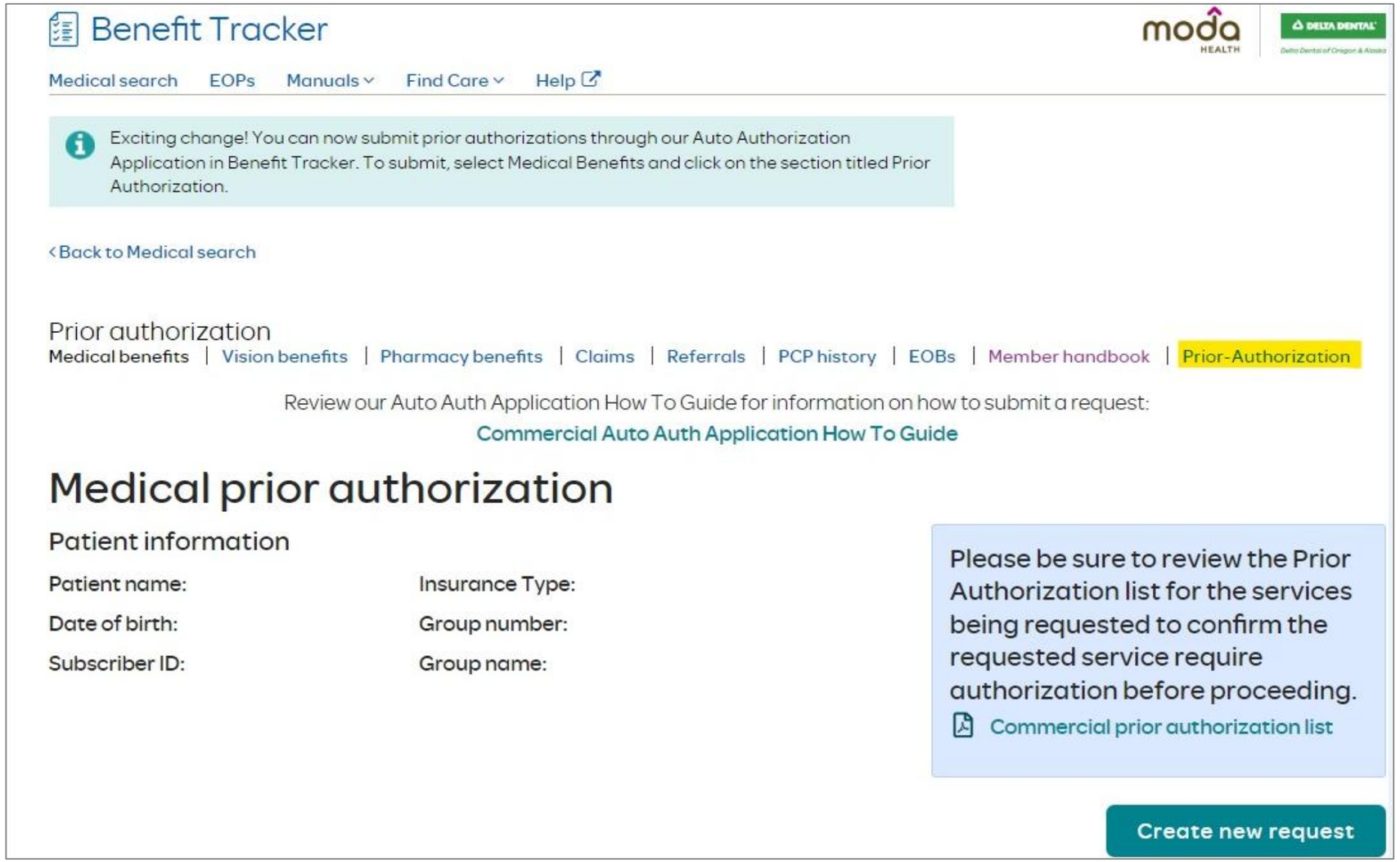
Failure to get prior authorization when required may result in claim denial. Members cannot be balance billed.

*Note: Prior authorizations are not required when Moda is the secondary payer.

Authorizations and referrals | Moda Health - Alaska Providers

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Auto Authorization Application



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Prior authorizations

moda HEALTH | Providers

I'm in: Alaska search Log in

Payment and authorization Join our network Patient care Resources Contact us



Providers > Payment and Authorization > Authorizations and Referrals

Authorizations and referrals

If you are an in-network provider, most authorizations and referrals can be completed online using the Moda Health Benefit Tracker. For out-of-network providers, call us at 844-746-0540 for assistance.

[Authorizations and referrals | Moda Health - Alaska Providers]

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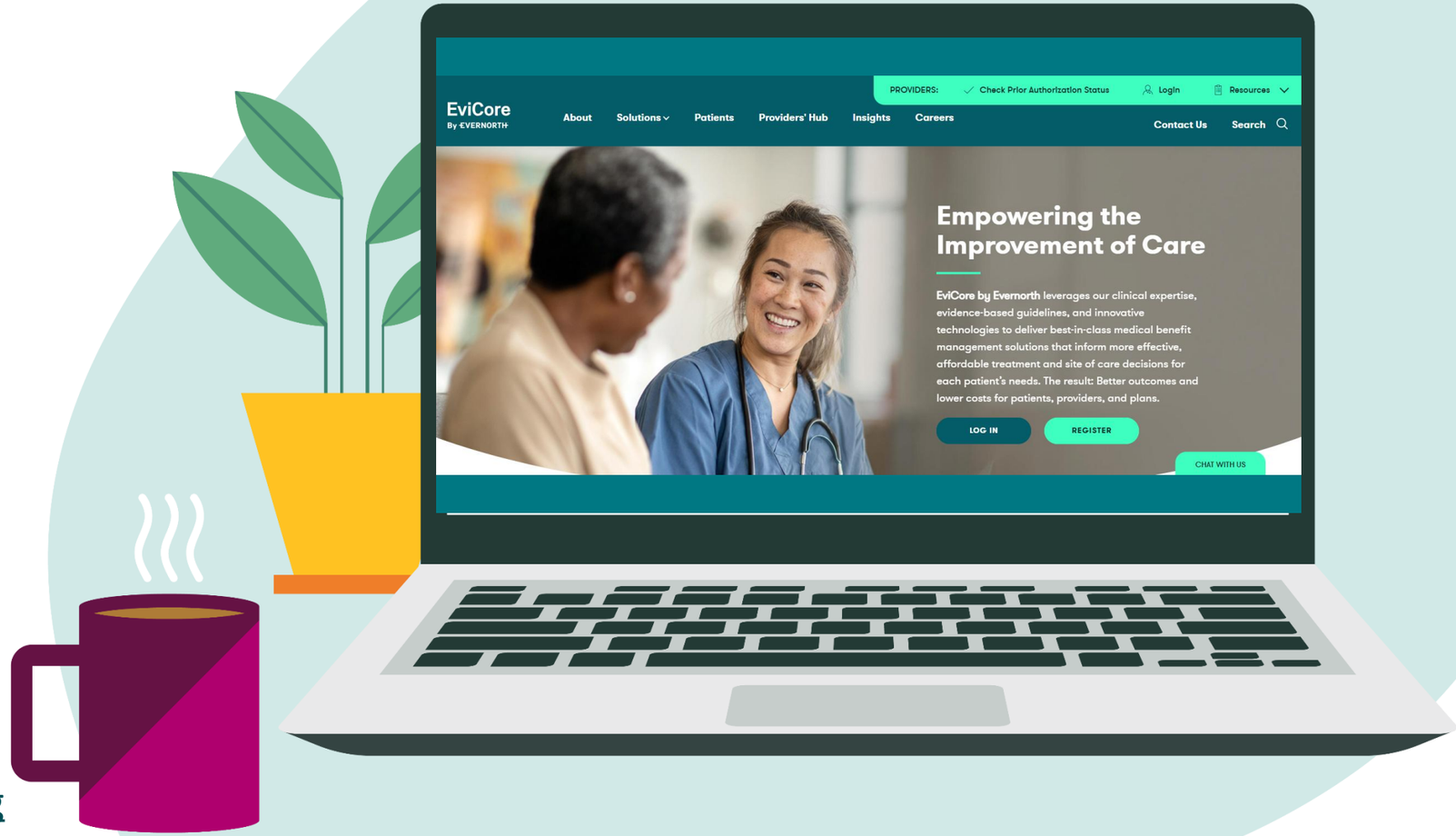
Prior authorizations

EviCore reviews authorization requests for the following services:

- Advanced imaging
- Musculoskeletal therapies
- Pain management
- Spine and joint surgery

Services that require prior authorization through EviCore are listed on our website:

modahealth.com/medical/utilizationmanagement.shtml

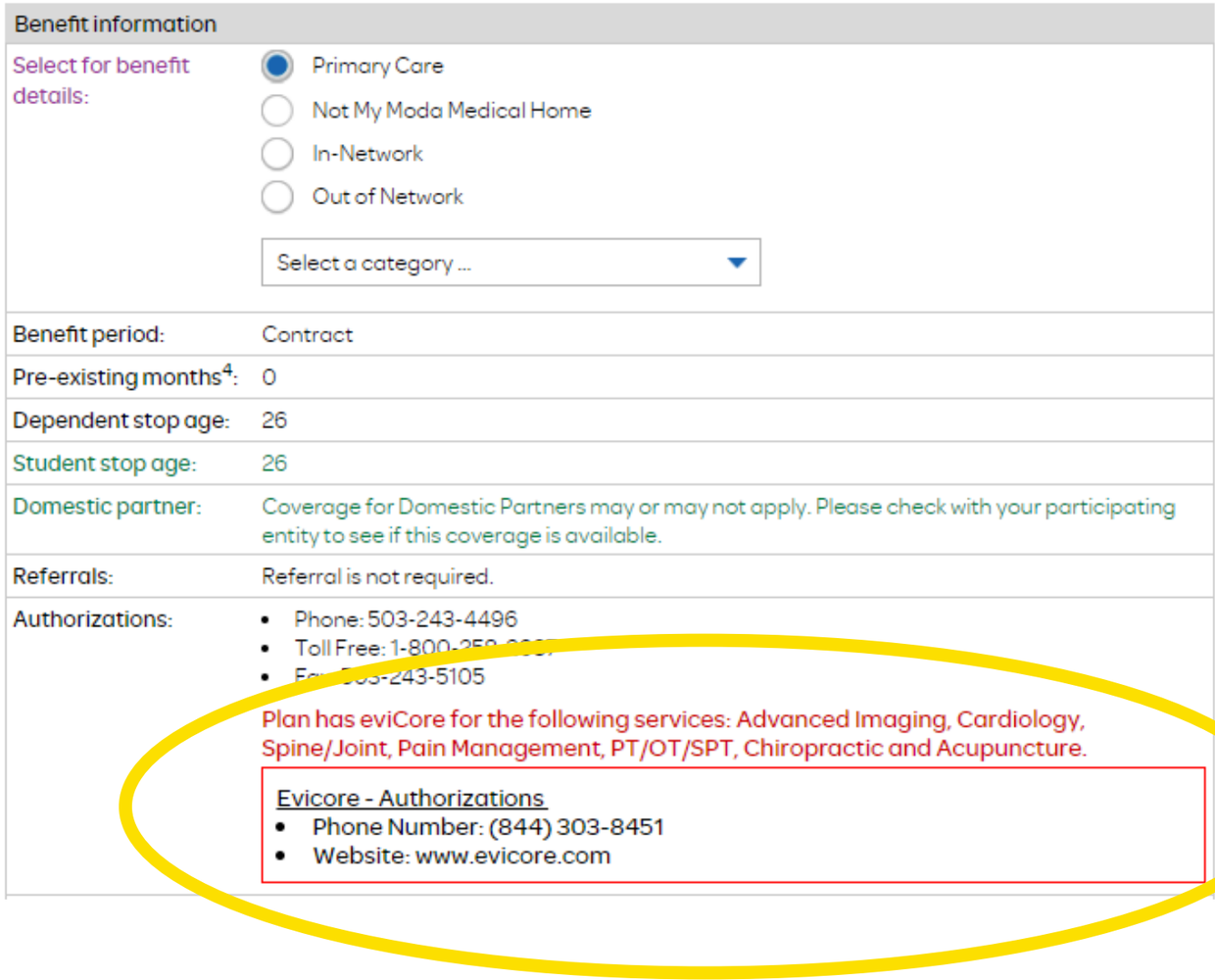


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Prior authorizations

Check Benefit Tracker to determine if the member's plan uses EviCore, and for what services.

This information can be found on the main benefit page at the bottom.



Benefit information

Select for benefit details:
- (●) Primary Care
- ( ) Not My Moda Medical Home
- ( ) In-Network
- ( ) Out of Network

Select a category ...

Benefit period:	Contract
Pre-existing months[4]:	0
Dependent stop age:	26
Student stop age:	26
Domestic partner:	Coverage for Domestic Partners may or may not apply. Please check with your participating entity to see if this coverage is available.
Referrals:	Referral is not required.
Authorizations:	• Phone: 503-243-4496 • Toll Free: 1-800-[illegible] • Fax: [illegible]-243-5105 Plan has eviCore for the following services: Advanced Imaging, Cardiology, Spine/Joint, Pain Management, PT/OT/SPT, Chiropractic and Acupuncture. Evicore - Authorizations • Phone Number: (844) 303-8451 • Website: www.evicore.com

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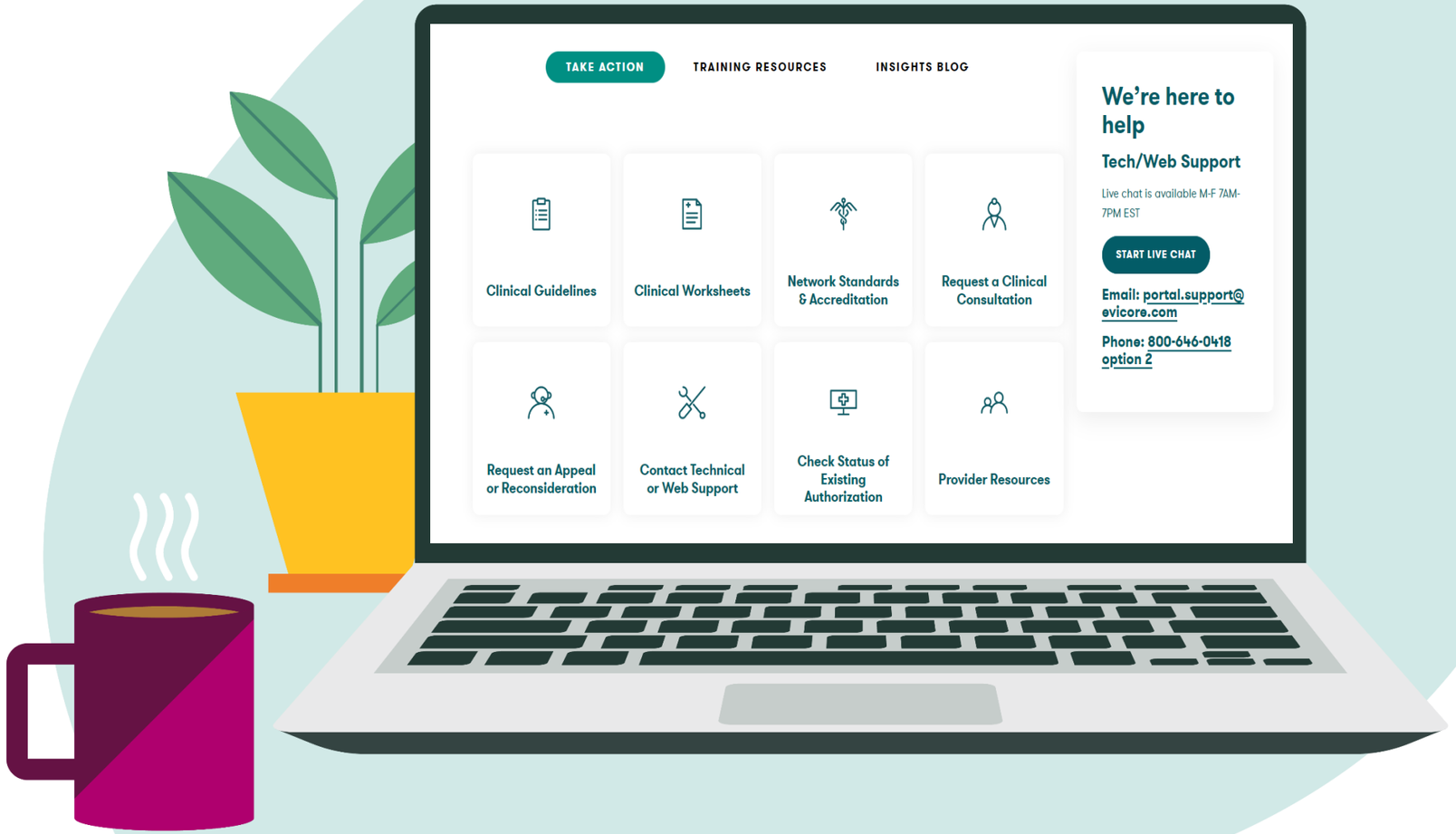
Provider Hub

Clinical guidelines/worksheets can be accessed before logging in to the portal [Provider's Hub | EviCore by Evernorth]

Resources

- Clinical guidelines
- Training resources
- Video tutorials
- ‘How To’ guides
- Existing newsletters
- Technical support

EviCore also provides “WebEx Training” for new or experienced users twice per quarter for therapies PT, OT and ST [eviCore Healthcare (webex.com)]



Questions?
clientservices@evicore.com

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Reconsideration options

The adverse determination letter will provide options on how to initiate a reconsideration request.

FAQ outlining the process of navigating post denial options with EviCore can be found here
Prior Auth Request Denied?

Options include:

Peer-to-peer clinical consultation
- Set up a clinical consultation with one of EviCore's medical directors educated in your provider's specialty
- Can be requested through the provider portal

Formal appeal
- Review the process outlined in the formal adverse determination letter for members and providers

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EviCore Newsletter

The newsletter can be helpful in providing the following updates:

- Portal and process news
- Authorization updates
- Reminders
- Provider training opportunities

[Provider's Hub | EviCore by Evernorth]



Stay Updated With Our Provider Newsletter

Your email address SUBSCRIBE →

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Prior authorizations

Moda Health contracted providers have access to an online Prime Therapeutics account:

- Visit the self-service provider portal at https://gatewaypa.com/
- Select “New Access Request-Provider” under “Quick Links” and select “Contact Us” to register

Urgent or expedited request
call 800-424-8114



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Prior authorizations

Provider-administered injectable drug program

Prior authorization required for specific injectable specialty medications.
modahealth.com/medical/injectables/

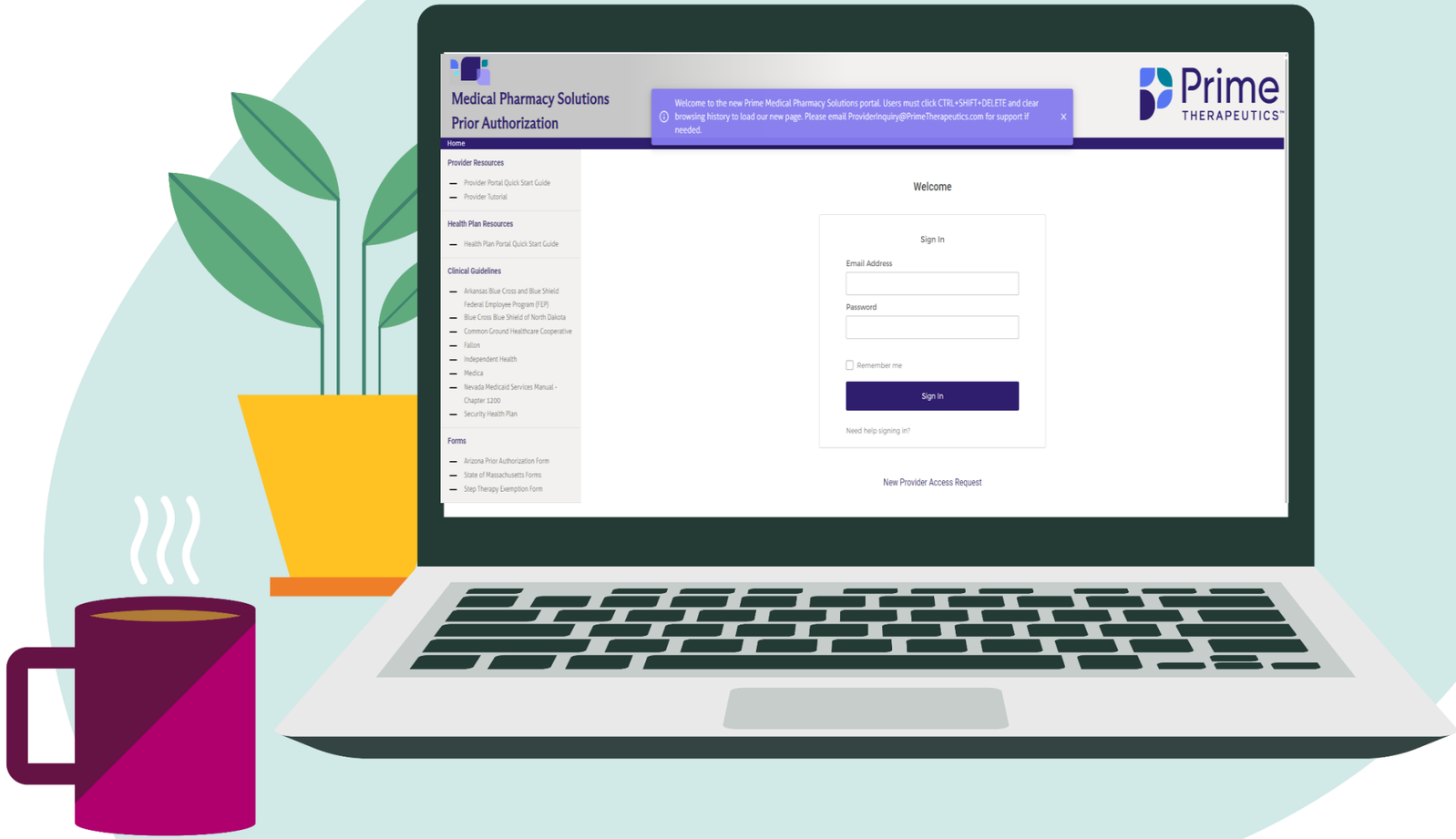
Site of Care program

Certain provider-administered drugs only authorized in outpatient setting or patient's home.
modahealth.com/medical/siteofcare.shtml

Claim edits program

Moda applies post-service pre-payment claims edits to diagnosis criteria and criteria for maximum units for the medications listed in the link below.
Claims and appeals (modahealth.com)

ProviderInquiry@PrimeTherapeutics.com



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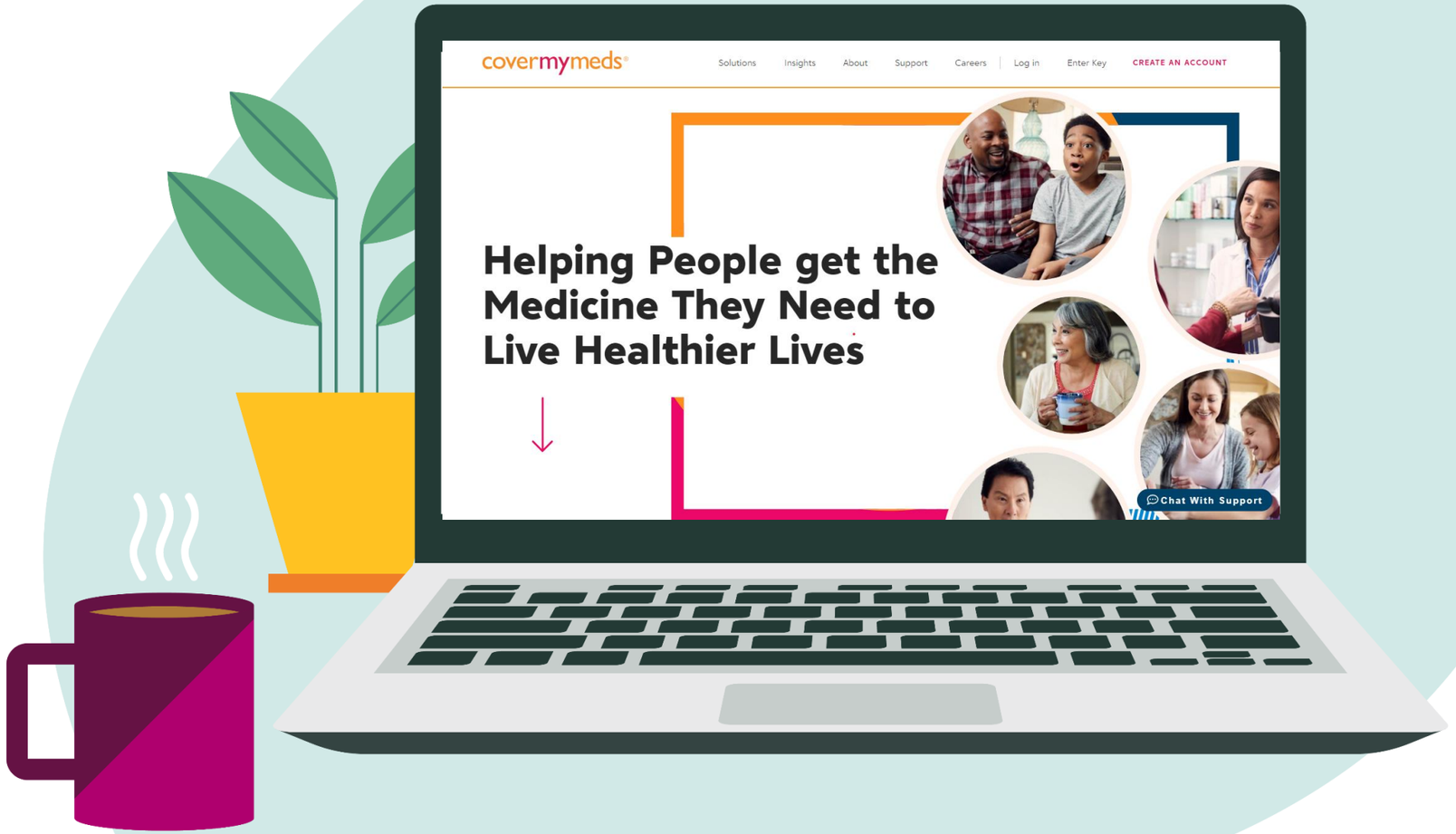
covermymeds®

Prior authorizations

Partnership with CoverMyMeds to process electronic prior authorization (ePA) requests for medications covered under a member's pharmacy benefit

- This free online tool is integrated with all health plans and most large EHR systems
- This does not replace Magellan Rx for injectable medications or Ardon Health for specialty pharmacy

Questions?
covermymeds.com
Toll Free: 888-361-1610



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Appeals



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Appeals

Provider appeals

Moda Health strives to informally resolve issues on initial contact whenever possible. Before entering the appeals process, please contact Moda Health's Medical Customer Service team at 877-605-3229.

Levels of appeals:

- Reconsideration
- First-level appeal
- Final appeal



Moda Health Plan, Inc.
Provider Appeal Unit
P.O. Box 40384
Portland, OR 97240
Fax: 855-260-4527

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Appeals

Timely Filing Limits

	Initial Claims	Coordination of Benefits Claims (Moda Health is secondary to another carrier)	Corrected Claims	Reconsideration or Claims dispute	First Level Appeal	Final Appeal
State	Calendar Days	Calendar Days	Calendar Days	Calendar Days	Calendar Days	Calendar Days
Alaska	365	365 days from the primary carrier's Explanation of Payment (EOP) date	365 days	180 days from the receipt of the denial	60 days to file first level appeal	60 days to file the Final Appeal

Moda-Health-Commercial-Provider-Manual.pdf

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Provider Inquiry/Appeal Form

Moda is excited to now be utilizing a Provider Inquiry/Appeal form. This change was effective as of January 1, 2026. This streamlined form is designed to make submitting inquiries and appeals easier, faster, and more complete, ensuring all the necessary information is included for a smooth review process.

Any appeals that are submitted must include the Appeal form. If the form is not attached, a review will not be completed, and a letter will be generated stating the dismissal of the appeal/inquiry.

Requests will not be processed until the required Appeal form has been completed and resubmitted.

Moda-Provider-Inquiry-and-Appeal-Form.pdf

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How to submit a reconsideration

The first time a request for review is submitted to the appeals team, it will always be considered a reconsideration.

The form must include the following information:

- Claim status
- Member eligibility
- Payment methodology (including bundling/unbundling, multiple surgery rules, etc.)
- Medical policies (if applicable)
- Coordination of benefits or third-party details

All supporting documentation submitted by the provider will be reviewed, along with the member's benefit plan.

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Appeals

How to submit a Peer-to-Peer

Peer-to-peer
This is a conversation between the requesting provider and the Moda Health medical director.
Providers may discuss the denial determination directly with the medical director who made the denial determination, generally this takes place within 10 business days of the denial.

Although an inquiry and an appeal are considered separate processes, both must be submitted in writing.

Include the following information:

- **Provider details:** Provider name, Tax ID, and contact name, address, and phone number.
- **Patient details:** Patient name and Moda Health member ID.
- **Claim or authorization details:** Date of service and claim number—or authorization number if there is no claim.
- **Payment documentation:** A copy of the original explanation of payment (EOP) for the claim.
- **Reason for review:** Explain what you believe is incorrect and include supporting medical records or documentation, when applicable.
- **Coordination of benefits:** Include the primary carrier's name and address for COB claims.

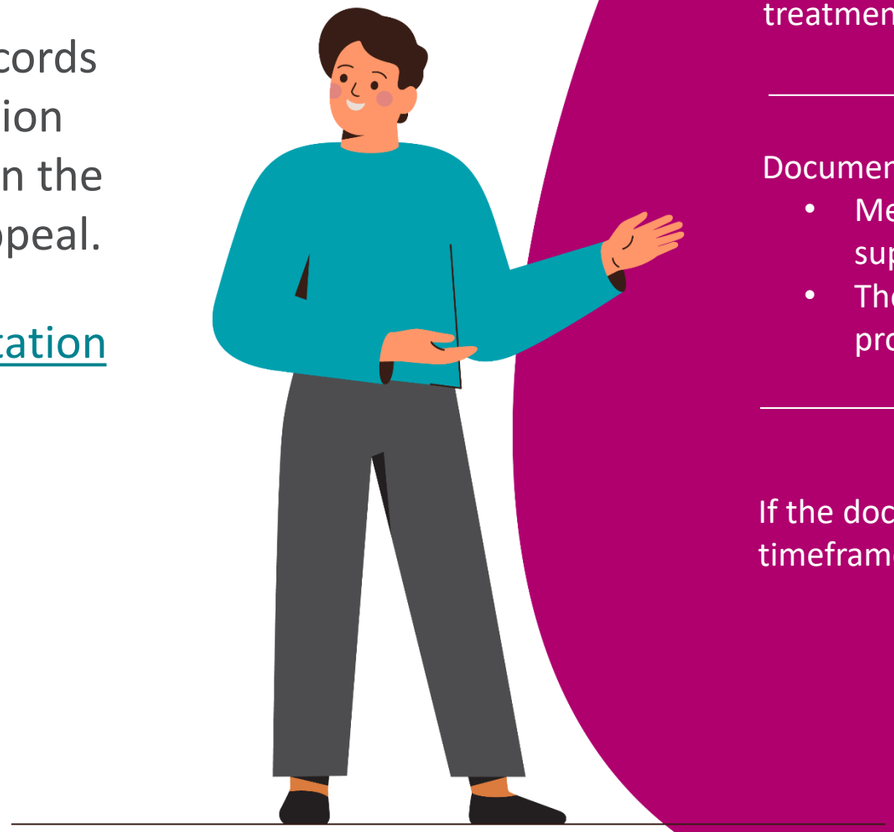
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Appeals

Medical record requests

We may request medical records and supporting documentation to assist in a final decision on the provider reconsideration/appeal.

Medical Records Documentation Standards



Healthcare providers and health plans meet the definition of a covered entity under the **Health Insurance Portability and Accountability Act** and may share information for treatment purposes without a signed patient authorization.

Documentation is necessary to determine the following:

- Medical necessity or appropriateness of a service or supply to be covered
- The standard and/or quality of care or services provided

If the documentation is not provided within the timeframe specified, coverage may be denied.

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Appeals

Expedited or rush requests



On receipt of a request, a Moda Health medical director decides whether the request qualifies for an expedited review.

If the medical director qualifies the request, the staff processes it as expedited or rush.

If it is decided that the request does not qualify for expedited review, the staff processes the request using the standard timelines.

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Member appeals

A member appeal is a pre-service or post-service appeal initiated by a member about an adverse determination on an authorization request or a claim.

- A provider may file a pre-service member appeal on behalf of a member in writing
- The commercial member must complete a Moda Health Protected Health Information (PHI) form if they want a provider to appeal on their behalf.

modahealth.com/pdfs/auth_provider.pdf

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Appeals

Common appeal misinterpretations

Prior authorizations

Many services require prior authorization, including anesthesia and dermatology services.

- **If prior authorization was not obtained before the service:** Providers have up to **14 calendar days** to request a retroactive authorization.
- **If EviCore or Moda denies the authorization as not medically necessary:** If the provider chooses to proceed with the service, the claim will be denied for **no authorization**.
- The services will **not be reviewed again for medical necessity**, and the denial will remain upheld.

Hospital audits

When reimbursement is reduced as the result of a hospital audit, the reduction is based on Moda's policies and procedures.

- These reductions are **not overturned through an appeal**.
- Submitting an appeal will not change the reimbursement decision.
- The reduction is commonly based on **Reimbursement Policy RPM043 – Hospital Routine Supplies**.

Inappropriate primary diagnosis

Appeals for an inappropriate primary diagnosis denial are generally not overturned.

- The appropriate resolution is to submit a **corrected claim with an appropriate primary diagnosis code**.
- A letter explaining why the original primary diagnosis code is valid **will not change the denial decision**.

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Healthcare Services



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Case management

This service is offered to Moda Health members needing assistance with complex health conditions or catastrophic events.

To make a referral:

- Call: 800-592-8283
- Fax: 855-232-6904
- Email: casemgmtrefer@modahealth.com

Include the following in your referral:

- Member name and ID
- Contact name and number
- Reason for referral

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Health navigators

Member health navigators

- Provide health education related to preventive health
- Assist with provider searches, locating community resources, vendor programs, referrals to case management and health coaching

Telephonic health coaches

- Provide in-depth disease management/self-management programs for members dealing with chronic health conditions and diagnoses

To make a referral:

- Call: 855-466-7155
- Email: memberadvocateteam@modahealth.com or healthcoachteam@modahealth.com

Include the following in your referral:

- Member name and ID number
- Contact name and number
- Reason for referral



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HEDIS/Quality Measures & Population Health



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HEDIS & Quality

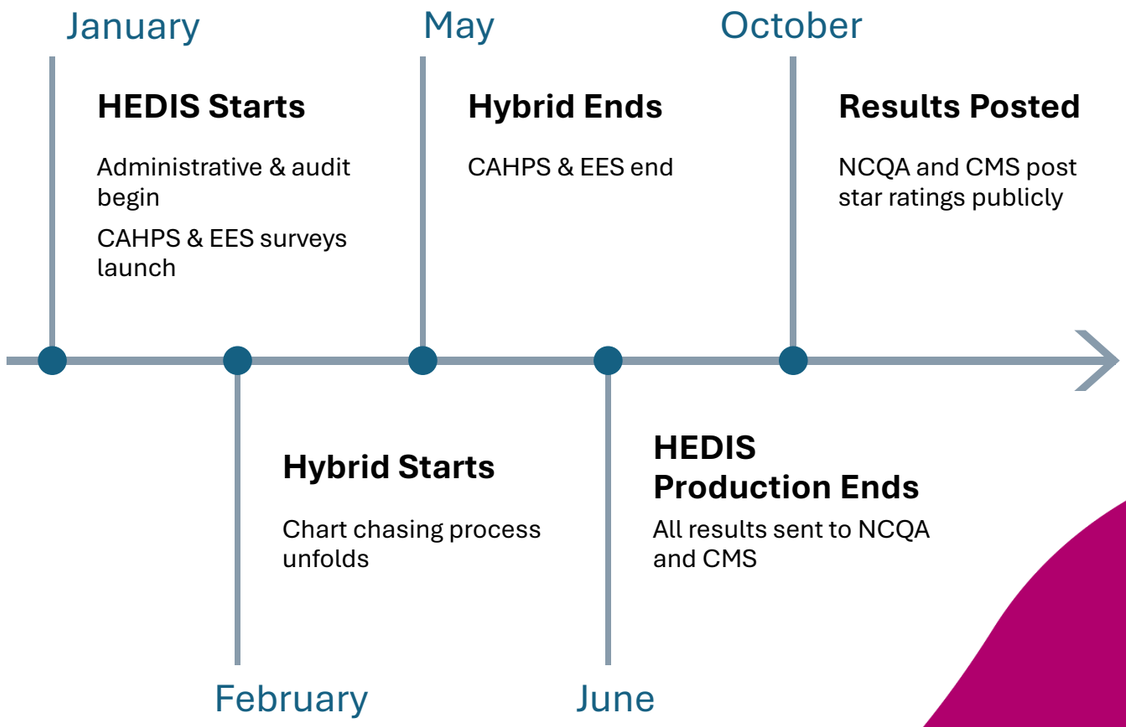
HEDIS® stands for Healthcare Effectiveness Data and Information Set

- Created and managed by the National Committee for Quality Assurance (NCQA)
- Rules and requirements are updated annually

HEDIS measures track how well healthcare organizations perform within 6 key quality domains:

- Effectiveness of Care
- Access and Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Electronic Clinical Data Systems (ECDS)

HEDIS production season annual timeline:



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HEDIS Star Ratings & Vendors

Different organizations produce different overall ratings. For Moda, the following currently apply:

- **CMS**
  - Marketplace Star Ratings
  - *Individual/Small Group On-Exchange*
- **NCQA**
  - Commercial Health Plan Ratings
  - *Large/Small Group, Individual Off-Exchange*

Moda's HEDIS vendors may reach out to provider offices to arrange chart collection for HEDIS deliverables. These vendors include:

- **Cotiviti**
  - HEDIS engine
  - Record retrieval by fax, onsite, and mail
- **KDJ Consultants**
  - Remote EMR retrieval
  - Third party "copy service" retrieval
  - All record abstractions
  - Over-reads

Questions?

HEDIS@modahealth.com

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NCQA Accreditations at Moda

Moda maintains active Health Plan Accreditation across the following products:

- Oregon Commercial & Exchange
- Alaska Commercial & Exchange
- Idaho Exchange
- Texas Exchange

Moda is also seeking Health Outcomes Accreditation through NCQA for the first time in 2026.

What is Health Outcomes Accreditation?

- Data-driven program helping healthcare organizations identify, measure, and address disparities in care
- Enables Moda to identify where disparities exist in our populations' health outcomes, experiences, or access and take action to improve

Why are we taking part?

- Aligns with our mission to reduce health disparities and improve member outcomes
- Utilize our individual-level data to meet our members where they are at
- Meet state-based requirements
  - Starting with Oregon Commercial & Exchange in 2026
  - Expanding to additional products over the next 1-3 years
- Highlight our organizational commitment to health equity

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Quality Improvement Priorities

Moda's QI Team prioritizes the following key topic areas & actions to engage in continuous quality improvement efforts, all with the aim of improving member health outcomes and equity.

Member Experience	Avoidable ER	Asthma	Chronic Conditions	Child & Maternal
• Know Your Care methodology • Primary Care Navigation for High-Risk Members • Claims Explained initiative	• Post-ER follow-up member outreach • Supportive conversations within Moda programs • Care Access social media campaign	• Post-acute member outreach • Provider EMR connection for medication management support • Provider incentives	• Targeted health screening events • Value-based insurance design • Comprehensive condition management member campaigns	• Bi-annual parent/guardian education for annual well visits and vaccines • Culturally-relevant messaging

To truly meet patients where they are at and create positive outcomes, we're seeking to engage with you – our valued provider partners. Here are some ways we're doing so:

- **Collaborative quality measure review monthly meetings & JOCs** – formal spaces for us to delve into performance, assess barriers, and collaborate through solutions together
- **Monthly open office hours** – a space for you to ask your questions and engage in QI discussions with us!
- **Various communications** – like Moda's provider newsletters, our annual practitioner survey, and more
- **Provider SPARK initiative** – our newest program where provider groups partner with us in a 6 to 12-month to pilot high-priority QI work together.

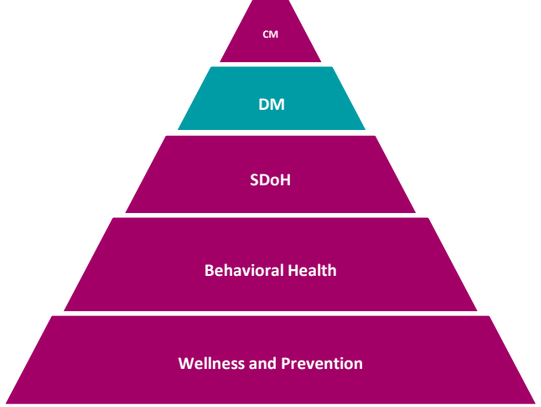
Ready to partner? Reach out to us directly at

QualityImprovement@modahealth.com

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Population Health Strategy

Supporting Better Health Outcomes Across the Care Continuum



Program	Description	Contact Us
Case Management	Guides members through care, from transitions and brief consultations to complex case management.	800-592-8283 casemgmtrefer@modahealth.com
Disease Management	Helps members manage ambulatory care sensitive conditions through personalized health coaching and care planning.	800-592-8283 healthcoachteam@modahealth.com.
SDoH Advocates	Connects members facing social barriers with resources, action plans, and follow-up.	resourceadvocates@modahealth.com
Behavioral Health Champions	Helps members find and engage with appropriate behavioral health care.	833-212-5027 bhchampions@modahealth.com
Wellness and Prevention	Digital engagement platform that combines health assessments, personalized recommendations, wellness challenges, and social support.	888-217-2363
Women's Health	**Maternity Program** - Provides education and coaching throughout pregnancy and the first postpartum year.	maternitycare@modahealth.com
	Menopause Program - Offers stage-specific guidance, group coaching, and peer support throughout menopause.	menopausecare@modahealth.com

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Provider information/ resources



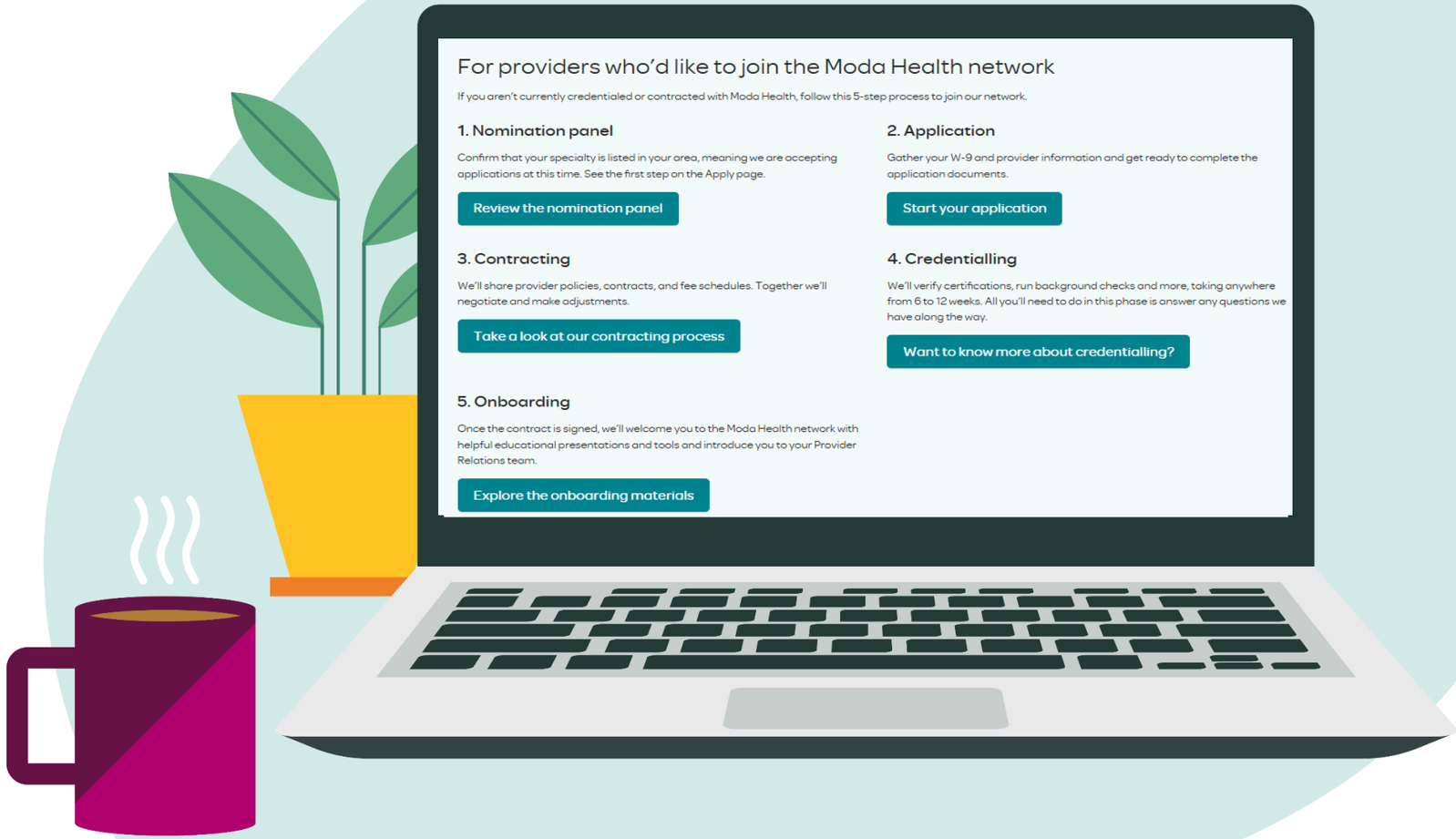
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Joining our network

If you have a provider that leaves a group setting and opens a new clinic, follow the steps below -

1.) Review the nomination panel (this can vary throughout the year)
2.) Submit your application
3.) Contracting
4.) Credentialing
5.) Onboarding

[Join our network | Moda Health - Alaska Providers]



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Upgraded Moda Website

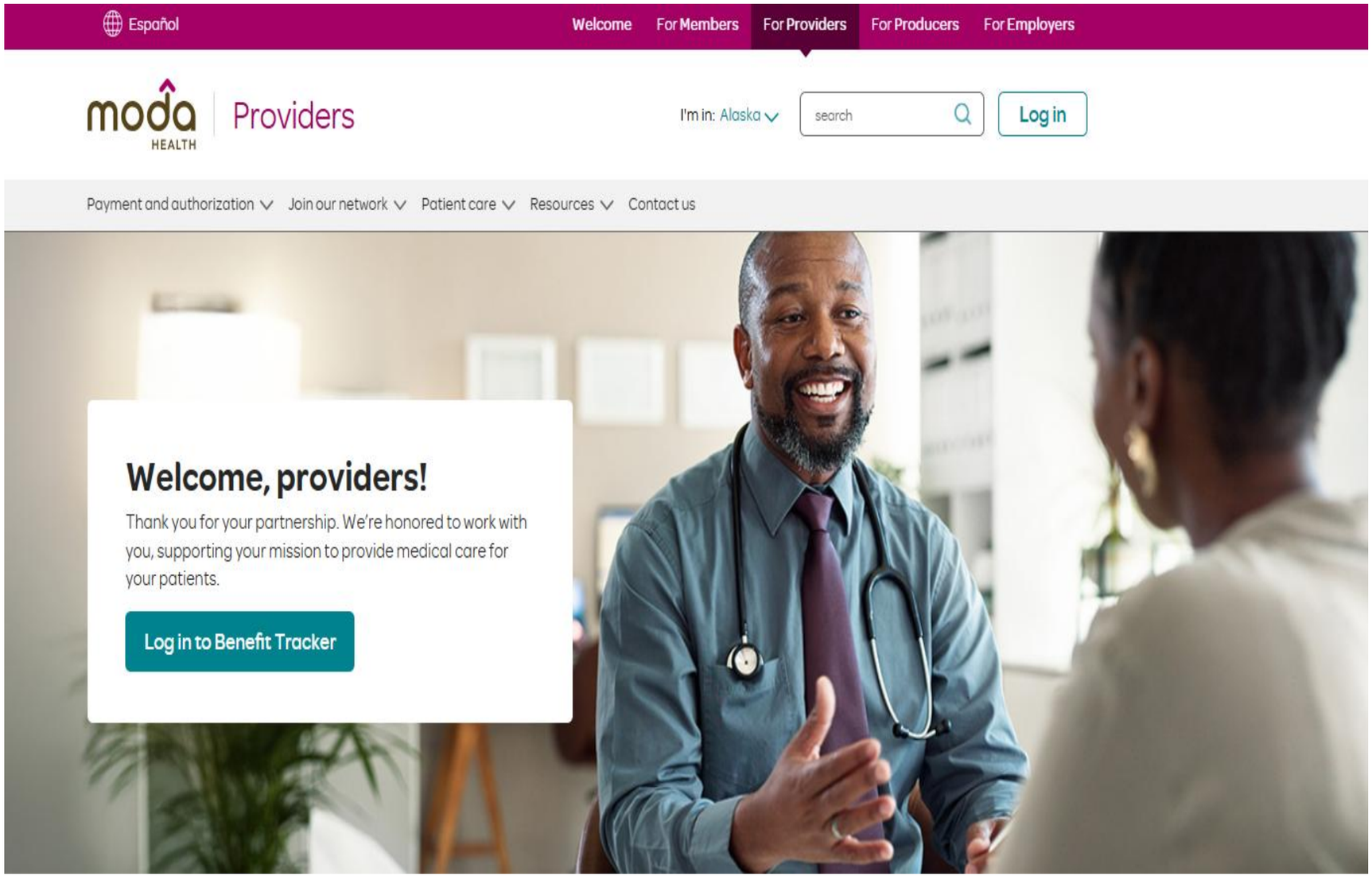
Our website recently underwent an upgrade, giving a new seamless experience.

Modahealth.com still has all the same great resources with some newly added features.

- Join our network
- Find Care Directory
- Payment and authorization
- Benefit Tracker
- Reimbursement Policies
- Contact Info

Questions?
888-217-2363
medical@modahealth.com

Providers | Moda Health - Alaska Providers



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Find Care directory

Find Care was also recently enhanced to improve the provider and member experience.

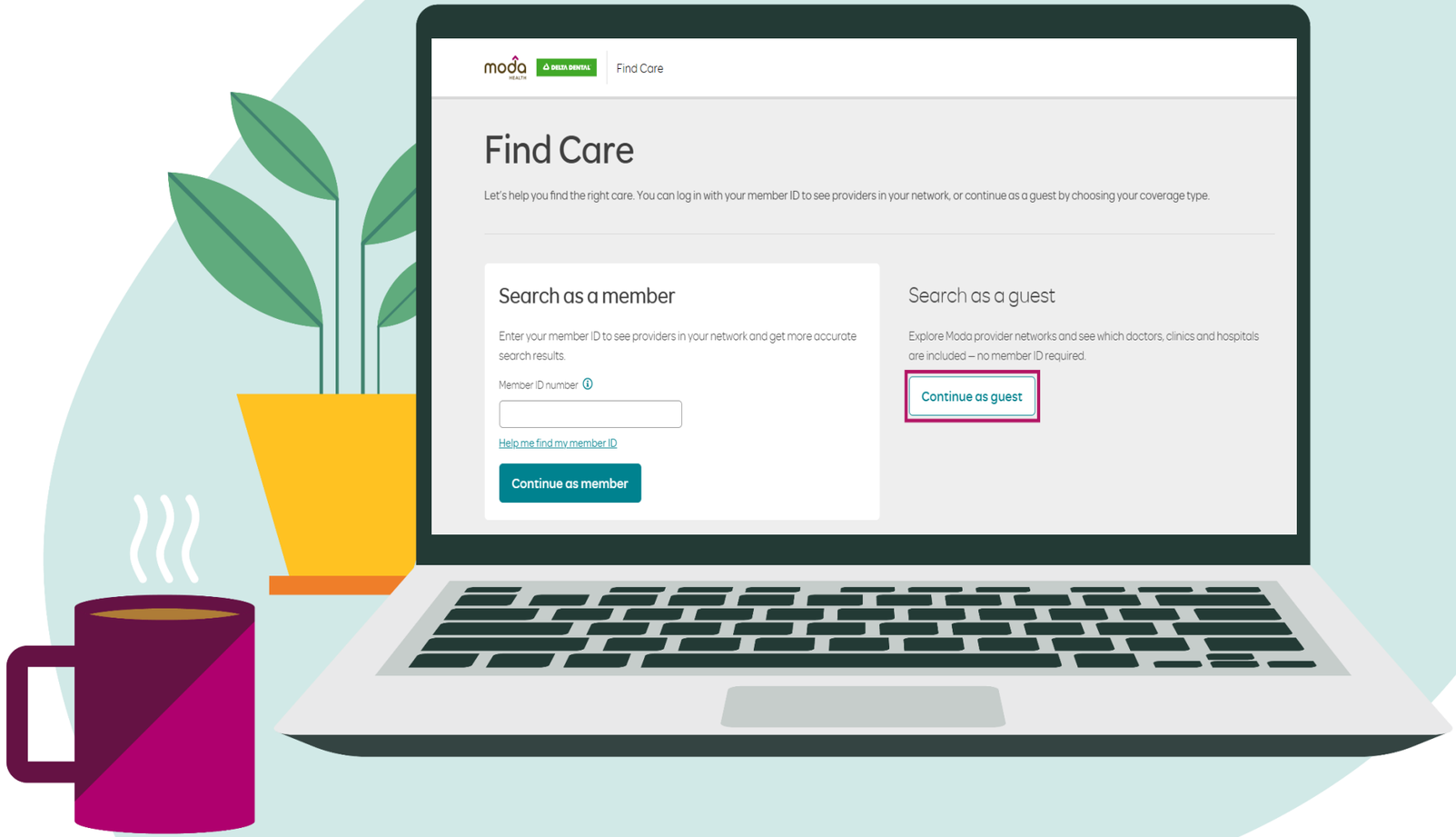
When using this tool, follow these steps below for the best results-

- Click continue as guest for your search
- Click start your search for a medical provider, facility or specialty.
- Choose any medical network
- Click find a provider/facility
- Choose a location
- Search provider by name

This tool allows our members to view in-network, contracted providers.

We ask that our providers periodically check Find Care to confirm the displayed information is accurate.

Updates to info?
ProviderUpdates@modahealth.com



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Credentialing contact

Credentialing is a multi-step, regulated process that ensures every provider in our network has the education, licenses and training needed to provide care to our members.

This process can take up to 90 days from receipt of a complete application. Unsolicited applications from providers that are not currently contracted or approved to contract will not be accepted.

Moda utilizes the CAQH ProView site as an application source.

CAQH Provider Data Management

Contact information:
Call: 855-801-2993

Fax: 503-265-5707

Email: Credentialing@modahealth.com

Mailing address:
Moda Health
601 SW 2nd Ave. #900
Portland, OR 97204
Attn: Credentialing Dept.



Credentialing | Moda Health - Alaska Providers

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Contacting Moda

Medical Customer Service

For questions about single claim inquiry, adjustment request, appeals, billing policies and our provider search tool (Find Care)

Email: medical@modahealth.com

Call:

- 888-217-2363- Medical and Vision
- 888-217-2365-Dental
- 888-361-1610-Pharmacy

Provider updates

For all demographic changes such as address updates, or practitioner updates to add/remove

Email: providerupdates@modahealth.com

Contact us | Moda Health - Alaska Provider



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Contacting Moda Cont.

Electronic Data Interchange (EDI team)

For questions about electronic claims submissions, payments and EFT/ERA enrollment-

Email: edigroup@modahealth.com
Call: 800-852-5195

- eft_era_enrollment_form_medical.pdf
- Claims | Moda Health - Alaska Providers

Benefit Tracker (EBT team)

For questions about Benefit Tracker registration, locked-out account, password reset-

Email: ebt@modahealth.com
Call: 877-277-7270

- Registration
- Benefit Tracker | Moda Health - Alaska Providers

Provider Nominations

For follow up on a new contract request submitted **more than 60 days ago**-

Email: providernominations@modahealth.com



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Contacting Moda Cont.

Authorizations and Referrals
For questions about inpatient/outpatient elective procedures, skilled nursing facility long-term acute care, inpatient rehabilitation, managed care, home health/home infusion, hospice (initial evaluation and service), DME, and transplants:

- Local: 503-243-4496
- Call toll-free: 800-258-2037
- Fax: 503-243-5105

Hearing Aid Services/TruHearing

- Call: 888-217-2363

Vision Services/VSP

- Phone: 800-877-7195



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Provider Relations Contact Escalated outreach

When you have completed the following and are still needing further assistance to gain resolution-

- Checked Benefit Tracker
- Checked the Find Care Directory
- Reached out to Medical Customer Service
- Emailed the following teams **(If applicable)**
  - Credentialing
  - Provider Updates
  - EBT team
  - EDI team

Email: Providerrelations@modahealth.com



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Thank you



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