PROVIDER NEWSLETTER

A newsletter for Molina Healthcare Provider Networks

First Quarter 2021

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Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

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.

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Focusing together on a positive patient experience will have important benefits to your practice:

- Increase patient retention
- Increase compliance with physician clinical recommendations
- Improve patient's overall wellness and health outcomes
- Ensure preventive care needs are addressed more timely
- Reduce no show rates

Additional resources are available for office staff and patients:

- For additional after-hours coverage, Molina Healthcare members can call the 24-Hour Nurse Advice Line, (888) 275-8750, TTY: 711
- Molina Healthcare members can access Interpreter Services at no cost by calling Member Services
- Providers can access the Provider Web Portal at **www.MolinaHealthcare.com** to:
  - Search for patients & check member eligibility
  - Submit service request authorizations and/or claims & check status
  - Review Patient Care Plan
  - Obtain CAHPS® Tip Sheets
  - Participate in Cultural Competency trainings (also available on **www.MolinaHealthcare.com** under "Health Resources")

Please encourage your patients who have received the CAHPS® survey to participate. Listed below are several questions asked in the survey regarding patient care:

- When you needed care right away, how often did you get care as soon as you needed?
- When you made an appointment for a checkup 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?

Molina Healthcare's 2020 Quality Improvement Results

Molina Healthcare conducts an annual program evaluation to assess how well we meet the performance goals and objectives for improving the quality and safety of clinical care and services specified within the Quality Improvement Program Description and annual Work Plan. Below are highlights from the annual evaluation.

CAHPS®
The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a survey that assesses Molina members' satisfaction with their health care. It allows us to better serve our members.

Molina Healthcare has received the CAHPS® results of how our members rated our providers and our services.

Medicaid: In 2020, Molina Healthcare improved on how well doctors communicate and customer service ratings. We need to make improvements for CAHPS® measures: getting care quickly, getting needed care, coordination of care, rating of health plan, rating of overall health care, rating of personal doctor and rating of specialist seen most often.

Medicare: In 2020, Molina Healthcare demonstrated improvement in customer service, members getting needed care and the number of members who receive an annual flu vaccine. Areas with opportunity for improvement include getting care quickly, rating of health plan and rating of drug plan.

Marketplace: In 2020, Molina Healthcare reached the targeted goal for the following measures: access to information, coordination of care, rating of health plan, rating of all health care, rating of personal doctor and medical assistance with smoking and tobacco use cessation. We need to make improvements in access to care, customer service, annual flu vaccinations and rating of specialist seen most often.

HEDIS®
Another tool used to improve member care is the Healthcare Effectiveness Data and Information Set or HEDIS®. HEDIS® scores allow Molina Healthcare to monitor how many members are receiving the services they need. Measures include immunizations, well-child exams, Pap tests and mammograms. There are also scores for diabetes care, and prenatal and after-delivery care.

Medicaid: In 2020, Molina Healthcare improved on the HEDIS® measures related to cervical cancer screening, pharmacotherapy management of COPD, 7-day follow-up after hospitalization for mental illness and avoidance of antibiotic treatment for acute bronchitis and bronchiolitis. We also showed improvement in timeliness of prenatal care and postpartum care. We need to improve in breast cancer screening, chlamydia screening in women and making sure our younger members receive weight assessments.

Medicare: In 2020, Molina Healthcare demonstrated improvement in pharmacotherapy management of COPD, adherence of statin therapy for patients with cardiovascular diseases and the number of members with diabetes who received a comprehensive eye exam. We need to make improvements on HEDIS® measures for breast cancer screening, colorectal cancer screening, medication reconciliation post-discharge and functional status assessment for older adults.

Marketplace: In 2020, Molina Healthcare reached the goal for adult BMI assessment, antidepressant medication management and medical attention for nephropathy for members with diabetes. Areas that need improvement include cervical cancer screening, chlamydia screening in women and controlling high blood pressure for members with hypertension.

Culturally and Linguistically Appropriate Services
Molina Healthcare also assesses the cultural, ethnic, racial and linguistic needs and preferences of

members on an ongoing basis. Information gathered during regular monitoring and annual network assessment is used to identify and eliminate cultural and/or linguistic barriers to care through the implementation of programs and interventions.

In 2020, the majority of Molina Medicaid members identified English (88%) as their preferred language, followed by Spanish (10%) and Burmese (0.6%). Spanish was the most requested language for Molina's interpreter services, followed by Burmese and Karen. The percentage of requests for Karen interpreters decreased slightly between 2019 and 2020.

The majority of Molina Marketplace members in 2020 did not identify a preferred language (93%), followed by English (4%) and Spanish (3%). Spanish was the most requested language for Molina's interpreter services, followed by Mandarin and Burmese. The percentage of requests for Mandarin interpreters increased slightly between 2019 and 2020.

Overall, Molina found that the current Culturally and Linguistically Appropriate Services program resources, structure, and practitioner and community participation are sufficient based on member needs. Additionally, Molina has a series of short Culturally Competency training videos available via the Provider Portal: **https://provider.molinahealthcare.com/provider/login** and at **www.MolinaHealthcare.com** on the Culturally and Linguistically Appropriate Resources/Disability Resources page listed under Health Resources. The following new disability resources are available at this location under Molina Provider Education Series:

- Americans with Disability Act (ADA)
- Members who are Blind or have Low Vision
- Service Animals
- Tips for Communicating with People with Disabilities & Seniors

The progress related to the goals that Molina Healthcare has set for the annual CAHPS® (QHP for Market Place) survey results and the annual HEDIS® measures can be viewed in more detail on the Molina website. You can also view information about the Quality Improvement Program and print a copy if you would like one. Please visit the provider page on Molina's website at **www.MolinaHealthcare.com.**

Electronic Funds Transfer (EFT)

Molina has partnered with our payment vendor, ProviderNet, for Electronic Funds Transfer and Electronic Remittance Advice. Providers must be registered for EFT payments in order to access and receive the benefits of ProviderNet. Below are additional benefits and reminders:

Benefits:

- Providers get faster payment and eliminates mailing time (processing can take as little as 3 days from submission)
- Providers can search for a historical Explanation of Payment (EOP) by claim number, member number, etc.
- Providers can view, print, download and save a PDF version of the EOP for easy reference with no paperwork to store
- Transfer Protocol (FTP) and their associated Clearinghouse
- Electronic Funds Transfers ensure HIPAA compliance
- It's a free service for you!

ProviderNet Reminders:

- Providers should always login to their ProviderNet account and view their payment history before contacting Molina about a missing EFT payment.
- ProviderNet only facilitates the payments from Molina to the provider. Questions regarding claims payment should be directed to Provider Services.
- If a provider receives a Molina payment that is not on their ProviderNet account (frequently Accounts Payable payments), providers should contact Provider Services.
- Providers should be reminded to add all NPIs to their a account that receive Molina payments.

Get started today! Providers that are not registered for EFT payments should contact: Electronic Funds Transfer at: (866) 409-2935 or email: **EDI.Claims@Molinahealthcare.com**.

Molina Partners with PsychHub for Provider Education

PsychHub is an online platform for digital behavioral health education. Molina Providers are able to access PsychHub's online learning courses through their Learning Hub for FREE. Continuing Education opportunities are also available to select providers through a variety of courses. Contact your local Molina Provider Services team or **info@psychhub.com** for support.

Click here to visit PsychHub

Electronic Solutions for Streamlined Credentialing

The need for a current credentialing application goes beyond initial credentialing. Following NCQA (National Committee for Quality Assurance) guidelines requires providers to be recredentialed at a minimum of every three years.

To avoid an incomplete application, consider logging into your electronic application, CAQH (Council for Affordable Quality HealthCare), for regular maintenance. A few tips to improve and streamline your credentialing process:

- Attestations are considered current for 180 days. Electronically updated attestations are acceptable and encouraged.
- Professional Liability Insurance is considered current at time of sign off; update your application or attach your new year's policy as soon as it's available.
- If you recently became board certified, update your board status. Board certifications are not only quicker to verify than residencies and fellowships, if you have one, NCQA requires that it be verified.
- DEA certifications can be verified by attaching a current copy to your application.
- Review your specialty listed on your application. Do you have the corresponding education listed on your application? If not, complete the education section.
- NCQA also requires five years of work history. Make sure your application lists the MM/YY format. Be sure to also include gap explanations for any gaps over six months.

If you have any questions on how to complete or update your electronic application, please reach out to the Specialist listed on your credentialing request.

Centers for Medicare & Medicaid Services (CMS) Guidance for COVID-19 Vaccine Toolkits & COVID-19 Vaccine Significant Cost Determination

In preparation for the release of the COVID-19 vaccine, CMS developed centrally located COVID-19 vaccine toolkits to convey critical information to all stakeholders. As more information becomes available these toolkits will be updated as needed.

Additionally, CMS announced the legislative change in benefits to add Part B coverage of a COVID-19 vaccine, and its administration meets the significant cost threshold. Given the significant cost determination, Medicare payment for COVID vaccinations administered during calendar years 2020 and 2021 to Medicare Advantage (MA) beneficiaries will be made through the Medicare Fee for Service (FFS) program. Medicare beneficiaries enrolled in MA plans will be able to access the COVID-19 vaccine, without cost sharing, at any FFS provider or supplier that participates in Medicare and is eligible to bill under Part B for vaccine administration, including those enrolled in Medicare as a mass immunizer or a physician, non-physician practitioner, hospital, clinic, or group practice. Therefore, contracted Molina Healthcare providers should submit claims for administration of the COVID-19 vaccine to the appropriate CMS Medicare Administrative Contractor (MAC) for payment.

Links to MACs:

- **https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MedicareAdministrativeContractors**
- **https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs**

Additional Important links:

- **https://www.cms.gov/files/document/COVID-19-toolkit-issuers-MA-plans.pdf**
- **https://urldefense.com/v3/__https:/www.cms.gov/COVIDvax__;!!DOw_8Fim!fd6BCZyFuMFnLPailyiFgi0sUnN_K1cCW_CAMTH5h8Vt-riGEzN729oYcentaTpGlXtstm77yD7RbQ$**
- **https://www.cms.gov/newsroom/press-releases/trump-administration-acts-ensure-coverage-life-saving-covid-19-vaccines-therapeutics**
- **https://urldefense.com/v3/__https:/www.cms.gov/files/document/covid-vax-ifc-4.pdf__;!!DOw_8Fim!fd6BCZyFuMFnLPailyiFgi0sUnN_K1cCW_CAMTH5h8Vt-riGEzN729oYcentaTpGlXtstm6yFx5ELQ$**

Requirements for Submitting Prior Authorization for all Molina Lines of Business

Molina requires prior authorization (PA) for specific services. Molina offers three tools on the MolinaHealthcare.com website to assist you in knowing what services require prior authorization: The Prior Authorization Code Matrix, the Prior Authorization Guide, and the newly launched Prior Authorization Code Lookup Tool. Both the PA Code Matrix and the PA Lookup Tool offer detailed information by CPT and HCPCS code regarding PA requirements. Additional information about the new Prior Authorization Code Lookup Tool, including how to access the tool, is available in a separate article included in this newsletter.

When submitting a prior authorization request, it is important to include all clinical information and medical records necessary to support the medical necessity of the requested service/item. The following is an example of documentation needed:

- Current (up to six months) patient history related to the requested service/item
- Relevant physical examination that addresses the problem
- Relevant lab or radiology results to support the request (include previous MRI, CT, lab or X-ray report/results)
- Relevant specialty consultation notes
- Any other information or data specific to the request showing the member meets the criteria for approving the service/item

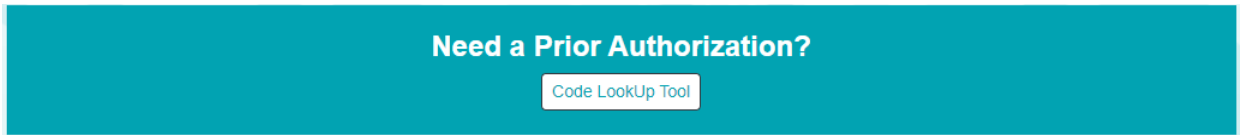
By providing all necessary clinical information with the initial request, Molina will be able to make a more timely and complete decision based on the member's current health condition while potentially avoiding a need to request additional supporting documentation. When submitting an expedited prior authorization request, be sure to submit all necessary clinical information as the timeframe to process the request is extremely short from date and time of receipt of the initial request. The goal is to have all necessary information to make the appropriate decision during the initial review of the service/item and avoid the need for an appeal if the service/item is denied.

NOTE: In the event a denial is issued and subsequently appealed, be sure to reference the original decision. If the denial was due to missing information needed to justify coverage, not providing that information with your appeal request will not change the decision and could further delay medically necessary covered services/items. Let's work together to ensure timely and appropriate care for your patients.

Molina's Prior Authorization Lookup Tool has Launched!

A new Prior Authorization Lookup Tool is now available on **www.MolinaHealthcare.com**. It allows you to look by CPT/HCPCS code (along with state and line of business) to determine if prior authorization is/is not required. Additionally, the tool will indicate if a code is not a covered benefit, or if authorization for that service has been delegated by Molina to a vendor along with information regarding how to contact the vendor.

This helpful tool is accessible via our Provider Portal and the Molina website provider landing page. Simply go to **www.MolinaHealthcare.com** and select "I'm a Provider" and choose your state from the pop-up. You will see the Prior Authorization Lookup Tool on the Provider Landing page under "Need a Prior Authorization?"



Utilization Management Updates
Molina Expands MCG Clinical Guidelines

Beginning in February, Molina Healthcare is expanding its partnership with MCG Health, a clinical criteria tool that specializes in informed clinical guidance for value-based care. **Note: The process for notifying MHWI of admissions and prior authorization approvals will remain the same.**

Effective Feb. 1, 2021, Molina Healthcare of Wisconsin, will utilize MCG clinical solutions that include but is not limited to:

- Inpatient & Surgical Care Guidelines
- General Recovery Care Guidelines
- Multiple Condition Management Guidelines
- Behavioral Health Care Guidelines
- Ambulatory Care Guidelines
- Home Care Guidelines
- Recovery Facility Care Guidelines
- Cite for Collaborative Care Guidelines

Benefits of this partnership also includes but is not limited to:

- Effective healthcare with evidence-based care guidelines
- Increased provider satisfaction via standardized clinical criteria review process
- Improved quality of care
- Better health outcomes through effective utilization management

To learn more about MCG, visit **MCG Website (http://www.mcg.com/)**.

Access Your Marketplace Members on the Molina Provider Portal

As a Primary Care Provider, you can always access the roster of Molina Marketplace members assigned to your practice via the provider portal. Note: you do not need to be designated as a member's PCP to provide services to Molina members. Eligibility and benefit terms apply.

Alert to Molina Providers
Change Made to ForwardHealth Resident Substance Use Disorder Treatment Coverage

As of Feb. 1, ForwardHealth is authorizing resident substance use disorder (RSUD) treatment for all Medicaid members.

All RSUD treatment providers ***must notify Molina within 48 hours*** of a Molina Medicaid member admission. This notification to Molina is ***required*** by ForwardHealth. Fax the notification and a signed release of information, including specific consent for release of substance use treatment, to Molina at (877) 708-2117, Att: RSUD Admission.

Following notification, Molina will assign a Molina care coordinator to assist with required coordination prior to the member's discharge.

Note: All treatments are authorized and paid for directly by Wisconsin Medicaid under Fee-For-Service. For more information visit **ForwardHealth Update NO. 2020-42**.

Provider Appeals Tips
Get Faster Results when Appealing a Claim with Molina

Providers ***appealing a claim*** previously adjudicated ***must request action within 90 calendar days*** of Molina's original remittance advice date, unless your Provider Agreement has different stipulations.

Regardless of appeal type (service denied, incorrect payment, administrative, etc.); all claim appeals ***must be submitted on the Molina Appeals Form*** found on the Molina Provider website and the Provider web portal.

Only fully completed forms can be processed. Note: clearly mark the submission as an appeal. Required with the form: must include the following:

- Provider name
- Date of service
- Date of billing
- Date of payment and/or nonpayment
- Member name
- Claim number ***Services cannot be appealed without a claim on file***
- BadgerCare Plus ID number

- The reason(s) the claim merits reconsideration. If the appeal relates to medical emergency, medical necessity and/or prior authorization, medical records and/or substantiating documentation must accompany the Provider request for reconsideration which must include but is not limited to::
    - Physician notes
    - Tests and reports
    - Medicine lists for the hospital stay
    - Nurse notes
    - Social Worker notes

Molina Seeks OBGYN Partners for Free Car Seat Initiative

Molina Healthcare of Wisconsin is looking for OBGYN providers to participate in a Molina Free Car Seat Program for Molina Medicaid members who are pregnant. The Free Car Seat Program is designed to support Molina Medicaid pregnant members and healthy births.

Requirements of the program include scheduling and attending a minimum of six prenatal visits. In addition to prenatal visits, participants in the program must select a pediatrician for their baby.

The Molina program, part of Molina's Healthy Starts Program, is scheduled to begin in June 2021.

The role of the provider would be to help promote and track the required prenatal visits for their Molina-insured Medicaid pregnant mothers. If interested in learning more about the program and working on this important initiative, contact Amber at **amber.lococo@molinahealthcare.com** or (414) 322-1112.

MyMolina App Supports Quality Appointments for Providers, Molina Patients

Want easier check-in for your Molina patients. Want improved dialogue with Molina patients during appointments.

Molina has an app for that!

The Molina Mobile App or MyMolina Portal puts medical information in the palm of your Molina patients' hands. This makes check-in smoother for your frontline staff and strengthens patient discussions, particularly about medication history, allergies and a patient's general health care history.

With MyMolina, patients will have accurate information they can share with you — all in one place. Information in MyMolina includes:

- View ID card and verify Molina eligibility
- List of patient allergies and medications
- Patient's medical service history, including office and ER visits
- Names of patient's Molina care team.

Encourage Molina patients to register with MyMolina.

For patients who struggle with technology, consider helping them register for MyMolina. Visit **MyMolina.com** or search for "MolinaHealthcare" in the Apple **App Store** or on **Google Play**.

Together let's strengthen health care delivery for your Molina patients.

HEDIS® Measures Improvement Tip Controlling Blood Pressure

Measure: The Controlling High Blood Pressure (CBP) measure looks at the percentage of patients 18 to 85 years old with a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Recently NCQA changed the HEDIS® specifications to allow telehealth, telephone, e-visits, or virtual check-in appointments to diagnosis patients with hypertension and get controlled BP readings to count for the measure. This allows patients to report blood pressure readings from any digital device.

Help your patients with hypertension by encouraging them to get an automated blood pressure monitor. This supports effective solutions to help patients regularly monitor their blood pressure, even during telehealth visits.

If a patient needs a new or replacement automated blood pressure monitor, you can assist them with locating an in-network Durable Medical Equipment (DME) provider by using **MolinaHealthcare.com** or calling Molina Member Services at 1 (888) 999-2404.

Remember

1. Certain automated blood pressure monitors do not require a prior authorization **if a member has not received a monitor within a 5-year period.** (a standard automated monitor life expectancy)

2. A prior authorization **is needed** when a member **needs a new automated blood pressure device** within a 5-year period.

Improvement Tips

The CBP HEDIS® measure requires proper clinic process and documentation. Molina's team of medical record abstractors reviews patient records to determine measure compliance.

Two common errors found during medical record review for the CBP measure are:

1. Not re-taking the BP a second time during an office visit if it is high

2. Rounding up the BP values.

Below are tips your clinic can take to **increase the CBP compliance rate**:

- ❑ Retake the BP if it is high at the office or telehealth visit (140/90 mm Hg or greater). HEDIS® allows Molina to use the lowest systolic and lowest diastolic readings in the same day and oftentimes the second reading is lower.

- ❑ **Do not round BP values up.** If using an automated machine, record exact values.

All summaries of the measures contained herein are reproduced with permission from HEDIS Volume 2: Technical Specifications for Health Plans by the National Committee for Quality Assurance (NCQA).

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