MOLINA HEALTHCARE

Provider Newsletter

For Molina Healthcare of California (MHC) providers

Second quarter 2024

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The provider newsletter is available to all network providers serving Molina Healthcare of California (MHC) members.

Important message: Updating provider information

Molina Healthcare of California (MHC) needs to keep our provider network information current. Up-to-date provider information allows MHC to accurately generate provider directories, process claims and communicate with our provider network. Providers must notify MHC in writing at least 30 days in advance, when possible, of changes, such as:

- Change in practice ownership or Taxpayer Identification Number (TIN)
- Practice name change
- A change in practice address, phone or fax numbers
- Change in practice office hours
- New office site location
- **Primary care providers (PCP) only:** If your practice opens or closes to new patients
- When a provider joins or leaves the practice

Send changes to:

- Los Angeles: **MHC_LAProviderServices@MolinaHealthcare.com**
- Sacramento: **MHCSacramentoProviderServices@MolinaHealthcare.com**
- San Bernardino: **MHCIEProviderServices@MolinaHealthcare.com**
- Riverside: **MHCIEProviderServices@MolinaHealthcare.com**
- San Diego: **MHCSanDiegoProviderServices@MolinaHealthcare.com**

Practitioner credentialing rights: What you need to know

MHC must protect its members by assuring their care is of the highest quality. One protection is assurance that Molina's providers have been credentialed according to the strict standards established by the state regulators and accrediting organizations. As a MHC provider, your responsibility includes full disclosure of all issues and timely submission of all credentialing and re-credentialing information.

MHC also has a responsibility to its providers to ensure that the credentialing information reviewed is complete and accurate. **As an MHC provider, you have the right to:**

- Strict confidentiality of all information submitted during the credentialing process
- Nondiscrimination during the credentialing process
- Be notified of information obtained during the credentialing process that varies substantially from what you submit
- Review information submitted from outside primary sources (e.g., malpractice insurance carriers, state licensing boards) to support your credentialing application – except for references, recommendations or other peer-review protected information
- Correct erroneous information
- Be informed of the status of your application upon request by calling Provider Contact Center at **(855) 322-4075** or your Provider Relations representative at **MolinaHealthcare.com/-/media/E5295860C0774A44AF9CA501EEDE4DC1**
- Receive notification of the credentialing decision within 60 days of the committee decision or shorter time frames as contractually required
- Receive notification of your provider's right to appeal an adverse decision made by the committee
- Be informed of the above rights

For further details on your rights as a MHC provider, please review our Provider Manual – available online at:

- **Medi-Cal Provider Manual: MolinaHealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/ca/Medicaid/2024-CA-MEDI-CAL-PROVIDER-MANUAL.pdf**
- **Medicare Provider Manual: MolinaHealthcare.com/~/media/Molina/PublicWebsite/PDF/Providers/ca/Medicare/2024%20CA%20MEDICARE%20PROVIDER%20MANUAL.pdf**
- **Marketplace Provider Manual: MolinaMarketplace.com/marketplace/ca/en-us/Providers/~/media/Molina/PublicWebsite/PDF/Providers/ca/Marketplace/2024%20CA%20Marketplace%20Provider%20Manual**

Molina's utilization management

One of the goals of our utilization management (UM) department is to render appropriate UM decisions consistent with objective clinical evidence. To achieve this goal, we maintain the following guidelines:

- Our highly trained UM staff evaluates medical information received by our providers against nationally recognized, objective and evidence-based criteria. We also consider individual circumstances (at minimum age, comorbidities, complications, progress of treatment, psychosocial situation and home environment, when applicable) and the local delivery system when determining the medical appropriateness of requested health care services.
- MHC's clinical criteria include:
    - MCG criteria that are utilized to conduct inpatient review, except when Change Healthcare InterQual® is contractually required.
    - American Society of Addiction Medicine (ASAM) criteria
    - National Comprehensive Cancer Network® (NCCN)
    - Hayes Directories
    - Applicable Medicaid guidelines
    - Molina Clinical Policy (MCP)
    - Molina Clinical Review (MCR) (developed by designated corporate medical affairs staff in conjunction with MHC physicians serving on the Medical Coverage Guidance Committee)
    - UpToDate®
    - Other nationally recognized criteria, including technology assessments and well-controlled studies that meet industry standards and MHC policy; and when appropriate, third-party board-certified physician reviewers.

- MHC ensures all criteria used for UM decision-making are available to providers upon request. The clinical policy website, **MolinaClinicalPolicy.com,** provides access to MCP and MCR criteria. Providers also can access the MCG Cite for Care Guideline Transparency tool through our Availity Essentials (Availity) provider portal. To obtain a copy of the UM criteria, call our UM department at **(844) 557-8434.**
- As the requesting provider, you will receive written notification of all UM denial decisions. If you need assistance contacting a medical reviewer about a case, please call the UM department at **(844) 557-8434.**

MHC wants to remind our providers that UM decision-making is based only on the appropriateness of care and service and the existence of coverage.

- MHC does not explicitly reward providers or other individuals for issuing denials of coverage or care.
- UM decision-makers do not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.
- Providers may freely communicate with patients about their treatment – regardless of benefit coverage.
- Medicaid members have the right to a second opinion from a qualified provider. If an appropriate provider is unavailable in-network, MHC will arrange for a member to obtain a second opinion out-of-network at no additional cost to the member. Members from all MHC lines of business and programs should refer to their benefit documents (such as schedule of benefits and/or evidence of coverage) for second-opinion coverage benefit details, limitations and cost-share information. If an appropriate provider is unavailable in-network, prior authorization (PA) is required to obtain the second opinion of an out-of-network provider. Claims for out-of-network providers that do not have a PA will be denied unless regulation dictates otherwise. All diagnostic testing, consultations, treatments and/or surgical procedures must be a benefit under the plan and meet all applicable medical necessity criteria to be covered.
- Some of the most common reasons for a delay or denial of a request include:
  - Insufficient or missing clinical information to provide the basis for making the decision
  - Lack of or missing progress notes or illegible documentation

MHC's UM department staff is available for inbound collect or toll-free calls during regular business hours to provide information about the UM process and the authorization of care. If you wish to speak with a UM staff member, please call **(844) 557-8434.** MHC's medical director is available to answer more complex medical decision questions and explain medical necessity denials.

Providers can quickly and conveniently submit and status check PA through the **Availity provider portal.**

MHC PA fax numbers include:

- **Advanced imaging: (877) 731-7218**
- **Medicaid: (800) 811-4804**
- **Marketplace: (800) 811-4804**
- **Medicare-Medicaid Plan (MMP) physical and behavioral health fax: (844) 251-1541**
- **Medicare physical and behavioral health fax: (844) 251-1540**
- **Medicare and MMP inpatient fax: (844) 834-2152**
- **Medicare Part D pharmacy fax: (866) 290-1309**

Please refer to the *Drug formulary and pharmaceutical procedures* article for information about MHC's formulary PA and the exception process.

MHC's regular business hours are Monday-Friday (excluding holidays), 8 a.m.-5 p.m. Voicemail messages and faxes received after regular business hours will be returned the following business day. MHC has language assistance and TDD/TTY services for members with language barriers, members who are deaf or hard of hearing and those with speech disabilities.

Drug formulary and pharmaceutical procedures

At MHC (Marketplace), the drug formulary – sometimes referred to as a Preferred Drug List (PDL) – and pharmaceutical procedures are maintained by the National Pharmacy and Therapeutics (P&T) Committee. This committee meets quarterly or more frequently if needed.

The P&T committee is responsible for developing and updating drug formularies that promote safety, effectiveness and affordability where state regulations allow. The committee objectively reviews new Food and Drug Administration (FDA) approved drugs, drug classes, new clinical indications for existing drugs, new line extensions and generics, new safety information, new clinical guidelines and practice trends that may impact previous formulary placement decisions. Additional committee oversight includes PA, step therapy, quantity limits, generic substitutions, medical exception protocols to allow coverage for non-formulary drugs, other drug utilization management activities that affect access, drug utilization evaluations and intervention recommendations for MHC health plans. Drug formulary activities include prescriber-administered specialty medications as a medical benefit and pharmacy benefit services.

The drug formularies reviewed and approved by the P&T Committee are updated quarterly and include an explanation of quantity limits, age restrictions, therapeutic class preferences and step therapy protocols.

Providers may request a formulary exception for coverage of a drug outside of the drug formulary restrictions. A formulary exception should be requested to obtain a drug not included on a member's drug formulary or to request that a UM requirement be waived (e.g., step therapy, PA, quantity limit) for a formulary drug. Select medications on the drug formulary, or those not listed, may require PA. PA requires that a prescriber obtains advance approval from MHC before a specific drug is prescribed to a member to qualify for payment coverage.

The drug formulary/PDL and all current documents are posted on our website at:

- **CA Marketplace: MolinaMarketplace.com/marketplace/ca/en-us/Providers/Drug-List**

The P&T committee also promotes member safety. In the event of a Class II recall or voluntary drug withdrawal from the market for safety reasons, affected members and prescribing providers will be notified by MHC within 30 calendar days of the FDA notification. An expedited process is in place to ensure notification to affected members and providers of Class I recalls as quickly as possible. These notifications will be sent by fax, mail and/or via telephone.

For CA Molina Medicaid, the drug formulary is determined by the state and state processes and called the Covered Drug List (CDL). More information on Medical-RX and their management of the state covered drug list can be found at **medi-calrx.dhcs.ca.gov/home/.**

The drug formulary for CA Medicaid can be found on the state Medi-Cal RX website at **medi-calrx.dhcs.ca.gov/home/cdl/.**

Case management

MHC offers you and your patients the opportunity to participate in our complex case management program. Members must have the most complex service needs for this voluntary program. This may include members with multiple medical conditions, high levels of dependence, conditions that require care from multiple specialties and/or additional social, psychosocial, psychological and emotional issues that exacerbate their condition, treatment regimen and/or discharge plan.

The purpose of the MHC complex case management program is to:

- Conduct a needs assessment of the patient, the patient's family and/or caregiver
- Provide intervention and care coordination services within the benefit structure across the continuum of care
- Empower our members to optimize their health and level of functioning
- Facilitate access to medically necessary services and ensure they are provided at the appropriate level of care promptly
- Provide a comprehensive and ongoing care plan for continuity of care in coordination with the member, the member's family, the provider and the provider's staff
- Collaborate with the member's interdisciplinary care team
- Assess unmet needs and gaps in care
- Assit the memberwith accessing community resources and Medi-Cal benefits, as needed
- Refer the member to external and internal programs and collaborate with the entities to mitigate risk for duplication of services and member burden
- Assist member with obtaining the Five Wishes Advance Care Planning tool

If you would like to learn more about this program, you can speak with a complex case manager and/or refer a member for an evaluation by calling toll-free **(833) 234-1258.**

Molina MyCare program

The Molina My Care program is a community-based palliative care program focused on Medi-Cal patients with life-threatening illnesses. Molina considers any member with advanced, complex and life-threatening disease a candidate for My Care. The services can take place anywhere but are focused primarily in the home. Palliative care services are provided by a team of providers who will work with patients, families, and their treating physicians to alleviate symptoms related to their disease. **Patients may continue to receive ongoing treatment while in the program.** Molina fully covers the cost of the program. Members should meet the general eligibility criteria.

General eligibility criteria:

- Your patient has advanced illness.
- You are seeing increased use of ER and inpatient hospital services related to your patient's disease.
- Death within the next year would not be unexpected.
- Other therapies are no longer effective, or the patient is not ready for hospice.
- The patient is no longer in an acutely reversible state of decompensation.
- The patient/advocate agree to attempt home or outpatient disease management.
- The patient is willing to consider advance care planning discussions.

Molina My Care services:

- Initial care assessment and consultation
- Development of a support care plan for services at home
- Advance care planning discussion(s)
- Services provided by a care support team, including provider, nurse practitioner, registered nurse, physician, licensed vocational nurse, social worker and chaplain
- Four monthly visits (in-person and/or telephonic)
- Care coordination with the treating provider and Molina (facilitate auths for Durable Medical Equipment, etc.)
- Provide symptom management (pain, difficulty breathing, etc.)
- Mental health and medical social services support
- Molina's 24-hour Nurse Advice Line to support the member

Physician referral process

1. The treating physician identifies patients who potentially meet the Molina My Care program criteria and sends an order to the Molina palliative care provider.
2. The Molina My Care vendor submits a prior authorization request for My Care to Molina.
3. Molina reviews the vendor's request using criteria for the program.
    - Once approved, the palliative care provider and physician will be notified.
    - If not eligible for My Care, a referral is made to Molina Complex Case Management.

Program participation:

1. Patients are typically enrolled in a palliative care program from 6-12 months.
2. Patients will remain in the program until:
   - They move on to hospice.
   - Their clinical status improves unexpectedly.
   - They stop participating.

Treating physician benefits:

- Additional support services for your patient and their families.
- Additional support services for you and your staff.
- The vendor's care team can monitor your patient's condition and follow up on concerns. The Care Plan will be shared with the referring physician, along with any changes in condition.

Molina My Care contacts:

Pamela Valmonte, RN, BSN
Lead/Case manager
My Care – San Diego County

Email: **Pamela.Valmonte@MolinaHealthcare.com**
Phone: **(858) 974-1734**

Shelley Martin, LVN
Lead/case manager
My Care – Los Angeles/Sacramento Counties

Email: **Shelley.Martin@MolinaHealthcare.com**
Phone: **(562) 485-4919**

Name	County coverage	Contact information	Population served
Lightbridge Hospice	San Diego	Phone: **(858) 458-2992** Fax: **(760) 796-3784**	Adults only
Silverado Hospice	San Diego, Los Angeles, Riverside, San Bernardino	Phone: **(833) 668-6676** Fax: **(866) 299-8639**	Adults only
Elizabeth Hospice	San Diego	Phone: **(760) 796-3771** Fax: **(760) 796-3784**	Adults and pediatric members
Roze Room Hospice	Los Angeles	Phone: **(626) 446-7673** Fax: **(626) 446-7676**	Adults only
MedZed	Los Angeles	Phone: **(323) 203-0070** Fax: **(310) 561-1902** or **(404) 962-6803**	Adults only
Faith and Hope Hospice	Los Angeles	Phone: **(818) 559-1460** Fax: **(818) 559-1466**	Adults only
Holistic Care Hospice and Palliative Care	Los Angeles	Phone: **(951) 734-1300** Fax: **(951) 734-1800**	Adults only
Providence Trinity Care Kids	Los Angeles	Phone: **(800) 535-8446** Fax: **(424) 322-2857**	Adults and pediatric members
Roze Room (Juno DBA)	Sacramento	Phone: **(909) 332-6030** Fax: **(909) 708-4655**	Adults only
ProHealth Home Health and Hospice	Sacramento	Phone: **(916) 891-5072** or **(877) 246-3830** Fax: **(877) 867-1787**	Adults only
Snowline Hospice	Sacramento	Phone: **(916) 817-2338** Fax: **(916) 480-9283**	Adults only

Resources available on Molina's provider website

Featured online at **MolinaHealthcare.com:**

- Clinical practice and preventive health guidelines
- Health management programs
- Quality improvement programs
- Member rights and responsibilities
- Privacy notices
- Provider Manual
- Current formulary
- Diversity, equity and inclusion provider trainings

If you would like to receive any of the information posted on our website in a printed format, please call **(855) 322-4075.**

Translation services

MHC can provide information in our members' primary language. We can arrange an interpreter to help you speak with our members in almost any language. We also provide written materials in different languages and formats. If you need an interpreter or written materials in other languages or alternate format, please contact MHC at **(855) 322-4075**. You can also call TTD/TTY: 711 if a member has a hearing or speech disability.

Patient safety

Patient safety activities encompass appropriate safety projects and error avoidance for MHC members in collaboration with their PCPs.

The MHC patient safety activities address the following:

- Continued information about safe office practices
- Member education about members taking an active role in reducing the risk of errors in their care
- Member education about safe medication practices
- Diversity, equity and inclusion training
- Improvement in the continuity and coordination of care between providers to avoid miscommunication
- Improvement in the continuity and coordination between care sites, such as hospitals and other facilities, to ensure timely and accurate communication

MHC also monitors nationally recognized quality index ratings for facilities from:

- Leapfrog Quality Index Ratings (leapfroggroup.org)
- The Joint Commission Quality Check® (qualitycheck.org)

Providers also can access the following links for additional information on patient safety:

- The Leapfrog Group (leapfroggroup.org)
- The Joint Commission (jointcommission.org)

Care for older adults

Many adults over 65 have co-morbidities that often affect their quality of life. As this demographic ages, it's common to see decreased physical function and cognitive ability and increased pain. Regular assessment of these additional health aspects can help ensure that older adults' needs are appropriately met.

- **Advance care planning –** discussion regarding treatment preferences, such as advance directives, should start before the patient is seriously ill
- **Medication review –** the patient's medications should be reviewed, including prescriptions and over-the-counter or herbal therapies
- **Functional status assessment –** including assessments such as functional independence or loss of independent performance
- **Pain screening –** consisting of notating the presence or absence of pain

Providers should include these components in the standard well-care practice for older adults to help identify unrecognized ailments and increase their quality of life.

Hours of operation

MHC requires that providers offer our members hours of operation no less than hours offered to commercial members.

Non-discrimination

All providers joining the MHC provider network must comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS), the Office for Civil Rights (OCR), state law and federal program rules prohibiting discrimination. For additional information, please refer to:

- Medi-Cal: Member Evidence of Coverage (EOC), Member Handbook located at **MolinaHealthcare.com/members/ca/en-us/-/media/Molina/PublicWebsite/PDF/members/ca/en-us/Medi-Cal/2023-English-Spanish-EOC.pdf**
- Medicare: Member Evidence of Coverage (EOC), Member Handbook located at **MolinaHealthcare.com/members/ca/en-US/mem/medicare/plan-materials.aspx**
- Marketplace: Member Evidence of Coverage (EOC), Member Handbook located at **MolinaMarketplace.com/marketplace/ca/en-us/MemberForms.aspx**

Additionally, participating providers or contracted medical groups/Independent Physician Associations (IPAs) may not limit their practices because of a member's medical (physical or mental) condition or the expectation for frequent or high-cost care.

Member rights and responsibilities

MHC wants to inform its providers about some of the rights and responsibilities of MHC members.

MHC members have the right to:

- Receive information about MHC, its services, its practitioners and providers, and member rights and responsibilities
- Be treated with respect and recognition of their dignity and their right to privacy
- Help make decisions about their health care
- Participate with practitioners in making decisions about their health care
- A candid discussion of appropriate or medically necessary treatment options for their conditions – regardless of cost or benefit coverage
- Voice complaints or appeals about MHC or the care provided
- Make recommendations regarding MHC member rights and responsibilities policy

MHC members have the responsibility to:

- Supply information (to the extent possible) that MHC and its practitioners and providers need to provide care
- Follow plans and instructions for care that they have agreed to with their practitioners
- Understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- Keep appointments and be on time (If members are going to be late or cannot keep an appointment, they are instructed to call their practitioner)

You can find your state's complete **Member Rights and Responsibilities Statement** on our website at **MolinaHealthcare.com/members/ca/en-us/Pages/home.** Written copies and more information can be obtained by contacting Provider Contact Center at **(855) 322-4075.**

Population Health

(Health education, disease management, care management and complex case management)

The tools and services described here are educational support for our members. We may change them at any time necessary to meet our members' needs.

MHC offers programs to help our members and their families manage a diagnosed health condition or transition from one care setting to another or home. As a provider, you also help us identify members who may benefit from these programs. Members can request to be enrolled or disenrolled in these programs. Our programs include:

- Asthma management
- Diabetes management and prevention
- High blood pressure management
- Cardiovascular disease (CVD) management/congestive heart disease
- Chronic obstructive pulmonary disease (COPD) management
- Depression management
- High-risk obstetrician-gynecologist (OB/GYN) case management
- Transition of care (TOC)

MHC provides comprehensive maternal health programs and doula support services for pregnant and postpartum members. Through the Motherhood Matters program, members receive screenings and are offered pregnancy support and additional resources. Members identified as high-risk are referred to the high-risk OB program for specialized case management. Providers interested in learning more about our doula support services can contact us at **MHCDoulaSupport@MolinaHealthcare.com**.

Community health worker (CHW) services are available to most MHC Medi-Cal members without prior authorization. CHWs, non-licensed support individuals with lived experience, can provide health education, health navigation, support and advocacy and complete screening and assessments. Members are eligible if they are not currently enrolled in Enhanced Care Management. The CHW referral form can be found at **Community Health Worker (CHW) Member Referral form Molina Healthcare of California**.

Providers can check member enrollment in the CHW benefit by going to the Care Coordination portal in Availity and searching member name or Medi-Cal number. MHC is contracting with street medicine providers to deliver health and social services directly to individuals experiencing unsheltered homelessness in their lived environment.. Providers interested in becoming a designated street medicine provider or understanding more about this person-centered system of care can reach out to **CA_StreetMedicine@MolinaHealthcare.com.**

You can find more information about our programs online at **MolinaHealthcare.com/members/ca/en-us/Pages/home.**

If you have additional questions about our programs, please call Provider Contact Center at **(855) 322-4075** (TTY/TDD at 711 Relay).

Quality Improvement and Health Equity Transformation program

MHC's Quality Improvement and Health Equity Transformation (QIHET) program provides the structure and key processes that enable the health plan to carry out our commitment to ongoing improvement in members' health care and service. The QIHET committee assists the organization in achieving these goals. It is an evolving program responsive to the changing needs of MHC's members and the standards established by the medical community and regulatory and accrediting bodies.

The key quality processes include but are not limited to:

- Implementation of programs and processes to improve members' outcomes and health status
- Collaboration with our contracted provider network to identify relevant care processes, develop tools and design meaningful measurement methodologies for provided care and service
- Evaluation of the effectiveness of programs, interventions and process improvements and determination of further actions
- Design of effective and value-added interventions
- Continuous monitoring of performance parameters and comparing to performance standards and benchmarks published by national, regional or state regulators, accrediting organizations and internal MHC thresholds
- Analysis of information and data to identify trends and opportunities and the appropriateness of care and services
- Oversight and improvement of functions that may be delegated: claims, UM and/or credentialing
- Confirmation of the quality and adequacy of the provider and health delivery organization network through appropriate contracting and credentialing processes

The QIHET program promotes and fosters accountability of employees, networks and affiliated health personnel for the quality and safety of care and services provided to MHC members.

The effectiveness of QIHET program activities in producing measurable improvements in the care and service provided to members is evaluated by:

- Organizing multi-disciplinary teams – including clinical experts – to analyze service and process improvement opportunities, determine actions for improvement and evaluate results
- Tracking the progress of quality activities and goals through appropriate quality committee minutes and reviewing/updating the quality work plan quarterly
- Revising interventions based on analysis when indicated
- Evaluating member satisfaction with their experience of care through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey
- Reviewing member satisfaction with their experience with behavioral health services through survey questions and/or evaluation of behavioral health-specific complaints and appeals
- Conducting provider satisfaction surveys with specific questions about the UM process, such as determining the level of satisfaction with getting a service approved, obtaining a referral and case management

MHC would like to help you promote the important care activities you have undertaken in your practices. If you would like to have your projects and programs highlighted on the MHC website, please contact the QI department at **(888) 665-4623.**

If you want more information about our QIHET program or initiatives and the progress toward meeting quality goals, you can visit our website at **MolinaHealthcare.com/members/ca/en-us/Pages/home** and access the **Health Resources** area on our provider website pages. If you would like to request a paper copy of our documents, please call the QI department at **(888) 665-4623.**

Standards for medical record documentation

MHC has established medical record documentation standards to help assure our members' highest quality of care. Medical record standards promote quality care through communication, coordination and continuity of care and efficient and effective treatment.

MHC's medical record documentation standards include:

- Medical record content
- Medical record organization
- Information filed in medical records
- Ease of retrieving medical records
- Confidential patient information
- Standards and performance goals for participating providers

Below are commonly accepted standards for documentation in medical records and must be included in each medical record:

- History and physicals
- Allergies and adverse reactions
- Problem list
- Medications
- Documentation of clinical findings and evaluation for each visit
- Preventive services/risk screening

For more information, please call the QI department at **(888) 665-4623.**

Preventive health guidelines

Preventive health guidelines can be beneficial to providers and our members. Guidelines are based on scientific evidence, a review of the medical literature or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations.

These guidelines are meant to recommend a standard level of care and do not preclude the delivery of additional preventive services based on the member's needs.

You can also view all guidelines at **MolinaHealthcare.com/members/ca/en-us/Pages/home** by accessing the **Health Resources** section within our provider web pages. To request printed copies of preventive health guidelines, please contact Provider Contact Center at **(855) 322-4075.**

Clinical practice guidelines

Clinical practice guidelines are based on scientific evidence, a review of the medical literature or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations. The care recommendations are suggested as guides for making clinical decisions. Providers and our members must work together to develop individual treatment plans tailored to each member's needs and circumstances.

MHC has adopted the following Clinical Practice and Behavioral Health Guidelines, which include but are not limited to:

- Acute stress and post-traumatic stress disorder (PTSD)
- Anxiety/panic disorder
- Asthma
- Attention deficit hyperactivity disorder (ADHD)
- Autism
- Bipolar disorder
- Children with special health care needs
- Chronic kidney disease
- Chronic obstructive pulmonary disease
- Depression
- Diabetes
- Heart failure in adults
- Homelessness – special health care needs
- Hypertension
- Obesity
- Opioid management
- Perinatal care
- Pregnancy management
- Schizophrenia
- Sickle cell disease
- Substance use disorder (SUD)
- Suicide risk
- Trauma-informed primary care

You can also view all guidelines online at **MolinaHealthcare.com/members/ca/en-us/Pages/home** in the **Health Resources** section of the provider website. To request a copy of any guidelines, please contact Provider Contact Center at **(855) 322-4075.**

Advance directives

Advance care planning (ACP) is an ongoing process in which people explore and discuss their goals, values and understanding of their health to guide future treatment decisions. Providers can assist members in preparing an advance directive. Anyone 18 or older can have an advance directive, including a living will and a durable power of attorney.

A living will is written instruction explaining the wishes of a MHC member regarding health care in the case of a terminal illness or any medical procedures that can prolong life. A durable power of attorney names a person to make decisions for our members if they cannot.

The following links provide free forms and information to help create an advance directive:

- **caringinfo.org**
- **nlm.nih.gov/medlineplus/advancedirectives.html**

Members will need two witnesses for the living will document and valid notarization for the durable power of attorney document.

An advance directive must be honored to the fullest extent permitted under law. Providers should discuss advance directives and provide appropriate medical advice if the member desires guidance or assistance, including any objections they may have to a directive before service whenever possible. Providers cannot refuse treatment or otherwise discriminate against members because they completed an advance directive. Members have the right to file a complaint if they are dissatisfied with the handling of an advance directive and/or if there is a failure to comply with advance directive instructions.

Providers should put a copy of the completed form in a prominent medical record section. The medical record should also document if a member chooses not to execute an advance directive. Providers should inform members that advance care planning is a part of good health care.

Behavioral health

PCPs provide outpatient behavioral health services by coordinating their practice's scope and coordinating members' physical and behavioral health care.

Behavioral health services are a direct access benefit and are available with no referral required; however, PCPs are responsible for coordinating a referral if needed. If you or the member need assistance with obtaining behavioral health services, please contact Member Services at **(888) 665-4621.** Our 24-hour Nurse Advice Line is also available to members 24 hours a day, 7 days a week, 365 days per year for mental health or substance use disorder. The services received will be confidential.

Providers may refer to the MHC Behavioral Health Toolkit for providers online under the **Health Resources** tab at **MolinaHealthcare.com/members/ca/en-us/Pages/home** for additional clinical guidance, recommendations and training/education opportunities related to behavioral health conditions.

Care coordination and transitions

Coordination of care during planned and unplanned transitions for MHC members

MHC is dedicated to providing quality care for our members during planned or unplanned transitions. A transition is when members move from one setting to another, such as when a member is discharged from a hospital. By working with providers, MHC makes a special effort to coordinate care during transitions to avoid potential adverse outcomes.

MHC has resources to assist you in easing the challenge of coordinating patient care. Our staff – including nurses – can work with all parties to ensure appropriate care.

To appropriately coordinate care, we'll need the following information in writing from the facility *within one business day* of the transition from one setting to another:

- Discharge plan when the member is transferred to another setting
- A copy of the member's discharge instructions when discharged to home

This information should be faxed to MHC at:

- UM department: **(866) 553-9623**
- Member Services: **(800) 811-4804 (TTY/TDD: 711)**

Health Risk Assessment and self-management tools

We provide members with a Health Risk Assessment (health appraisal) on the My Molina® member portal. Our members are asked questions about their health and behaviors and receive a report about possible health risks. A self-management tool is also available to offer guidance for weight management, depression, financial wellness and various other topics. Members can access these tools online at **MyMolina.com.**

Initial Health Appointment (IHA) for children, adults and seniors

New members must receive a comprehensive Initial Health Appointment (IHA) by a provider within the primary care medical setting within the first 120 days of enrollment with Molina, or within periodic timelines established by the American Academy of Pediatrics for ages two and younger whichever is less, in accordance with regulatory requirements and increased focus from the California Department of Health Care Services.

The IHA requirement can be completed over the course of multiple visits. Telehealth visits can be an option for completing one or more components of the IHArequirement, but not all of the requirement.

The IHA is not required if the member's PCP determines that the member's medical record contains complete information within the previous 12 months. This information must be assessed by the PCP during the first 120 days of member enrollment. The conclusion of the PCP's assessment must be documented in the member's medical record. Additional reasons for not completing an IHA include:

- Member disenrolled before 120 days
- Member refuses IHA
- Reasonable attempts to contact the member were unsuccessful. All attempts should be documented in the member's medical record.

An IHA must include all of the following:

- A history of the member's physical and mental health
- An identification of risks
- An assessment of the need for preventive screens or services
- Health education
- Diagnosis and plan for treatment of any disease
- Dental exam (all ages)
- Dental referral (for age 3 to < 21 only)

For additional information about the IHA, call the QI department at **(888) 665-4623.**