PROVIDER NEWSLETTER

A newsletter for Molina Healthcare of WA Provider Networks

Second Quarter 2019

In this Issue

Important Message – Updating Provider Information

It is important for Molina Healthcare of Washington (Molina Healthcare) to keep our provider network information up to date. Up to date provider information allows Molina Healthcare to accurately generate provider directories, process claims and communicate with our network of providers. Providers must notify Molina Healthcare in writing at least 30 days in advance when possible of changes, such as:

- Change in practice ownership or Federal Tax ID number
- Practice name change
- A change in practice address, phone or fax numbers
- Change in practice office hours
- New office site location
- Primary Care Providers Only: If your practice is open or closed to new patients

- When a provider joins or leaves the practice

Changes should be submitted on the "Provider Information Change Form" located on the Molina website at MolinaHealthcare.com under the Provider Forms section.

Send changes to:
Email: MHWProviderInfo@MolinaHealthcare.com
Mail: Molina Healthcare of Washington
PO Box 4004
Bothell, WA 98041-4004
ATTN: Provider Information

Practitioner Credentialing Rights: What You Need to Know

Molina Healthcare has a duty to protect its members by assuring the care they receive is of the highest quality. One protection is assurance that our providers have been credentialed according to the strict standards established by the state regulators and accrediting organizations. Your responsibility, as a Molina Healthcare provider, includes full disclosure of all issues and timely submission of all credentialing and re-credentialing information.

Molina Healthcare also has a responsibility to its providers to assure the credentialing information it reviews is complete and accurate. As a Molina Healthcare 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 is submitted by you
- Review information submitted from outside primary sources (e.g., malpractice insurance carriers, state licensing boards) to support your credentialing application, with the exception of references, recommendations or other peer-review protected information
- Correct erroneous information
- Be informed of the status of your application upon request by calling the Credentialing Department at (800) 423-9899
- Receive notification of the credentialing decision within 60 days of the committee decision
- Receive notification of your rights as a provider to appeal an adverse decision made by the committee
- Be informed of the above rights

For further details on all your rights as a Molina Healthcare provider, please review your Provider Manual. You may also review the provider manual on our website at MolinaHealthcare.com or call your Provider Services Representative for more details.

Molina Healthcare's Utilization Management

One of the goals of Molina Healthcare's Utilization Management (UM) department is to render appropriate UM decisions that are consistent with objective clinical evidence. To achieve that goal, Molina Healthcare maintains the following guidelines:

- Medical information received by our providers is evaluated by our highly trained UM staff against nationally recognized objective and evidence-based criteria. We also take individual circumstances and the local delivery system into account when determining the medical appropriateness of requested health care services.

- Molina Healthcare's clinical criteria includes McKesson InterQual® criteria, MCG (formerly Milliman Care Guidelines), Health Technology Assessment (HTA), Hayes Directory, Medicare National and Local Coverage Determinations, applicable Medicaid Guidelines, Molina Medical Coverage Guidance Documents (developed by designated Corporate Medical Affairs staff in conjunction with Molina Healthcare physicians serving on the Medical Coverage Guidance Committee) and when appropriate, third party (outside) board-certified physician reviewers.

- Molina Healthcare ensures that all criteria used for UM decision-making are available to practitioners upon request. **To obtain a copy of the UM criteria guideline(s) used in the decision-making process, call our UM Department at (800) 869-7175.**

- As the requesting practitioner, you will receive written notification of all UM adverse benefit determinations. The notification will include the name and telephone number of the Molina Healthcare physician that made the decision. Please feel free to call him or her to discuss the case. If you need assistance contacting a medical reviewer about a case, please call the UM Department at (800) 869-7175.

It is important to remember that:

1. UM decision-making is based only on appropriateness of care and service and existence of coverage.
2. Molina Healthcare does not specifically reward practitioners or other individuals for issuing adverse benefit determinations of coverage or care.
3. UM decision makers do not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.
4. Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage.
5. Medicaid members have the right to a second opinion from a qualified practitioner. If an appropriate practitioner is not available in-network, Molina Healthcare will arrange for a member to obtain the second opinion out of network at no additional cost to the member than if the services were obtained in-network.
6. Some of the most common reasons for a delay in decision or an adverse benefit determination decision 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
    - Request for an urgent review when there is no medical urgency

Molina Healthcare'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 member of the UM staff, please call (800) 869-7185. You may also fax a question about a UM issue to (800) 767-7188. The Medical Director is available for more complex medical decision questions and explanations of medical necessity denials. For information about pre-authorization and the exception process, please refer to the *Drug Formulary and Pharmaceutical Procedures* article.

Molina Healthcare's regular business hours are Monday – Friday (excluding holidays), 7:30 a.m. – 6:30 p.m. Voicemail messages and faxes received after regular business hours will be returned the following business day. Molina Healthcare has language assistance and TDD/TTY services for members with language barriers or with hearing and/or speech problems.

Drug Formulary and Pharmaceutical Procedures

At Molina Healthcare, the Drug Formulary (sometimes referred to as a Preferred Drug List, or PDL) and pharmaceutical procedures are maintained by the Pharmacy and Therapeutics (P&T) Committee. This committee usually meets on a quarterly basis or more frequently if needed. It is composed of your peers – practicing physicians (both primary care physicians and specialists) and pharmacists. The committee's goal is to provide a safe, effective and comprehensive Drug Formulary/PDL. The P&T Committee evaluates all therapeutic categories and selects the most cost-effective agent(s) in each class. In addition, the committee reviews prior authorization procedures to ensure that medications are used safely, and in accordance with the manufacturer's guidelines and FDA-approved indications. The committee also evaluates and addresses new developments in pharmaceuticals and new applications of established technologies, including drugs. Molina Healthcare has two PDLs; one is for over-the-counter (non-prescription drugs) and the other is for prescription drugs.

Medications prescribed for Molina Healthcare members must be listed in the Drug Formulary/PDL. The Drug Formulary/PDL also includes an explanation of limits or quotas, any restrictions and medication preferences, and the process for generic substitution, therapeutic interchange and step-therapy protocols. Select medications listed on the Drug Formulary/PDL may require prior authorization, as well as any medication not found on the listing. When there is a medically necessary indication for an exception, such as failure of the formulary choices, providers may request authorization by submitting, via fax, a Medication Prior Authorization Form or by calling the Pharmacy Prior Authorization Department for the plan. The Drug Formulary/PDL is available online at MolinaHealthcare.com and printed copies may be obtained by calling the Provider Services Department at (800) 869-7175.

The Drug Formulary/PDL, processes for requesting an exception request and generic substitutions, therapeutic interchanges and step-therapy protocols are distributed to our network providers through fax and/or mail once updates are made. These changes and all current documents are posted on the Molina Healthcare website at MolinaHealthcare.com.

When there is a Class II recall or voluntary drug withdrawal from the market for safety reasons, affected members and prescribing practitioners are notified by Molina Healthcare within 30 calendar days of the Food and Drug Administration notification. An expedited process is in place to ensure notification to affected members and prescribing practitioners of Class I recalls as quickly as possible. These notifications will be conducted by fax, mail and/or telephone.

Case Management

Molina Healthcare offers you and your patients the opportunity to participate in our Case Management Program. Patients appropriate for this voluntary program are those who have complex service needs. This may include your patients with multiple medical conditions, high level of dependence, conditions that require care from multiple specialties and/or who have additional social, psychosocial, psychological and emotional issues that exacerbate the condition, treatment regime and/or discharge plan.

The purpose of the Molina Healthcare Case Management Program is to:

- Conduct a needs assessment of the patient, 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 in a timely manner
- Provide a comprehensive and ongoing care plan for continuity of care in coordination with you, your staff, your patient, and the patient's family

If you would like to learn more about this program, speak with a Case Manager and/or refer a patient for an evaluation for this program, please call (800) 869-7175.

Disease Management and Prevention

Molina's Disease Management program currently offers support to Molina members diagnosed with prediabetes, diabetes, asthma, hypertension, obesity, coronary artery disease (CAD) and congestive heart failure (CHF). The goals of this program are to work directly with you and your Molina patient to prevent the onset of chronic disease or stabilize existing disease. In practical terms, our Disease Management clinical staff can help:

- Reinforce and supplement the information you provide your Molina patient
- Improve medical compliance and management efforts
- Patients make healthy lifestyle changes and stay on track with their health-related goals
- Remove barriers to care and refer Molina patients to needed services
- Partner with you in developing, implementing and updating a care plan
- Provide you with updates on your patient's progress, areas of concern, and/or problems identified
- Offer smoking cessation services and incentives to support healthy behaviors

We understand resources for supporting patients in these ways may be limited. That is why we offer this voluntary program FREE OF CHARGE and welcome the opportunity to support you in caring for your Molina patient.

To refer your Molina patient to this program, please complete and fax a Care Management referral form (available on our Provider Portal at MolinaHealthcare.com/providers/wa/Medicaid/forms/Pages/fuf.aspx) or call us directly at (425) 424-7121. Please be sure to provide the name and DOB of your patient, and a few details outlining the needs of your patient.

We look forward to working with you in keeping your Molina patients healthy!

At each point of contact, members are encouraged to discuss their care with their provider and follow their plan of treatment. Other services available to members include having access to the 24-hour Nurse Advice Line at (888) 275-8750. Members can call and speak to a nurse for advice on any health problems.

Website

Featured at MolinaHealthcare.com:

- Clinical Practice and Preventive Health Guidelines
- Health Management Programs for Asthma, Diabetes, Hypertension, CAD, CHF & Pregnancy
- Quality Improvement Programs
- Member Rights & Responsibilities
- Privacy Notices
- Claims/Denials Decision Information
- Provider Manual
- Current Formulary & Updates
- Pharmaceutical Management Procedures
- UM Affirmative Statement (re: non-incentive for underutilization)
- How to Obtain Copies of UM Criteria
- How to Contact UM Staff & Medical Reviewer
- New Technology
- How to access language services

If you would like to receive any of the information posted on our website in hard copy, please call (800) 869-7175.

Translation Services

We can provide information in our members' primary language. We also provide written materials in different languages and formats. If you need an interpreter or written materials in a language other than English, please contact Molina's Member Services Department at (800) 869-7175. 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 Molina Healthcare members in collaboration with their primary care providers.

Safe Clinical Practice

The Molina Healthcare Patient Safety activities address the following:

- Continued information about safe office practices
- Member education; providing support for members to take an active role to reduce the risk of errors in their own care

- Member education about safe medication practices
- Cultural competency training
- Improvement in the continuity and coordination of care between providers to avoid miscommunication
- Improvement in the continuity and coordination between sites of care such as hospitals and other facilities to assure timely and accurate communication
- Distribution of research on proven safe clinical practices

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

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

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

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

Care for Older Adults

Many adults over the age of 65 have comorbidities that often affect their quality of life. As this population ages, it's not uncommon to see decreased physical function and cognitive ability, and increase in pain. Regular assessment of these additional health aspects can help to ensure this population's needs are appropriately met.

- **Advance care planning** – Discussion regarding treatment preferences, such as Advance Directives, should start early before patient is seriously ill.
- **Medication review** – All medications that the patient is taking should be reviewed, including prescription and over-the-counter medications or herbal therapies.
- **Functional status assessment** – This can include assessments, such as functional independence or loss of independent performance.
- **Pain screening** - A screening may comprise of notation of the presence or absence of pain.

Including these components into your standard well care practice for older adults can help to identify ailments that can often go unrecognized and increase their quality of life.

Hours of Operation

Molina Healthcare requires that providers offer Medicaid patient hours of operation no less than hours offered to commercial patients.

Non-Discrimination

As a Molina provider, you have a responsibility to not differentiate or discriminate in providing covered services to members because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, socioeconomic status, or participation in publicly financed health care programs. Providers are to render covered services to patients in the same location, in the same manner, in accordance with the same standards and within the same time availability regardless of payer.

Member Rights and Responsibilities

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

Molina Healthcare members have the right to:

- Receive information about Molina Healthcare, 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 Molina Healthcare or the care it provides.
- Make recommendations regarding Molina Healthcare's member rights and responsibilities policy.

Molina Healthcare members have the responsibility to:

- Supply information (to the extent possible) that Molina Healthcare and its practitioners and providers need in order 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 the complete Molina Healthcare Member Rights and Responsibilities statement for your state at our website (MolinaHealthcare.com). Written copies and more information can be obtained by contacting the Provider Services Department at (800) 869-7175.

Quality Improvement Program

The Molina Healthcare Quality Improvement Program (QIP) 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 Quality Improvement Committee (QIC) assists the organization to achieve these goals. It is an evolving program that is responsive to the changing needs of the health plan's customers and the standards established by the medical community, 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 Molina Healthcare threshold
- 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 QIP promotes and fosters accountability of employees, network and affiliated health personnel for the quality and safety of care and services provided to Molina Healthcare members.

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

- Organizing multidisciplinary 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 QI work plan quarterly.
- Revising interventions based on analysis, when indicated.
- Evaluating member satisfaction with their experience of care through the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey.

- Reviewing member satisfaction with their experience with behavioral health services through a focused survey and 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.

Molina Healthcare would like to help you to promote the important care activities you have undertaken in your practices. If you would like to have your projects and programs highlighted on the Molina Healthcare website, please contact the Quality Improvement Health Education Line at (800) 423-9899, ext. 141428.

If you would like more information about our Quality Improvement Program or initiatives and the progress toward meeting quality goals, please call the Quality Improvement Department at (888) 562-5442, ext. 147181. You can also visit our website at MolinaHealthcare.com to obtain more information.

Standards for Medical Record Documentation

Providing quality care to our members is important; therefore, Molina Healthcare has established standards for medical record documentation to help assure the highest quality of care. Medical record standards promote quality care though communication, coordination and continuity of care, and efficient and effective treatment.

Molina Healthcare'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 Credentialing Department at (800) 423-9899.

Preventive Health Guidelines

Preventive Health Guidelines can be beneficial to the provider and his/her patients. Guidelines are based on scientific evidence, 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 depending on the individual needs of the patient.

To request printed copies of Preventive Health Guidelines, please contact the Quality Improvement Department at (888) 562-5442, ext. 147181. You can also view all guidelines at MolinaHealthcare.com.

Clinical Practice Guidelines

Clinical practice guidelines are based on scientific evidence, 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 recommendations for care are suggested as guides for making clinical decisions. Clinicians and their patients must work together to develop individual treatment plans that are tailored to the specific needs and circumstances of each patient.

Molina Healthcare has adopted the following Clinical Practice Guidelines, which include but are not limited to:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Asthma
- Depression
- Diabetes
- Hypertension
- Chronic Obstructive Pulmonary Disease (COPD)

To request a copy of any guideline, please contact Molina Healthcare's Provider Services Department at (801) 542-7914. You can also view all guidelines at MolinaHealthcare.com.

Advance Directives

Helping your patients prepare Advance Directives may not be as hard as you think. Any person 18 years or older can create an Advance Directive. Advance Directives include a living will document and a durable power of attorney document.

A living will is written instruction that explains your patient's wishes regarding health care in the case of a terminal illness or any medical procedures that prolong life. A durable power of attorney names a person to make decisions for your patient if he or she becomes unable to do so.

The following links provide you and your patients with free forms to help create an Advance Directive:
nlm.nih.gov/medlineplus/advancedirectives.html
order.nia.nih.gov/sites/default/files/2017-07/End_of_Life_508.pdf
aging.utah.edu/programs/utah-coa/directives/
caringinfo.org

For the living will document, your patient will need two witnesses. For a durable power of attorney document, your patient will need valid notarization.

A patient's Advance Directive must be honored to the fullest extent permitted under law. Providers should discuss Advance Directives and provide appropriate medical advice if the patient desires guidance or assistance, including any objections they may have to a patient directive prior to service

whenever possible. In no event may any provider refuse to treat a patient or otherwise discriminate against a patient because the patient has completed an Advance Directive. Patients 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.

It is helpful to have materials available for patients to take and review at their convenience. Be sure to put a copy of the completed form in a prominent section of the medical record. The medical record should also document if a patient chooses not to execute an Advance Directive. Let your patients know that advance care planning is a part of good health care.

Behavioral Health

Primary Care Providers provide outpatient behavioral health services, within the scope of their practice, and are responsible for coordinating members' physical and behavioral health care, including making referrals to Behavioral Health providers when necessary. If you need assistance with the referral process for Behavioral Health services, please contact Member Services at (800) 869-7165.

Care Coordination & Transitions

Coordination of Care during Planned and Unplanned Transitions for Medicare Members

Molina Medicare 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 Molina member is discharged from a hospital. By working together with providers, Molina makes a special effort to coordinate care during transitions. This coordination of specific aspects of the member's transition is performed to avoid potential adverse outcomes.

To ease the challenge of coordinating patient care, Molina has resources to assist you. Our Utilization Management nurses, Care Management team, and Member Services staff are available to work with all parties to ensure appropriate care. In addition, Molina has hospital-based Transition of Care nurses at our high-volume hospitals to meet our members face-to-face. Our nurses will work with the hospital's case management and discharge planning teams to determine if there are any barriers to a safe discharge to the next level of care.

In order to appropriately coordinate care, Molina Medicare will need the following information in writing from the facility *within one business day* of the transition from one setting to another:

- Initial notification of admission within 24 hours of the admission
- Discharge plan when the member will be transferred to another setting
- A copy of the member's discharge instructions

This information can be faxed to Molina at: (800) 767-7188

To assist with the discharge planning of Molina Medicare members, please note the following important phone numbers:

- **Medicare Member Services & Pharmacy:** (800) 665-1029

- **Behavioral health services and substance abuse treatment** for Molina Medicare members can be arranged by contacting: (800) 665-1029
- **Transportation services** for Molina Medicare Options Plus members may be arranged by calling **Secure Transportation at: (844) 368-1502**
- The **Nurse Advice Line** is available to members 24 hours a day, 7 days a week at: (888) 275-8750 (TTY: 711)

Important information you need to know about Molina Medicare Options Plus:

- All beneficiaries have rights that are defined in our provider manual. They are also available in the member EOC posted on our website at **MolinaHealthcare.com/Medicare**.
- Molina Medicare Options Plus members have Medicare and Medicaid benefits designed to meet their special needs, therefore the state agency or its designated health plans have the responsibility for coordinating care, benefits and co-payments. Please be aware of your patients' status and Medicaid benefits and bill the correct entity.
- Health plans and providers can never charge these members more than they would have paid under Original Medicare and Medicaid. Members can also call the Medicaid agency for details and have specific rights with regard to their Medicaid benefits.
- Providers are responsible for verifying eligibility and obtaining approval for services that require prior authorization as outlined in the Provider contract. Our Medicare Member Services department can assist you in this regard.

Please contact the UM Department or Medicare Member Services if you have questions regarding planned or unplanned transitions at:

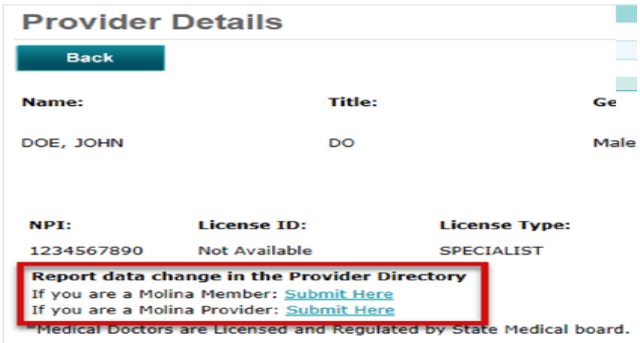
UM Department: (800) 745-4044

Member Services: (800) 665-1029

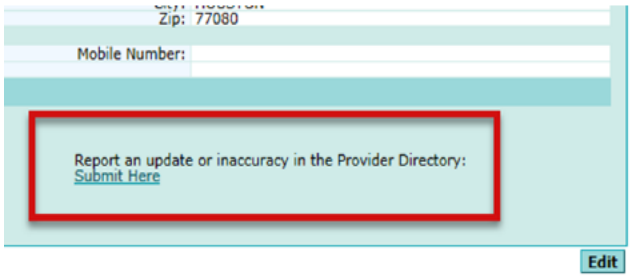
Provider Portal Corner

We improved the way you can report a data change to us. The new feature allows a Provider or Member to submit demographic corrections directly to Molina.

Online Correction Locations:



POD – Search Details page



Provider Portal