MOLINA® HEALTHCARE

Provider Services
PO Box 242480
Milwaukee, WI 53224-9931

Looking Ahead:

Molina's Provider Web Portal is an easy-to-use, online tool designed to meet your needs! All Molina Providers have access to our portal.

Register for our Provider Web Portal Today.

Visit our website at MolinaHealthcare.com

MolinaHealthcare.com

MOLINA® HEALTHCARE
Your Extended Family.

Table of Contents

All newsletters available at MolinaHealthcare.com.

Model of Care

The 2019 Model of Care Provider Training materials are now available on MolinaHealthcare.com. This training complies with the Centers for Medicare and Medicaid Services (CMS) requirement that contracted providers who have been identified as directly or indirectly facilitating and/or providing Medicare Part C or D benefits for any Molina Healthcare Medicare and/or MMP Members complete both an initial training and an annual Model of Care training. In order to ensure Molina Healthcare remains compliant with CMS Regulatory Requirements for Model of Care training, receipt of your completed Attestation Form is due to Molina Healthcare no later than Nov. 1, 2019.

Provider Training material can be found on the Molina Medicare website under Molina Healthcare Model of Care or through the following link:

Provider Training material can be found on the Molina Medicare website under Molina Healthcare Model of Care or through the following link:
https://www.MolinaHealthcare.com/providers/common/medicare/PDF/2019-MOC-Provider-Training.pdf

For a copy of the MOC Attestation, visit the Molina Medicare website at:
https://www.MolinaHealthcare.com/providers/common/medicare/PDF/model-of-care-wi-2019.pdf

If you have questions, contact your local Molina Healthcare Provider Services Representative at WIProviderEngagement@MolinaHealthcare.com

Submitting Electronic Data Interchange (EDI) claims

Molina Healthcare of Wisconsin requires network providers to enroll in our e-solutions. There are many benefits to using EDI:

- Electronic Claims Submission ensure HIPAA compliance
- Electronic Claims Submission helps to reduce operational costs associated with paper claims, such as printing, postage, etc.
- Electronic Claims Submission increases accuracy of data and efficient information delivery
- Electronic Claims Submission reduces claim delays since errors can be corrected and resubmitted electronically!
- Electronic Claims Submission eliminates mailing time, and claims reach Molina faster!

MolinaHealthcare.com

EDI Claims Submission

The easiest way to submit EDI claims to Molina Healthcare is through a Clearinghouse. You may submit the EDI through your own Clearinghouse or use Molina's contracted Clearinghouse, Change Healthcare. If you do not have or use a Clearinghouse, Molina offers additional electronic claims submissions options. Log onto Molina's Provider Services Web Portal https://provider.MolinaHealthcare.com, for additional information about the claims' submission options available to you.

FAQs

- Can I submit COB claims electronically?
    - Yes, Molina and our connected Clearinghouses fully support electronic COB.
- Do I need to submit a certain volume of claims to send EDI?
    - No, any number of claims via EDI saves both time and money.
- Which Clearinghouses are currently available to submit EDI claims to Molina?
    - Molina Healthcare uses Change Healthcare as our channel partner for EDI claims. You may use the Clearinghouse of your choice. Change Healthcare partners with hundreds of other Clearinghouses.
- What claims transactions are currently accepted for EDI transmission?
    - 837P (Professional claims), 837I (Institutional claims).
- Will you continue to accept paper claims?
    - While Molina requires all providers to utilize EDI claims submission options, there are certain circumstances where exceptions may be made. For more information contact your Provider Services Representative.
- What if I still have questions?
    - More information is available at molinahealthcare.com under the EDI tab.

MolinaHealthcare.com

Electronic Fund Transfer (EFT)

Molina has partnered with our payment vendor, ProviderNet, for Electronic Funds Transfer and Electronic Remittance Advice. Access to the ProviderNet portal is FREE to our participating providers. We encourage you to register after receiving your first check from Molina.

EFT allows for fater access to your payments!

New ProviderNet User Registration:

1. Go to https://providernet.adminisource.com
2. Click "Register"
3. Accept the Terms
4. Verify your information
   a. Select Molina Healthcare from Payers list
   b. Enter your primary NPI
   c. Enter your primary Tax ID
   d. Enter recent claim and/or check number associated with this Tax ID and Molina Healthcare
5. Enter your User Account Information
   a. Use your email address as user name
   b. Strong passwords are enforced (8 or more characters consisting of letters/numbers)
6. Verify: contact information; bank account information; payment address
   a. Note: Any changes to payment address may interrupt the EFT process.
   b. Add any additional payment addresses, accounts, and Tax IDs once you have logged in.

If you are associated with a Clearinghouse:

1. Go to "Connectivity" and click the "Clearinghouses" tab
2. Select the Tax ID for which this clearinghouse applies
3. Select a Clearinghouse (if applicable, enter your Trading Partner ID)
4. Select the File Types you would like to send to this clearinghouse and click "Save"

If you are a registered ProviderNet user:

1. Log in to ProviderNet and click "Provider Info"
2. Click "Add Payer" and select Molina Healthcare from the Payers list
3. Enter recent check number associated with your primary Tax ID and Molina Healthcare

BENEFITS

- Administrative rights to sign-up/manage your own EFT Account
- Ability to associate new providers within your organization to receive EFT/835s
- View/print/save PDF versions of your Explanation of Payment (EOP)
- Historical EOP search by various methods (i.e. Claim Number, Member Name)
- Ability to route files to your ftp and/or associated Clearinghouse

If a provider has questions regarding the actual registration process, they can contact ProviderNet at: (877) 389-1160 or email: wco.provider.registration@changehealthcare.com.

Note: Providers ensure you are registered for EFT for all participating Lines of Business.

Are you culturally competent?

Cultural and linguistic competency is the ability to provide respectful and responsive care to members with diverse values, beliefs and behaviors, including tailoring health care delivery to meet members' social, cultural and linguistic needs. The National CLAS Standards, developed by the Health and Human Services Office of Minority Health, aim to improve health care quality and advance health equity by establishing a collective set of mandates and guidelines that in form, guide and facilitate culturally and linguistically appropriate services.

Communicating Across Cultures

Clear communication is the foundation of culturally and linguistically competent care.

MolinaHealthcare.com

Guiding the conversation

- Initial greetings can set the tone for an interaction. If the patient's preference is not clear, ask how they would like to be addressed (i.e. Mr. Jones, Michael, Ms. Gonzalez).
- Ask open-ended questions whenever possible.
- Some individuals can tell you more about themselves through storytelling than by answering direct questions.
- Inquire about preferred language and preferred method of communication (i.e. written, spoken, graphics, sign language, assistive listening devices, etc.).
- Consider treatment plans with respect to the patient's culture-based beliefs about health.
- Ask about any complimentary or alternative medicine possibly used by the patient.

Assisting patients whose first language is not English

- Speak slowly and try not to raise your voice
- Use simple words and avoid jargon
- Do not use acronyms, idioms and avoid technical language if possible. (i.e. shot vs. injection)
- Articulate words
- Give information in small chunks and short sentences
- Repeat important information and have the patient repeat information back to you
- Inform the interpreter of any specific patient needs
- Hold a brief introductory discussion
- Reassure the patient about confidentiality
- Allow enough time for the interpreted sessions
- Avoid interrupting during interpretation
- Speak in the first person
- Talk to the patient directly, rather than addressing the interpreter

Remember it is never permissible to ask a minor, family member or friend to interpret.

Molina's language access services

Molina strives to ensure good communication with members by providing language access services. Providing language access services is a legal requirement for health care systems that are recipients of federal funds. A member cannot be refused services due to language barriers. Language access services ensure mutual understanding of illness and treatment, increase patient satisfaction and improve the quality of health care for

Limited English proficiency patients.

Molina provides the following services to members at no cost, when needed:

- Written material in other formats (i.e. large print, audio, accessible electronic formats, braille)
- Written material translated into languages other than English
    - Oral and Sign Language Interpreter Services
    - Relay Service (711)
    - 24-Hour Nurse Advice Line
    - Bilingual/Bicultural Staff

Molina's materials are always written simply in plain language and at required reading levels. For more information on Molina's language access services or cultural competency resources, contact Provider Services or visit MolinaHealthcare.com.

Sources:
U.S. Department of Health & Human Services: Office of Minority Health. Health Research & Educational Trust, 2013. Industry Collaboration Effort, Better Communication, Better Care: Provider Tools to Care for Diverse Populations. Industry Collaboration Effort, Cultural and Linguistic Services, 2017.

Is your authorization request urgent?

CMS defines expedited/urgent authorization requests as - "applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function."

Impacts of submitting urgent requests and ensuring understanding of guidelines associated with submitting a routine/non-urgent vs urgent request through targeted education. Providers are to be advised of the following:

- Urgent/Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition will be handled as routine non-urgent.
- Priority is based on turnaround time and then order of receipt.
- Molina Healthcare's typical turnaround time is 72 hours for urgent and 14 days for standard, however this could vary based on state and line of business.

Provider Portal Corner

New Feature! Provider Online Directory Provider Portal

Providers and members are now able to quickly and easily report single corrections to the Provider Online

MolinaHealthcare.com

Directory or Provider Portal online. This new feature allows providers and members to submit demographic corrections directly to Molina. Review the details of this exciting update here!

Corrected Claim requirements

Molina Healthcare considers corrected claims as new claims for processing purposes. Corrected claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Molina's Provider Portal includes functionality to submit corrected Institutional and Professional claims. Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct re-submission code for an 837P.

When submitting corrected claims to Molina Healthcare, follow these billing requirements:

- Always submit through the Web Portal or electronically.
- The original claim number must be included, or the claim will be denied.
- **Do not** submit corrected claims through the claims reconsideration process.
- Always include the original claim in its entirety with the corrections made.

Claims submitted without the correct coding will be denied.

New codes requiring Prior-Authorization that became effective April 2019

Take time to review the codes below. These codes became effective April 1, 2019 and prior authorization is required.

NEW PA required codes below:

0509T, 0510T, 0511T, 0512T, 0513T, 0514T, 0515T, 0516T, 0517T, 0518T, 0519T, 0520T, 0521T, 0522T, 0523T, 0524T, 0525T, 0526T, 0527T, 0528T, 0529T, 0530T, 0531T, 0532T, 0533T, 0534T, 0535T, 0536T, 0537T, 0538T, 0539T, 0540T, 0541T, 0542T

Our updated Q4 2019 code matrix is now available and can be viewed here

Provider Information update changes

Molina Healthcare requires providers to notify us of all provider changes 30 days prior to the change. Take time to review our updated guide to provider changes here.

MolinaHealthcare.com

Changes can be submitted via the:

- Provider Information Update Form: Utilize and follow the instructions on the Molina Provider Information Change Form found at MolinaHealthcare.com
- **New** - Provider Online Directory: report data changes at Providersearch.MolinaHealthcare.com. You must first open provider record

Please utilize and follow the instructions on the Molina Provider Information Change Form found here or at MolinaHealthcare.com under frequently used forms. Directions for completion and submission are provided on the form.

Submit changes via email to MHWIProvider.Services@MolinaHealthcare.com

Verify patient eligibility & reduce costly claim denials

Providers are responsible for verifying eligibility every time a member is seen in the office. PCPs should also verify a member is assigned to them. A member ID card is not proof of coverage.

Eligibility can be verified through:

- Logging into the Molina Healthcare **Provider Portal**.
- Logging into **ForwardHealth**.
- Calling the Member and Provider Service Center: (855) 326-5059.

If you need assistance logging into the Provider Portal, contact your Provider Representative.

Molina Healthcare and CAQH are partnering to improve provider data

In an effort to improve provider directory quality, Molina Healthcare will be implementing the use of the CAQH DirectAssure™ tool to update your provider directory information.

Your office will be receiving an attestation form from CAQH DirectAssure™ requesting permission for Molina Healthcare to use your attested data in CAQH to update our provider records with your most current demographic information. Those who regularly audit, revise, and attest to data within CAQH DirectAssure will receive fewer requests from Molina to update provider data for use in our practitioner directories. As a reminder, you must authorize Molina to have access to your CAQH application.

Please note that as with the credentialing tool ProView, DirectAssure is also free of charge.

Additions or terminations of practitioners affiliated with your group practice should continue to be communicated through the normal process:

MolinaHealthcare.com

- Provider Information Update Form: Utilize and follow the instructions on the Molina Provider Information Change Form found at MolinaHealthcare.com
- Provider Online Directory: report data changes at Providersearch.MolinaHealthcare.com.

Please reach out with questions to WIProviderEngagement@MolinaHealthcare.com.

New Sepsis guidelines

Beginning March 1, 2019, Molina Healthcare of Wisconsin started using the revised sepsis guidelines issued by the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3).

The new guidelines have consolidated three sepsis categories into two categories:
1. Sepsis and severe sepsis have been merged into one category, now called sepsis
2. Septic shock (or Sepsis 3) has not changed significantly

Molina contracted providers should note that patients who previously met the definition of sepsis may be excluded from the new sepsis category. For example, a patient with a urinary tract infection (UTI) may have met the previous definition of sepsis as evidenced by the systematic inflammatory response (elevated white cell count and an elevated temperature) and a site of infection. However, under the new definition, unless the patient has an elevated heart rate, elevated respiratory rate, confusion and other signs of organ dysfunction, he/she will no longer fit the definition of sepsis.

About the Sepsis Definitions:

These definitions are**:**
1. Recognized by the health care industry and professional associations as aids to determine sepsis and septic shock, and
2. The most recent evidence-based definitions for determining sepsis and septic shock.

The sepsis definition is used in clinical claims reviews to validate that sepsis was present and that related services were appropriately submitted. If clinical documentation reviewed by Molina does not support sepsis definitions, hospital payments will be adjusted appropriately.

Resources

For more information on the sepsis and sepsis-3 definitions, read The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3). Singer, M., Deutschman, C. S., et al. JAMA 2016; 315(8):801-810, https://jamanetwork.com/journals/jama/fullarticle/2492881

Questions

If you have questions related to sepsis and sepsis-3, call Provider Services at (855) 326-5059.

MolinaHealthcare.com

New NICU Authorization fax number

Effective May 13, 2019 NICU Authorizations should be sent to the Wisconsin UM fax number at (877) 708.2117.

The former Molina NICU fax number was inactivated on July 1, 2019. Please share with the appropriate staff. If you need further information, contact your Network Representative at WIProviderEngagement@MolinaHealthcare.com.

Revised Emergency Department (ED) outpatient facility Evaluation and Management (E/M) coding policies

As part of our continued efforts to reinforce accurate coding practices, Molina Healthcare will revise the current Emergency Department (ED) outpatient facility Evaluation and Management (E/M) coding reimbursement policy and procedure. This revision applies as of September 2019.

These policies focus on outpatient facility ED claims that are submitted with level 1 (99281, G0380), level 2 (99282, G0381), level 3 (99283, G0382), level 4 (99284, G0383), or level 5 (99285, G0384) E/M codes. These policies were developed using our national experience to address inconsistencies in coding accuracy and were based on the E/M coding principles created by the Centers for Medicare and Medicaid Services (CMS) that require hospital ED facility E/M coding guidelines to follow the intent of CPT® code descriptions and reasonably relate to hospital resource use.

These policies will apply to all facilities, including freestanding facilities, that submit ED claims with level 1, 2, 3, 4, or 5 E/M codes for members of the affected plans, regardless of whether they're under contract to participate in our network.

As part of the implementation of these policies and procedures, we'll begin using the Optum Emergency Department Claim (EDC) Analyzer tool, which determines appropriate E/M coding levels based on data from the patient's claim including the following:

- Patient's presenting problem
- Diagnostic services performed during the visit
- Any patient complicating conditions

To learn more about the EDC Analyzer™ tool, visit **EDCAnalyzer.com**.

Facilities submitting claims for ED E/M codes may experience adjustments to level 1, 2, 3, 4, or 5 E/M codes to reflect an appropriate level E/M code or may receive a denial, based on the reimbursement structure within their contracts with Molina Healthcare. Facilities will have the opportunity to submit reconsideration or appeal requests if they believe a higher level E/M code is justified and is in accordance with the terms of their contract.

Criteria that may exclude outpatient facility claims from these policies include, but are not limited to:

- Claims for patients who were admitted from the emergency department or transferred to another health care setting (Skilled Nursing Facility, Long Term Care Hospital, etc.)
- Claims for patients who received critical care services (99291, 99292)
- Claims for patients who are under the age of 2 years
- Claims with certain diagnosis codes that when treated in the ED most often necessitate greater than average resource usage, such as significant nursing time
- Claims for patients who expired in the ED

Ultimately, the mutual goal of facility coding is to accurately capture ED resource utilization and align that with the E/M CPT® code description for a patient visit per CMS guidance.

For further information, contact your Network Representative at WIProviderEngagement@MolinaHealthcare.com.

New approach aims to educate and reduce evaluation and management billing errors

The proper coding of Evaluation and Management (E/M) services is a well-known challenge for many of us in the health care industry. We are often faced with the difficult task of determining which level of CPT code appropriately reflects the complexity of the visit, E/M coding constitutes a high percentage of mistakes compared to coding for other services.

To assist our providers and their offices, Molina Healthcare has contracted with Change Healthcare to implement their Coding Advisor solution to assist with coding E/M services. Coding Advisor will review the use of E/M codes, Psychotherapy Assessments, and the billing of modifier 25 for providers submitting claims to Molina Healthcare. The program's aim is to provide useful data insights to the provider community, maximize coding efficiency and accuracy through education, and reduce the burdens associated with traditional audits.

Beginning May 15, 2019, Coding Advisor initiated an outreach to qualifying providers who are submitting claims to Molina Healthcare. This program will consist of a series of communications which may include: outbound notification letters, education-based telephone calls, and clearinghouse level claim status messaging.

Throughout the course of this program, Coding Advisor will continue to monitor billing practices, and will send updated report(s) periodically. They may contact your practice with the intention of identifying any coding discrepancies and to perform one-on-one coding education. All correspondences will be sent to you from Change Healthcare.

If you have questions, call Change Healthcare Coding Advisor's Customer Support at (844) 592-7009, Option 3.

Prepayment claim reviews started June 2019

Molina Healthcare is committed to continuously improving its overall payment integrity solutions. This is a

notification that we will begin performing additional prepayment claim reviews in June 2019. As a result, the health care professional may be asked for medical records and billing documents that support the charges billed.

Molina Healthcare utilizes widely acknowledged national guidelines for billing practices and supports the concept of uniform billing for all payers. These prepayment claims reviews will look for overutilization of services or other practices that directly or indirectly result in unnecessary costs to the health care industry. A health care professional's order must be present to support all charges, along with clinical documentation to support the diagnosis and services or supplies billed.

Health care professionals will receive detailed instruction regarding how to submit requested documentation. Health care professionals who do not submit the requested documentation may receive a technical denial, which will result in the claim being denied until all information necessary to adjudicate the claim is received.

If it is determined that a coding and/or payment adjustment is applicable, the health care professional will receive the appropriate claim adjudication. Health care professionals retain their right to dispute results of reviews.

Claim management for member match requirements

Molina Healthcare would like to remind our provider partners how claims are managed to match member information. This communication is to assist you with any questions you may have.

Providers are subject to certain coding requirements for claim submissions. To match to the appropriate member record, the following information must be billed on each claim:

- Member ID – located on the member's identification card
- Name – first and last name
- Date of Birth – month, day, and year
- Correct Plan Address - the plan where the member has coverage; this may not be the state in which the provider is located

To ensure claims are processed in a timely manner and not returned, Molina recommends the following:

1. Verify insurance information is updated each time a patient is seen
2. Include current and complete member information when submitting a claim
3. Check that claims are being submitted to the appropriate Health Plan addresses

Frequently Asked Questions:

- **What is changing?**

There are no changes. This bulletin is a reminder of member information required on each billed claim.

- **Are claims denied?**

Claims are returned unpaid with a notice, not denied. The correct member information should be submitted to the member's plan as a new claim submission, not as an adjustment.

MolinaHealthcare.com

Sample Notice for Returned Claims

Editor EDI Claim Returns Denials

ABC Provider

ABC Provider
123 ABC Street
Any City, ST 98765

Provider

Patient Acnt # 123456789 **Member ID #** Jane Doe

Member Jane Doe **Member DOB** 10/15/1962

Form Type 1500

Claim ID	Claim Line	Date of Service	CPT/HCPC	Modifier	Units	Billed Amount	Status
1834136p073	1	11/13/2018	A0425	NH	13.00	$195.00	Rejected
1834136p073	2	11/13/2018	A0429	NH	1.00	$500.00	Rejected
						$695.00	

Summary of Acct # 123456789

Message: Cannot find member in plan database

- **Why am I not allowed to submit an adjustment?**

As noted above, claims are returned for member information. The claims are not entered into our claims processing systems. These claims are not denied. For returned claims, a new claim must be submitted with the corrected member information.

- **What Payer ID should I use?**

Payer ID: abri1

MolinaHealthcare.com

- **How do I know the appropriate Health Plan Address?**

Claims should be submitted to the member's plan. This is not always the same state where the provider is located. Reference this chart for the appropriate billing address:

Box Name	Purpose of Box	Address
Molina Healthcare	IL Encounter paper claim receipts	PO BOX 8 Long Beach, CA 90801
Molina Healthcare	IL Medicaid paper claim receipts	PO BOX 540 Long Beach, CA 90801
Molina Healthcare CA	Molina Dual Options CA - Claims	PO BOX 2040 Long Beach, CA 90801
CHDP/Encounters - Pacific Station - CA	CHDP/Encounter claims	PO BOX 16027 Long Beach, CA 90801
Molina Healthcare of WA	MHW paper claims	PO BOX 22612 Long Beach, CA 90801
Molina Healthcare of NY	NY Paper Claims	PO BOX 22615 Long Beach, CA 90801
Molina Healthcare of Idaho	Paper Claims	PO BOX 22617 Long Beach, CA 90801
Molina Healthcare of Mississippi	Paper Claims	PO BOX 22618 Long Beach, CA 90801
Molina Healthcare of UT - Urban	MHU paper claims	PO BOX 22630 Long Beach, CA 90801
Molina Healthcare of UT - Rural	MHU paper claims	PO BOX 22633 Long Beach, CA 90801
Molina Healthcare	South Carolina Medicaid Paper Claim Receipts	PO BOX 22664 Long Beach, CA 90801
Molina Healthcare of MI	MHM Paper Claims	PO BOX 22668 Long Beach, CA 90801
Molina Healthcare - Los Angeles	MHC paper claims	PO BOX 22702 Long Beach, CA 90801
Molina Healthcare of OH	MHO paper claims	PO BOX 22712 Long Beach, CA 90801
Molina Healthcare of TX	MHT paper claims	PO BOX 22719 Long Beach, CA 90801
Molina Healthcare of NM	MHNM paper claims	PO BOX 22801 Long Beach, CA 90801
Molina Advantage of CA Encounters	MHC MA Encounter paper claims	PO BOX 22802 Long Beach, CA 90801
Molina Advantage - Claims Correspondence	Information requested by Corporate MA Claims Unit	PO BOX 22803 Long Beach, CA 90801
Molina Healthcare of WA - LTC	MHW LTC paper claims	PO BOX 22805 Long Beach, CA 90801

Molina Healthcare of CA - Encounters	CA Encounter paper claims	PO BOX 22807 Long Beach, CA 90801
Molina Healthcare of WA - Encounters	WA Encounter paper claims	PO BOX 22808 Long Beach, CA 90801
Molina Medicare Options Encounters	MMedOps Encounters	PO BOX 22809 Long Beach, CA 90801
Molina Medicare Options Claims	MMedOps Claims	PO BOX 22811 Long Beach, CA 90801
Molina Healthcare of FL - Claims	MHF paper claims	PO BOX 22812 Long Beach, CA 90801
Molina Healthcare	Paper Claims from Wisconsin	PO BOX 22815 Long Beach, CA 90801
Molina Healthcare	Paper Claims from Puerto Rico	P.O. BOX 364828 San Juan, PR 00936-4828

- **Who do I contact with questions?**

Please contact our Provider Services at WIProviderEngagement@MolinaHealthcare.com.

**** Now Available** Opiate Educational Resources**

Molina Healthcare is committed to doing its part to help improve the safety of members who suffer from Opioid use disorders, and to helping prevent problems related to Opioid use. As part of a comprehensive Pain Safety Initiative, Molina Healthcare offers resources to enhance the knowledge available to its providers, and to support safe pain management practices. Opioid education materials can be found here.