PROVIDER NEWSLETTER

A newsletter for Molina Healthcare Provider Networks

Important Message–Updating Provider Information

It is important for Molina Healthcare of Illinois (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 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 Update Information Form located on the Molina Healthcare website at MolinaHealthcare.com under the Provider Forms section. Send changes to:

Fax: (844) 488-7054
Mail: Molina Healthcare of Ill.
1520 Kensington Drive, Suite 212
Oak Brook, Illinois 60523
ATTN: Provider Services Department

In this Issue

Email: MHILProviderNetworkManagement@MolinaHealthCare.Com

Contact your Provider Services Representative at (855) 866-5462 if you have questions.

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 such 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.
- Non-discrimination during the credentialing process.
- Notification 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, 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 the Credentialing Department at (855) 866-5462.
- 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 (at minimum age, comorbidities, complications, progress of treatment, psychosocial situation, home environment, when applicable) and the local delivery system into account when determining the medical appropriateness of requested health care services.
- Molina Healthcare's clinical criteria includes Change Healthcare InterQual® criteria, 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 used in the decision-making process, call our UM Department at (855) 866-5462.
- As the requesting practitioner, you will receive written notification of all UM denial decisions. 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 (855) 866-5462.

It is important to remember that:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Molina Healthcare does not specifically reward practitioners 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.
- Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage.
- 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.
- 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.
    - 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 (855) 866-5462. You may also fax a question about an UM issue to (866) 617-4971. 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 through Friday (excluding holidays) 8 a.m. to 5 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 from areas where Molina Healthcare practitioners are located. 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 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 in 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 a Medication Prior Authorization Form via fax to (855) 365-8112, 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.

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

In the case of 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.

Complex Case Management

Molina Healthcare offers you and your patients the opportunity to participate in our Complex Case Management Program. Patients appropriate for this voluntary program are those who have the most 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 have additional social, psychosocial, psychological, and emotional issues that exacerbate the condition, treatment regime and/or discharge plan.

The purpose of the Molina Healthcare Complex 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 patients to optimize their health and level of functioning.
- Facilitate access to medically necessary services and ensure that 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.

To learn more about this program, contact a Complex Case Manager and/or refer a patient for an evaluation for this program, by calling (855) 866-5462.

Website

A variety of helpful information is featured at MolinaHealthcare.com:

- Clinical Practice and Preventive Health Guidelines
- Health Management Programs
- 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 under-utilization)
- How to Obtain Copies of UM Criteria
- How to Contact UM Staff & Medical Reviewer
- New Technology
- Provider Resources for Behavioral Health, Culturally and Linguistically Appropriate Services, Diabetes, and Opioid Prevention
- Cultural Competency Provider Trainings
- How to Access Language Services

To receive any of the information posted on our website in hard copy, please call (855) 866-5462.

Translation Services

Molina can provide information in our members' primary language. We can arrange for 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 a language other than English, please contact Molina's Member Services Department at (855) 866-5462. 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 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 co-morbidities that often affect their quality of life. As this population ages, it's not uncommon to see decreased physical function and cognitive ability, and an increase in pain. Regular assessment of these additional health aspects can help ensure this population's needs are appropriately met.

- **Advance care planning**—Discussion regarding treatment preferences, such as advance directives, should start early before the patient becomes 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 include notation of the presence or absence of pain.

Including these components in your standard well-care practice for older adults can help increase their quality of life by identifying ailments that often go unrecognized.

Hours of Operation

Molina Healthcare requires that providers offer Medicaid members hours of operation no fewer than hours offered to commercial members.

Non-Discrimination

As a Molina Healthcare 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 Members 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

Providers must understand 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 condition(s), 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 quality 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.

The complete Molina Healthcare Member Rights and Responsibilities statement for Illinois can be found on our website (MolinaHealthcare.com). Written copies and more information can be obtained by contacting the Provider Services Department at (855) 866-5462.

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 as necessary to meet the needs of our members.

Molina offers programs to help members and their families manage a diagnosed health condition. As a provider, you can 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
- High blood pressure management
- Cardiovascular Disease (CVD) management/Congestive Heart Disease
- Chronic Obstructive Pulmonary Disease (COPD) management

- Depression management

For more information about our programs, call the Provider Services Department at (855) 866-5462 or TTY/TDD at 711 relay. More information can be found on our website: MolinaHealthcare.com.

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 in achieving these goals. It is an evolving program that is responsive to the changing needs of the health plan's members and the standards established by the medical community, and regulatory and accrediting bodies.

QIP's 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 comparisons with 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 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 QI work plan quarterly.
- Revising interventions based on analysis, when indicated.
- Evaluating members' satisfaction with their experience of care through the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey.
- Reviewing members' 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 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 Department at (855) 866-5462.

For more information about our Quality Improvement Program or initiatives, and the progress toward meeting quality goals, or to request a paper copy of our documents, please call the Quality Improvement Department at (855) 866-5462, or visit our website at MolinaHealthcare.com.

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 treatment that is both efficient and effective.

Molina'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.

These commonly accepted standards for documentation in medical records 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 Health Care Services at (855) 866-5462.

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 (855) 866-5462. 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's Clinical Practice Guidelines include but are not limited to:

- Asthma
- Attention Deficit Hyperactivity Disorder
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Sickle Cell Disease
- Substance Abuse Treatment

To request a copy of any guideline, please contact Molina Healthcare's Provider Services Department at (855) 866-5462. 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, including a living will document and a durable power of attorney document.

A living will is a 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.

These resources provide you and your patients with free forms to help create an Advance Directive:
nlm.nih.gov/medlineplus/advancedirectives.html
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 offer 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 Health Care Services at (855) 866-5462.

Care Coordination & Transitions (Planned and Unplanned)

Molina Medicare is dedicated to providing quality care for our Medicare members during planned or unplanned transitions. A transition is when members move from one setting to another, such as when a Molina Medicare member is discharged from a hospital. By working together with providers, Molina Medicare makes a special effort to coordinate care during transitions. This coordination of specific aspects of the member's transition is implemented to avoid potential adverse outcomes.

To ease the challenge of coordinating patient care, Molina Medicare has resources to assist you. Our Utilization Management nurses and Member Services staff are available to work with all parties to ensure appropriate care.

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

This information can be faxed to Molina Medicare at (844) 251-1450.

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

- Medicare Member Services & Pharmacy: (855) 866-5462
- Behavioral health services and substance abuse treatment: (855) 866-5462
- Transportation services for Dual Options members: (844) 644-6353
- Nurse Advice Line (24 hours a day, 7 days a week): (888) 275-8750

Important information about Molina Medicare Complete Care:

- 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 Complete Care 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 the status and Medicaid benefits of your patients, 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 have specific rights regarding their Medicaid benefits and can also call the Medicaid agency for details.
- 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:

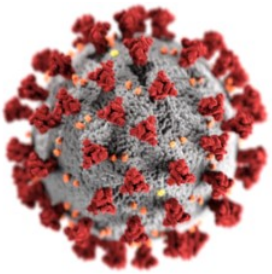
- UM Department: (855) 866-5462
- Member Services: (855) 866-5462

Verifying NPPES Data

CMS recommends that Providers routinely verify and attest to the accuracy of their NPPES data. The National Plan and Provider Enumeration System (NPPES) now allows providers to attest to the accuracy of their data. If the data is correct, the provider can attest, and NPPES will reflect the attestation date. If the information is not correct, the provider may request a change to the record and attest to the changed data, resulting in an updated certification date.

Molina supports the CMS recommendations around NPPES data verification and encourages our provider network to verify provider data via nppes.cms.hhs.gov. Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQs) document published here: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Coronavirus Information



Molina Healthcare is monitoring COVID-19 developments daily. Our corporate Chief Medical Officer (CMO) is working closely with our health plan CMOs across the country to ensure that we are prepared to assist our members and providers. Some things to note:

- No changes to our prior authorization process at this time.
- Visits for our members to primary care provider offices or the ER do **not** require prior authorization.
- Our inpatient prior authorization process remains the same.

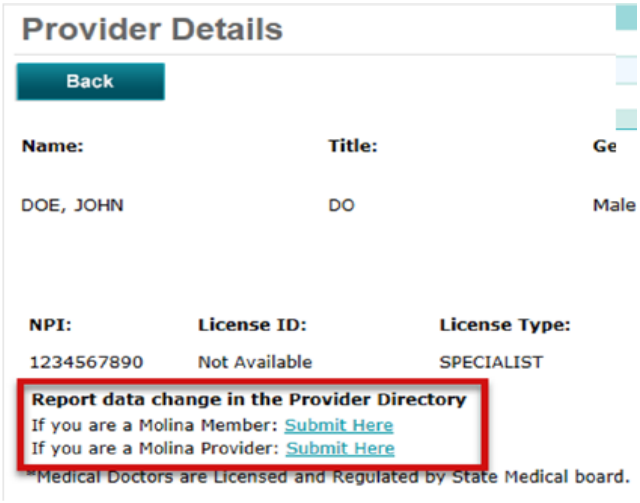
We strongly encourage you to monitor the CDC website (cdc.gov/coronavirus/2019- ncov/index.html) for additional clinical information and coronavirus updates.

The pandemic continues to be a rapidly developing public health matter. We will update you of any changes as quickly as possible.

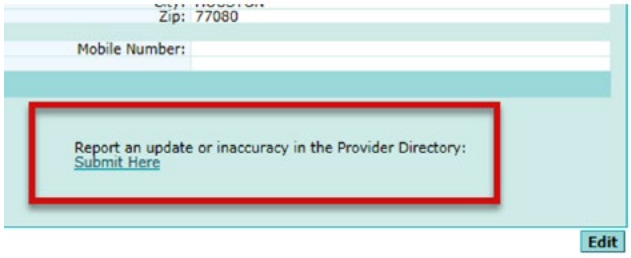
Provider Portal Corner

We have improved the way in which you can report a data change to Molina. The new feature allows a provider or a member to submit demographic corrections directly to Molina.

Online corrections can be made in these locations in the Molina Provider Portal:



POD – Search Details page



Provider Portal