Senior Whole Health
BY MOLINA HEALTHCARE

Provider Newsletter

For Senior Whole Health LLC providers

Fourth quarter 2024

In this issue

The provider newsletter is available to all network providers serving Senior Whole Health LLC members.

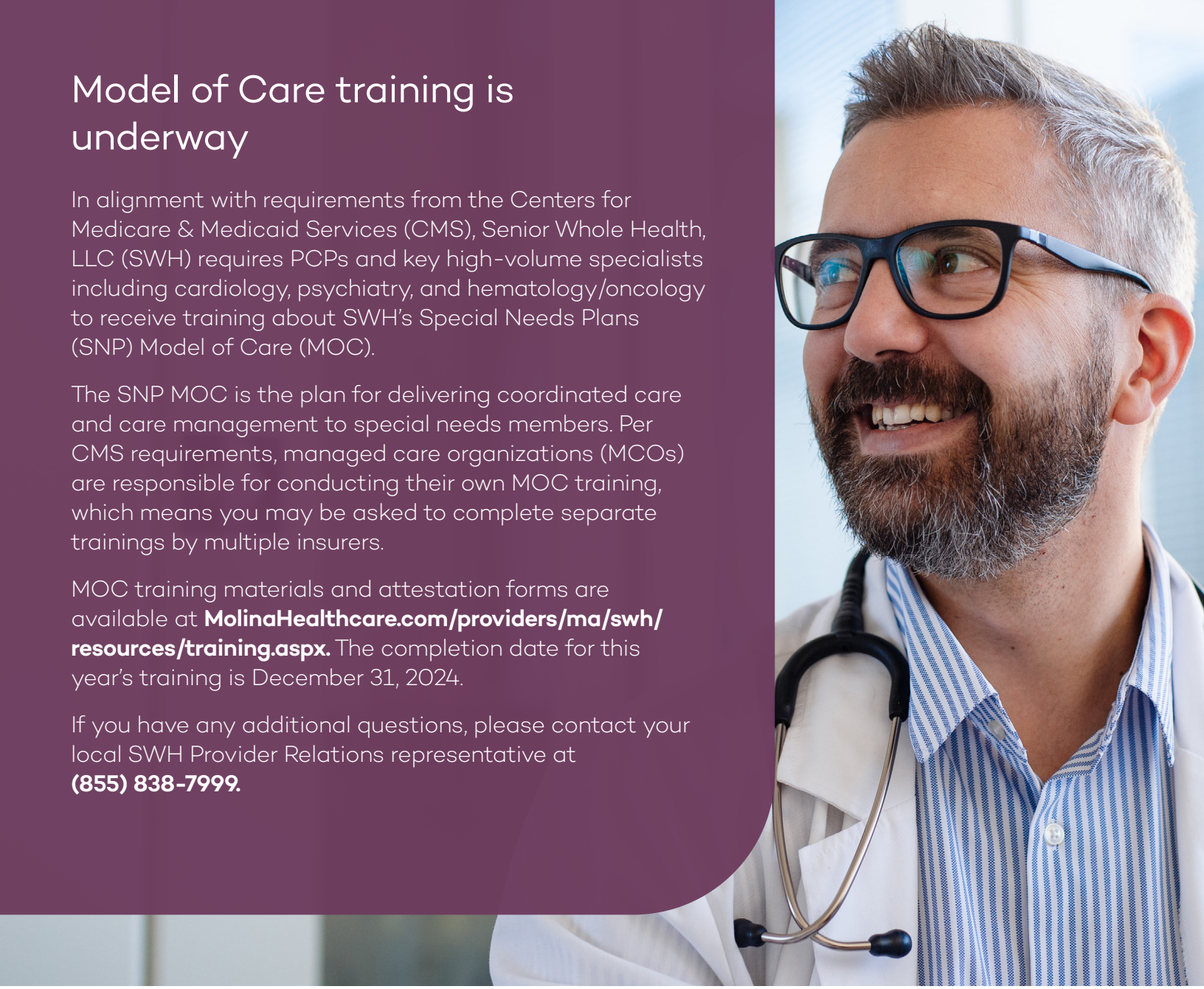
Model of Care training is underway

In alignment with requirements from the Centers for Medicare & Medicaid Services (CMS), Senior Whole Health, LLC (SWH) requires PCPs and key high-volume specialists including cardiology, psychiatry, and hematology/oncology to receive training about SWH's Special Needs Plans (SNP) Model of Care (MOC).

The SNP MOC is the plan for delivering coordinated care and care management to special needs members. Per CMS requirements, managed care organizations (MCOs) are responsible for conducting their own MOC training, which means you may be asked to complete separate trainings by multiple insurers.

MOC training materials and attestation forms are available at **MolinaHealthcare.com/providers/ma/swh/resources/training.aspx.** The completion date for this year's training is December 31, 2024.

If you have any additional questions, please contact your local SWH Provider Relations representative at **(855) 838-7999.**



Third-party liability (TPL) on explanation of payments (EOP)

Third-party liability (TPL) refunds are an internal way Molina posts refunds received and do not reflect recoupment from a payee. The Molina 835 will indicate a WO/72 adjustment on the PLB segment, indicating the amount (which is the refund) and the claim ID in the reference field. In addition, on the EOP itself, the reversal claim will show a $0.00 amount, and a remit message will indicate that a TPL refund has been applied. No recoupment occurs to decrease a provider's payment.

Refunds received from a provider will remain on the EOP/835 and reflect in the same fashion, although without the TPL remit description.

If a claim has a $0.00 refund and reflects a negative amount and no reference in the PLB section, that is an actual recovery performed by Molina that will decrease the payment.

2024-2025 flu season

The Advisory Committee on Immunization Practices (ACIP) continues to recommend annual influenza vaccinations for all individuals aged six months and older who do not have contraindications. Influenza vaccination is particularly important for those at high risk of serious flu-related complications. These high-risk groups include the elderly, young children, pregnant individuals, and those with underlying medical conditions such as asthma, heart disease, or diabetes. It is also essential for people who live with or care for high-risk individuals to get vaccinated to help reduce the potential spread of the virus.

According to the August 2024 ACIP report, all seasonal flu vaccinations expected to be available in the United States for the 2024-2025 season are trivalent. These vaccines will contain hemagglutinin (HA) derived from one influenza A(H1N1)pdm09 virus, one influenza A(H3N2) virus, and one influenza B/Victoria lineage virus. Previously, quadrivalent vaccines also included the B/Yamagata lineage, but this strain is not included in the 2024-2025 vaccines due to the absence of naturally occurring B/Yamagata viruses in global surveillance since March 2020. The following vaccine types are expected to be available: inactivated influenza vaccines (IIV3s), recombinant influenza vaccines (RIV3), and live attenuated influenza vaccines (LAIV3).

Other 2024-2025 vaccination recommendations

- For most individuals who need only one dose of the influenza vaccine for the season, vaccination should ideally be offered during September or October. However, vaccination can continue beyond October as long as influenza viruses are circulating, and unexpired vaccines are available.
- Early vaccination (during July or August) is generally not recommended, particularly for adults aged 65 years and older and for pregnant individuals in their first or second trimester, due to concerns about waning immunity later in the season. However, early vaccination may be considered for those unlikely to return for vaccination later or for children who require two doses.
- ACIP recommends specific vaccines for certain populations:
  - Adults aged ≥ 65 years, and
  - Individuals with immunocompromising conditions or chronic medical conditions that prevent them from receiving live attenuated vaccines.

These groups are at a higher risk for severe influenza-related complications, and certain vaccines have demonstrated greater efficacy.

- For adults aged ≥ 65 years, ACIP recommends the preferential use of any of the following higher-dose or adjuvanted vaccines:
  - High-dose inactivated influenza vaccine (HD-IIV3),
  - Recombinant influenza vaccine (RIV3), or
  - Adjuvanted inactivated influenza vaccine (aIIV3)

If none of these vaccines are available at the time of vaccination, any age-appropriate inactivated influenza vaccine may be used. The preference for high-dose or adjuvanted vaccines is based on evidence showing greater efficacy in preventing influenza-related hospitalizations and complications in older adults compared to standard-dose, non-adjuvanted vaccines.

- Immunocompromised individuals, including those with congenital or acquired immunodeficiencies, or those undergoing treatments like chemotherapy or solid organ transplants, should receive either IIV3 or RIV3. These vaccines are not live, meaning they pose no risk of causing influenza in immunocompromised individuals. Live attenuated influenza vaccine (LAIV3) should not be used for this population.
- Solid organ transplant recipients aged 18 through 64 years who are receiving immunosuppressive medications may also receive either HD-IIV3 or aIIV3 as acceptable options, based on recent systematic reviews showing their effectiveness and safety. However, there is no preference between these vaccines and other age-appropriate inactivated or recombinant vaccines.

Updates included in 2024-2025 ACIP report

- The ACIP 2024-2025 recommendations include updates to the composition of the U.S. seasonal influenza vaccines and new recommendations for the vaccination of adult solid organ transplant recipients. The composition of the 2024-2025 vaccines includes the following:
  - Hemagglutinin (HA) derived from:
    - Influenza A/Victoria/4897/2022 (H1N1)pdm09-like virus (for egg-based vaccines) or Influenza A/Wisconsin/67/2022 (H1N1)pdm09-like virus (for cell culture-based and recombinant vaccines,
    - Influenza A/Thailand/8/2022 (H3N2)-like virus (for egg-based vaccines) or Influenza A/Massachusetts/18/2022 (H3N2)-like virus (for cell culture-based and recombinant vaccines), and
    - Influenza B/Austria/1359417/2021 (Victoria lineage)-like virus (for egg-based, cell culture-based, and recombinant vaccines)
- Influenza B/Yamagata lineage will no longer be included in vaccines for the 2024-2025 season due to the absence of confirmed detections since March 2020.
- For adult solid organ transplant recipients, ACIP has updated the recommendations for those aged 18 through 64 years who are receiving immunosuppressive medication regimens. These individuals may receive either HD-IIV3 or aIIV3. Both vaccines are now considered acceptable options, with no preference over other age-appropriate inactivated influenza vaccines (IIVs) or recombinant influenza vaccines (RIVs).
- A systematic review and GRADE evidence evaluation was conducted to compare the effectiveness and safety of HD-IIV3 and aIIV3 against standard-dose unadjuvanted IIVs. The review found that both HD-IIV3 and aIIV3 demonstrated better immunogenicity and were associated with a greater likelihood of seroconversion for influenza A(H1N1), A(H3N2), and B components, particularly for solid organ transplant recipients. However, there was no increased risk of graft rejection observed with either vaccine.

For a complete copy of the ACIP recommendations and updates or for more information on flu vaccine options for the 2024-2025 flu season, please review the report at **cdc.gov/mmwr/volumes/73/rr/rr7305a1.htm**.

Molina Healthcare will cover the following flu vaccines during the 2024 – 2025 flu season:

- Afluria Preservative Free SUSY 0.5ML (2024-2025)
- Afluria SUSP (2024-2025)
- Flublok SOSY 0.5ML (2024-2025)
- Flucelvax SUSP (2024-2025)
- Flucelvax SUSY 0.5ML (2024-2025)

Molina Healthcare's Special Investigation Unit is partnering with you to prevent fraud, waste and abuse

The National Healthcare Anti-Fraud Association estimates that at least three percent of the nation's health care costs, amounting to tens of billions of dollars, is lost to fraud, waste and abuse. That money would otherwise cover legitimate care and services for the neediest in our communities. To address the issue, federal and state governments have passed several laws to improve overall program integrity, including required audits of medical records against billing practices. Like others in our industry, Molina must comply with these laws and proactively ensure that government funds are used appropriately. Molina's Special Investigation Unit (SIU) aims to safeguard Medicare, Medicaid and Marketplace funds.

You and the SIU

The SIU utilizes state-of-the-art data analytics to proactively review claims to identify statistical outliers within peer (specialty) groups and services/coding categories. Our system employs approximately 1,900 algorithms to identify billing outliers and patterns, over- and underutilization, and other aberrant billing behavior trends. The system pulls information from multiple public data sources and historical databases known to identify and track fraud, waste and abuse. Our system allows us to track providers' compliance with correct coding, billing, and their provider contractual agreement.

As a result, providers may receive a notice from the SIU if they have been identified as having outliers that require additional review or by random selection. If your practice receives a notice from the SIU, please cooperate with the notice and any instructions, such as providing requested medical records and other supporting documentation. Should you have questions, please contact your Provider Relations representative.

"Molina Healthcare appreciates the partnership it has with providers in caring for the medical needs of our members," explains Scott Campbell, the Molina vice president who oversees the SIU operations. "Together, we share a responsibility to be prudent stewards of government funds. We all should take it seriously because it is important in protecting programs like Medicare and Medicaid from fraudulent activity."

Molina appreciates your support and understanding of the importance of SIU's work. We hope to minimize any inconvenience the SIU audit might cause you and/or your practice.

To report potential fraud, waste and abuse, contact the Molina AlertLine toll-free at **(866) 606-3889**, 24 hours per day, 7 days per week. In addition, use the website to make a report at any time at **MolinaHealthcare.Alertline.com**.

Clinical Policy

Molina Clinical Policies (MCPs) are located at **MolinaClinicalPolicy.com**. Providers, medical directors and internal reviewers use these policies to make medical necessity determinations. The Molina Clinical Policy Committee (MCPC) reviews MCPs annually and approves them bimonthly.

Provider Manual updates

The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at **MolinaHealthcare.com/providers/ma/swh/resources/provider-materials.aspx.**

Electronic Medical Records – The case for sharing

The Centers for Medicare and Medicaid Services (CMS) set requirements for Medicare Advantage (MA) plans in January to improve the electronic exchange of health information and prior authorization (PA) processes for medical items and services, to improve the exchange of health data and strengthen access to care. According to CMS, PA processes will be streamlined, reducing the burden on patients, providers and payers. By reducing or eliminating complicated forms, wait times for PAs and lengthy phone calls, there is improvement to timely access to care and cost savings due to the reduction in time spent on administrative tasks[1]. You can read more on this ruling from CMS **here**.

Please work with our network team to establish electronic health record (EHR) connections. To set up EHR access with SWH, please contact Alisha Ely, RN, at **(614) 516-4621.**

Reducing readmissions

Transition of care surrounding a hospital discharge is a complex and multi-faceted process. Those complexities increase when patients are elderly with chronic medical conditions. Coordination and assessment from a variety of perspectives impact post-discharge success. The inpatient discharge team, patients and caregivers, care managers and primary care providers (PCPs) all play a part. Factors leading to readmissions within 30 days of discharge include quality of hospital care,discharge planning and inadequate coordination of post-discharge services[2]. Readmission rates occur at higher levels for patients with racial and socioeconomic disparities, highlighting health inequities among vulnerable patients. Socioeconomic factors come into play when considering readmission rates for patients with limited resources. Those patients often have challenges following dietary recommendations, getting needed medications or finding transportation to medical appointments due to access issues. The involvement of PCPs post-discharge is vital to ensure patients have the oversight and services in place to avoid preventable readmissions. Multi-component programs that address care transition challenges patients and providers face are the most successful.[3]

Some tips for reducing preventable readmissions among vulnerable patients include:

- Involve clinic care managers in post-hospital discharge planning
- Conduct timely medication reconciliation with the patient
- Implement a standardized system to contact patients upon notification of discharge
- Review patient understanding of discharge instructions using the teach-back method
- Ensure timely scheduling of follow-up appointments within 7 days of discharge
- Determine transportation needs of patients for follow-up appointments

[1] https://www.hhs.gov/about/news/2024/01/17/cms-finalizes-rule-to-expand-access-to-health-information-and-improve-the-prior-authorization-process.html

[2] CMS Office of Minority Health. (2024). Guide for reducing Disparities in Readmissions (pp. 4–45) [Report]. https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf

[3] Saluja S, Hochman M, Bourgoin A, Maxwell J. Primary Care: the New Frontier for Reducing Readmissions. J Gen Intern Med. 2019 Dec;34(12):2894-2897. doi: 10.1007/s11606-019-05428-2. Epub 2019 Oct 16. PMID: 31621049; PMCID: PMC6854170.

Diabetes and helping patients control Hemoglobin A1c

SWH would like to ask our providers to focus on improving Hemoglobin A1c (HbA1c) levels among members with diabetes. Successful diabetes care involves strongly supporting behavior change through a systematic approach. This includes attention to culturally sensitive education and support for patient self-management when making treatment recommendations. Providers must look at SWH members through the lens of health inequities and assess social determinants of health (SDOH) such as food insecurity, homelessness or housing insecurity, financial constraints and available community supports when making treatment decisions to reduce adverse diabetes outcomes associated with risk among disparate communities.[4] Other recommendations for supporting diabetic patients include:

- Routinely evaluate the need for additional diabetes education and support annually, during times when the patient is not meeting treatment targets, when complications develop and during life and/or care transitions
- Consider digital or virtual coaching to support diabetic patients
- Assess for food insecurity and refer to community organizations as needed
- Encourage exercise following clinical practice guidelines for the level and types of activity appropriate for your patient
- Recommend smoking cessation for all patients who smoke or use E-cigarettes
- Assess and treat psychosocial factors impacting adherence to diabetes treatment recommendations
- Monitor medication therapy closely for diabetic members on Insulin or other glucose-lowering medications
- Monitor HbA1c routinely

Please refer to the SWH-approved clinical practice guidelines (CPGs) Standards of Care in Diabetes from the American Diabetes Association for comprehensive, up-to-date treatment recommendations at **Standards of Care in Diabetes—2023 Abridged for Primary Care Providers | Clinical Diabetes | American Diabetes Association.**

Resources for integrated care

Resources for integrated care was recently added to the SWH website under Resources and Training at **MolinaHealthcare.com/providers/ma/swh/resources/training.aspx.** CMS promotes this organization for D-SNP plans and providers. They offer articles, webinars and a resource library with topics applicable to the D-SNP population.

[4] American Diabetes Association; Standards of Care in Diabetes—2023 Abridged for Primary Care Providers. Clin Diabetes 2 January 2023; 41 (1): 4–31. doi.org/10.2337/cd23-as01

Osteoporosis management in women who had a fracture (OMW)

As part of SWH's efforts to improve HEDIS® (Healthcare Effectiveness Data and Information Set) ratings, we would like to share information related to this measure with providers.

Did you know?

- Bone mineral density (BMD) testing used to diagnose osteoporosis helps determine the appropriate treatment for preventing potential fractures[5]
- The U.S. Preventive Services Task Force recommends central and peripheral dual-energy x-ray absorptiometry (DXA) as appropriate screening tools for bone mineral density (BMD) testing for predicting fracture risk and determining drug therapies for prevention of fractures
- Drugs to reduce fractures from osteoporosis include Alendronate, Alendronate-cholecalciferol, ibandronate, Risedronate, Zoledronic acid, Abaloparatide, Denosumab, Ralixifene, Romosozumab and Teriparatide
- The U.S. Preventive Services Task Force recommends BMD testing screening for women age 65 and older to prevent osteoporotic fractures[6]

Tips for treating women who have suffered a fracture:

- Ask female patients aged 65 and over and post-menopausal women under age 65 if they have had a fracture since their last appointment
- Order a screening BMD test such as DXA for female patients aged 65 and over or post-menopausal women under age 65 at risk for osteoporosis
- Order DXA for women with a fracture within six months of their fracture date or prescribe recommended medication to prevent osteoporotic fractures and improve bone strength
- Provide patient education on safety and fall prevention and/or consider a home assessment for vulnerable patients

You can find HEDIS® tip sheets with additional information on appropriate HEDIS® coding and helpful tips in the Payer Spaces section of the Availity portal. Information on how to register for the portal is located at **MolinaHealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/ma/comm/Availity-Intro-Letter_SWH-MA.pdf**

For more information on recommendations for osteoporosis management, visit **uspreventiveservicestaskforce.org/uspstf/recommendation/osteoporosis-screening#fullrecommendationstart**

[5] Osteoporosis to prevent fractures: screening. (2018, June 26). https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/osteoporosis-screening#bootstrap-panel--6

[6] Osteoporosis to prevent fractures: screening. (2018b, June 26). https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/osteoporosis-screening#bootstrap-panel--4