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MS Medicaid PROVIDER BULLETIN

MISSISSIPPI DIVISION OF MEDICAID

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New MMIS Will Help Medicaid Keep Up with Growing Technological Demands

From a big-picture standpoint, there are two core functions that form the foundation of the Mississippi Division of Medicaid (DOM) – processing payments to healthcare providers for the care they provide and determining the eligibility of Medicaid members. The backbone of these functions is what's defined by the Centers for Medicare and Medicaid Services (CMS) as a Medicaid Management Information System (MMIS).

In the March edition of the Provider Bulletin, we announced that DOM is working with a vendor to develop a new MMIS to replace the aging Envision system, which has been in use for many years. The new claims-processing solution is called MESA: Medicaid Enterprise System Assistance, and our goal is for this modernization to enhance connections between health services systems and improve access to health information for our Medicaid providers and the members they serve.

As with most technology, these types of systems are constantly evolving. In fact, the Medicaid program implemented its first computerized claims payment and information system in its first full year of operations. Fifty years ago in state fiscal year 1971, that inaugural system was established by a consultant management team contracted by the Mississippi Medicaid Commission and its fiscal agent at that time, Blue Cross – Blue Shield.

Times have certainly changed since 1971 as technological demands on Medicaid programs have grown at an ever-increasing rate and CMS requirements gotten more stringent. Our current system, Envision, was originally developed in the early 2000s. While our stakeholders are accustomed to and comfortable with the current system, DOM must keep up with those growing demands.

The new system – MESA – is expected to go-live during calendar year 2022, replacing outdated technology with a more efficient version that is easier to maintain. Recognizing how critically important it will be to ensure a smooth transition, DOM is focused on providing clear information and resources over the coming months to help all providers prepare for the switchover.

Although it will be an adjustment, MESA will allow for some distinct advantages over the current system. For example, a new and improved provider portal will allow for a streamlined provider-enrollment process. Healthcare providers will be able to submit and adjust claims in real-time for each claim type and submit batches of transactions, as well as verify a patient's eligibility status quickly and easily. The new system will also allow for a centralized credentialing process,

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eliminating the need for providers to credential with DOM and each coordinated care organization.

Although go-live is still months away, the User Acceptance Testing and initial training phase began this summer, a critical stage involving the expertise of select DOM employees to test the different functional components of the system, ensuring that it processes operations correctly and accurately.

Healthcare representatives are now becoming more involved in the project as providers will be tasked with testing the system on their end. This will require a continuous stream of clear and careful communication between DOM, the provider community, and Gainwell Technologies – the vendor building the new system.

As this implementation moves forward into the new year, we will provide timely updates, detailed information, and training resources through our appropriate channels.

PROVIDER COMPLIANCE

ATTENTION: NURSING FACILITY PROVIDERS
Types of Bill Clarification

Effective June 1, 2021, Types of Bill (TOB) 021X, 022X and 023X were made available to and should now be utilized by nursing facility providers. To allow providers and clearing houses the opportunity to transition to the use of TOB 021X, 022X and 023X, the Division of Medicaid (DOM) continued to permit the use of the TOB 089X between the period of June 1, 2021 through August 31, 2021. While TOB 089X was decommissioned for nursing facility providers effective August 31, 2021, any claim with a date of service prior to June 1, 2021, should still be billed using TOB 089X. After the transition period,

WEB PORTAL REMINDER

For easy access to up-to-date information, providers are encouraged to use the **Mississippi Envision Web Portal.** The Web Portal is the electronic approach to rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The **Mississippi Envision Web Portal** is available 24 hours a day, 7 days a week, 365 days a year via the Internet at www.ms-medicaid.com.

effective September 1, 2021, all Long Term Care claims with dates of service on or after June 1, 2021 must be submitted with TOB 021X, 022X, and 023X. If you have any questions, please contact the Office of Long Term Care by emailing **LaShunda.Woods@medicaid.ms.gov** or calling **601-359-5251**.

Changes for ID/DD Waiver Beneficiaries receiving Incontinence Garments and Urinary Catheter Supplies

Effective October 1, 2021, incontinence garments and urinary catheter supplies will no longer be reimbursable through the Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver. Incontinence garments and urinary catheter supplies are covered as a State Plan Service. Service authorizations issued by ID/DD Waiver Support Coordinators for incontinence garments and urinary catheter supplies for dates of services on or after October 1, 2021, will no longer be valid. Durable Medical Equipment (DME) suppliers will follow the same prior authorization and billing process as they do for non-waivered beneficiaries.

Prior authorization (PA) for incontinence garments for ID/DD Waiver beneficiaries should be obtained from Alliant Health Solutions. Please refer to Alliant Health Solutions' provider portal at: **https://ms.allianthealth.org/** or call Alliant directly at **1-888-224- 3067**. The revised Administrative Code was Propose Filed on August 6, 2021, and Final Filed on September 1, 2021, with the Secretary of State's office and can be accessed via this link Final Administrative Code Filings / Mississippi Division of Medicaid (ms.gov) **https://medicaid.ms.gov/providers/administrative-code/final-administrative-code-filings/**.

Urinary catheter supplies do not require prior authorization but must be medically necessary and prescribed by a licensed, qualified physician.

Changes for ID/DD Waiver Beneficiaries receiving Therapy Services (Physical, Occupational, and Speech Therapy)
Therapy services are only reimbursable under the ID/DD Waiver for persons over the age of 21 who receive therapy in their home. Therapies are not reimbursable under the ID/DD Waiver at a therapist office/clinic, outpatient department of a hospital, or physician office/clinic. Therapy providers rendering services in an office, clinic, or hospital setting will follow the same prior authorization and billing process as they do for any non-waivered beneficiaries. Please note: therapy services should only be provided in the beneficiary's home when the beneficiary is home-bound or there is a medical reason that services cannot be rendered in a provider's office, clinic, or hospital setting. If you have any questions, please contact the Office of Mental Health by emailing **Kimberly.Sartin-Holloway@medicaid.ms.gov** or calling **601-359-6630**.

Attention Community and Private Mental Health Centers

The new HCPCS code H0037 – Community Psychiatric Supportive Treatment Program, will be submitted for services rendered under the Mississippi Youth Program Around the Clock (MYPAC) program. Please review DOM Mental Health Services State Plan Amendment (SPA) 21-0028 located at **https://medicaid.ms.gov/wp-content/uploads/2021/09/Pages-from-MS-SPA-21-0028-Approval-Pages-1.pdf**. Filing of corresponding Division of Medicaid Administrative Code for MYPAC services with the Secretary of State's Office is pending.

HCPCS H0037 – Community Psychiatric Supportive Treatment Program

- Prior authorization will not be required for HCPCS code H0037
- Required Modifiers:
  - HW – State Mental Health Agency Funded
  - HT – Multi Disciplinary Team
- Allowed Provider Types:
  - X00 – Community Mental Health Center
  - X01 – Private Mental Health Center
- DOM Fee Schedule Per Diem Rate $214.00
- Effective Date – July 1, 2021
- Providers must be certified by the Department of Mental Health to provide MYPAC.
- This service is excluded from the Children's Health Insurance Program (CHIP).

This HCPCS code reimbursement is effective **July 1, 2021,** with corresponding certification for MYPAC services by the Department of Mental Health. Prior to submitting claims for this service, please verify with your Coordinated Care Organizations' Provider Representative to ensure corresponding claim system updates have been activated.

Please contact Kim Sartin Holloway at **Kimberly.Sartin-Holloway@medicaid.ms.gov** or **601-359-6630** if you have any questions.

PHARMACY NEWS

Growth Hormone Diagnosis Required for all Ages

As recommended by the MS Medicaid Drug Utilization Review (DUR) Board, on October 1, 2021, point-of-sale pharmacy claims for human growth hormone products require a qualifying diagnosis for payment. This requirement will apply to beneficiaries of all ages. A SmartPA (electronic prior authorization) process was implemented to seamlessly detect diagnoses in beneficiaries' medical claims for approval. Pharmacy providers may also submit a diagnosis which has either been verified by the prescriber or noted on the prescription by the prescriber. When no qualifying diagnosis is found, the submission of a manual prior authorization request is required. A human growth hormone prior authorization packet is available on the DOM pharmacy webpage.

2021-2022 Synagis Season

The FFS and MSCAN Prior Authorization Units began accepting Synagis prior authorization requests on October 11, 2021, for dates of service beginning November 1, 2021.

For beneficiaries who received Synagis doses during recent off-season months, the typical RSV season will be considered separately. For example: If the patient received doses in September and October (out of season), they are eligible for **five doses during** the 2021-2022 RSV season starting November 1, 2021, subject to meeting the criteria for coverage.

The 2021-2022 Synagis prior authorization form is available on the DOM pharmacy webpage.

Vaccine Administration by Pharmacy Providers

Due to the ever-changing nature of COVID-19 vaccines as well as their clinical and NCPDP billing guidelines, please continue to check the DOM Pharmacy website for current billing policy at Pharmacy | Mississippi Division of Medicaid (ms.gov) **https://medicaid.ms.gov/providers/pharmacy/**

PHARMACY NEWS

Pharmacy Licenses Expiring 12/31/2021-Action Required

In November, Conduent's Provider Enrollment department sent letters to pharmacy providers whose store licenses will expire on 12/31/2021. Providers must mail or fax a copy of their current store license prior to the 12/31/2021 expiration date to prevent their Medicaid provider number from being closed thereby resulting in prescription claim denials on 1/1/2022 and forward. Conduent Provider Enrollment Fax # **(888) 495-8169**

Mailing address:
Conduent State Healthcare
Attn: Provider Enrollment Department
P.O. Box 23078
Jackson, MS 39225
If you have any questions, please call Provider Enrollment at **(800) 884-3222** from 8am-5pm CST Monday through Friday.

COORDINATED CARE NEWS

magnolia health™

ATTENTION PROVIDERS: Billing a Third Party Source

Effective immediately, Magnolia Health Plan has adopted Medicaid's TPL policy as it relates to events where there is no response from the third party source within 60 days from date of filing. The provider may submit the Medicaid "No Response from Third Party Source" form to Magnolia along with a claim, claim reconsideration, or claim appeal for the impacted claim to be considered for processing.

The form is available here: **https://medicaid.ms.gov/wp-content/uploads/2014/03/6.2-Billing-3rd-Party-Source.pdf**

COORDINATED CARE NEWS

Coordination of Care during Planned and Unplanned Transitions for Molina Members

Molina Healthcare 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 Healthcare 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 Healthcare has resources to assist you. Our staff, including nurses, are available to work with all parties to ensure appropriate care. In order to appropriately coordinate care, Molina Healthcare 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 Healthcare at: (844) 206-0435

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

- **Member Services & Pharmacy: (844) 809-8438**, TTY: 711
- **Behavioral Health Services: (844) 809-8438**, TTY: 711
- **The Nurse Advice Line** is available to members 24 hours a day, 7 days a week at: **(844) 794-3638** TTY/TDD: 711

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

UM Department: (844) 826-4335
Member Services: (844) 809-8438, TTY: 711

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 and information to help create an Advance Directive:
www.caringinfo.org
http://www.nlm.nih.gov/medlineplus/advancedirectives.html

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.

COORDINATED CARE NEWS

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

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 on-going 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 Complex Case Manager and/or refer a patient for an evaluation for this program, please call toll-free **(844) 826-4335**.

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 and Behavioral Health Guidelines, which include but are not limited to:

- Acute Stress and Post-Traumatic Stress Disorder
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit and Hyperactivity Disorder
- Bipolar 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 Disorders

COORDINATED CARE NEWS

To request a copy of any guideline, please contact Molina Healthcare's Provider Services Department at (844) 826-4335. You can also view all guidelines at **www.MolinaHealthcare.com.**

Medicaid Preferred Drug List and Pharmaceutical Procedures

At Molina Healthcare, the Preferred Drug List and pharmaceutical procedures are maintained by the Pharmacy and Therapeutics (P&T) Committee. The Preferred Drug List (PDL) defined as a list of drugs reviewed and proposed by the Pharmacy and Therapeutics (P&T) Committee, comprised of a group of prescribers, pharmacists, nurse practitioners, and/or other health care professionals. This committee usually meets on a quarterly basis, or more frequently, if needed. The committee's goal is to provide a safe, effective and comprehensive Preferred Drug List. 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 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.

The Preferred Drug List (PDL) contains a wide range of generic and preferred brand name products approved by the FDA. Drugs and drug classes are evaluated for their safety, efficacy, and overall cost value. Prior authorizations for non-preferred drugs may be approved for medically accepted indications when criteria have been met. The Preferred Drug List includes an explanation of limits or quotas, any restrictions and medication preferences, and the process for generic substitution, therapeutic interchange and step-therapy protocols. . Final approval of the Preferred drug List (PDL) is the responsibility of the Executive Director of the Division of Medicaid. When there is a medically necessary indication for an exception, such as failure of the Preferred Drug List choices, providers may request authorization by submitting, via fax, a Medication Prior Authorization Form or by calling the Pharmacy Prior Authorization Department at **(844) 826-4335**. The Preferred Drug List is available online at **www.MolinaHealthcare.com**.

The Preferred Drug List, processes for requesting an exception request and generic substitutions, therapeutic interchanges and step-therapy protocols are reviewed routinely and updated at least annually, more frequently if appropriate. These changes and all current documents are posted on the Molina Healthcare website at **https://www.molinahealthcare.com/providers/ms/medicaid/drug/formulary.aspx**.

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.

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 **www.MolinaHealthcare.com**. Written copies and more information can be obtained by contacting the Provider Services Department at **(844) 826-4335**.

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 from 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 MCG criteria that is utilized to conduct inpatient review except when Change Healthcare InterQual® is contractually required; Hayes Directory; 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 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 **(844) 826-4335**
- The requesting practitioner 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 **(844) 826-4335**.

It is important to remember:

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 denials 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. Molina Healthcare provides for a second opinion from a qualified in-network practitioner. Members from all Molina lines of business and programs should refer to their benefit documents (such as Schedule of Benefits and/or Evidence of Coverage) for second opinion coverage benefit details, limitations, and cost-share information. If an appropriate practitioner is not available in-network, prior authorization is required to obtain the second opinion of an out of network provider. Claims for out of network providers that do not have a prior authorization will be denied. All diagnostic testing, consultations, treatment, and/or surgical procedures must be a benefit under the plan and meet all applicable medical necessity criteria to be covered.
6. 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 (844) 826-4335. You may also fax a question about an UM issue to (844) 826-4335. 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 *Medicaid Preferred Drug List/Marketplace Drug Formulary and Pharmaceutical Procedures* article.

Molina Healthcare's regular business hours are Monday – Friday (excluding holidays) 8:00 a.m. – 5:00 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.

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

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

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

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

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 our members and their families manage a diagnosed health condition. You as a Provider also help us identify members who may benefit from these programs. Members can request to be enrolled or dis-enrolled 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, please call: Provider Services Department at (844) 826-4335 (TTY/TDD at 711 Relay)

You can find more information about our programs on the Molina website at www.MolinaHealthcare.com.

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 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.

COORDINATED CARE NEWS

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 if information obtained during the credentialing process 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
- 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 the Molina Healthcare provider manual on our website at **www.MolinaHealthcare.com** or call your Provider Services Representative for more details.

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 Provider Services at **(844) 826-4335**. You can also view all guidelines at **www.MolinaHealthcare.com**.

Quality Improvement Program

Molina Healthcare's Quality Improvement Program provides the structure and key processes that enable the health plan to carry out our commitment to ongoing improvement in members' health care and service. The Quality Improvement Committee 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 thresholds
- Analysis of information and data to identify trends and opportunities, and the appropriateness of care and services
- Oversight and improvement of functions that may be delegated: Claims, UM and/or Credentialing
- Confirmation of the quality and adequacy of the provider and Health Delivery Organization network through appropriate contracting and credentialing processes

The Quality Improvement Program 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 Quality Improvement Program activities in producing measurable improvements in the care and service provided to members is evaluated by:

- Organizing multi-disciplinary teams, including clinical

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

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 Department at **(844) 826-4335**.

If you would like more information about our Quality Improvement Program or initiatives and the progress toward meeting quality goals or would like to request a paper copy of our documents, please call the Quality Improvement Department at **(844) 826-4335**. You can also visit our website at **www.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 Quality Improvement Department at **(844) 826-4335**.

Translation Services

We 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 Provider Services Department. You can also call TTD/TTY:711 if a member has a hearing or speech disability.

Updating Provider Information

It is important for 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

COORDINATED CARE NEWS

- 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 Update Form located on the Molina Healthcare website at **www.MolinaHealthcare.com** under the Provider Forms section.

Send changes to:
Email: **MHMSProviderContracting@MolinaHealthcare.com**
ATTN: Provider Contracting Department

Contact your Provider Services Representative at **(844) 826-4335** if you have questions.

MCG has provided Cite Guideline Transparency tool that allows providers to view all MCG guidelines that Molina currently uses

With MCG for Cite Guideline Transparency, Molina can share the clinical indications with the providers. The tool operates as a secure extension of Molina's existing MCG investment and helps meet regulations around transparency for care delivery

By Following these instructions (**https://www.molinahealthcare.com/providers/ms/medicaid/comm/-/media/31A167A891774EE79669203E292C8FAD.ashx**) , you will have access to view MCG guidelines via the Provider Portal.

By Following these instructions (**https://www.molinahealthcare.com/providers/ms/medicaid/comm/-/media/33FFC0684FB94F4E8AE5CD1F9641330B.ashx**), you will have access to view MCG guidelines via Availity.

For additional information, please contact your Provider Services Representative or Molina Provider Contact Center at **(844) 826-4335**.

Molina Healthcare Has Chosen Availity As Its Exclusive Provider Portal

Effective 06/15/2021, Molina Healthcare of MS launched the new Availity provider portal. Providers will still have access to our legacy portal to allow time to get acclimated with our new Availity platform. However, we highly encourage any provider who has not registered with Availity to do so as soon as possible.

On Availity, providers will have access to:
- Submit claims, send supporting claim documentation, and check claim status.
- Verify member eligibility and benefits.
- View remittances and EOPs/EOBs.
- Access Molina-specific resources through a dedicated payer space on the Availity Portal:
  - View and navigate through your member roster.
  - Submit claim appeal/dispute/reconsideration.
  - Compare your HEDIS scores with national benchmarks.
  - Submit and view prior authorizations.

Please access this link to login or register: **https://www.availity.com/molinahealthcare**

For additional information, please contact your Provider Services Representative or Molina Provider Contact Center at **(844) 826-4335**.

Molina Partners With ProgenyHealth

Molina Healthcare of Mississippi is happy to announce a partnership with ProgenyHealth, a company which specializes in Neonatal Care Management Services throughout the first year of life. This is an exciting opportunity. ProgenyHealth's care management program will enhance services to our members and support our mission to make a lasting difference in our members' lives by improving their health and well-being.

Under the agreement that begins 7/1/2021,ProgenyHealth's Neonatologists, Pediatricians and Neonatal Nurse

COORDINATED CARE NEWS

Care Managers will work closely with Molina Healthcare of Mississippi members, as well as attending physicians and nurses, to promote healthy outcomes for Molina Healthcare of Mississippi premature and medically complex newborns.

The benefits of this partnership to you:

- The support of a team who understands the complexity and stress of managing infants in the NICU and will work with you to achieve the best possible outcomes
- A collaborative and proactive approach to care management that supports timely and safe discharge to home
- A company that believes in sharing best practices and works with NICUs nationwide to improve the health outcomes of our next generation

Families will have a dedicated case manager who will give support and education to members in the program. Also, they will be able to access an extensive online library and an "on-call" staff member available 24/7. For our hospitals, ProgenyHealth will serve as a liaison for Molina Healthcare providing inpatient review services and assisting with the discharge planning process to ensure a smooth transition to the home setting.

Your process for notifying Molina Healthcare of Mississippi of infants admitted to a NICU or special care nursery will remain the same. Molina Healthcare of Mississippi will notify ProgenyHealth of admissions and their clinical staff will contact your designated staff to perform utilization management and discharge planning throughout the inpatient stay.

If you wish to learn more about ProgenyHealth's programs and services, call **1-888-832-2006** or visit **progenyhealth.com**. You may also call Molina at **(844) 826-4335**.

Thank you for your partnership in caring for Molina Healthcare of Mississippi members.

Molina is moving to a new Online Provider Directory and your accurate information is essential

Ensuring your information is current on the Molina Online Provider Directory is critical. Molina members utilize our directory to find the right providers for the care they need. Please take this opportunity to confirm your demographic information and any special areas of focus or training are up to date and relevant.

If you have updates, please contact Molina as outlined below within two (2) weeks of receiving this notification:

- **For Roster Submissions** – submit your most current roster following the standard process.
- **For Non-Roster Submissions** – submit your changes on the Provider Information Update Form located on the Molina Healthcare Provider website at **www.MolinaHealthcare.com** under the "Forms" section.

A few key benefits of our new Online Provider Directory are:

- User-friendly and intuitive navigation
- Provider profile cards for quick access to information
- Easy browse by category, search bar and common searches
- Expanded search options and filtering
- Enables members to easily save provider information

You can expect to see the new Online Provider Directory roll out in phases beginning this summer 2021.

Please contact your Provider Services Representative at **MHMSProviderServices@MolinaHealthcare.com** if you have any questions.

Thank you for serving Molina members.

COORDINATED CARE NEWS

Removal of OB Authorization Requirements (Molina MississippiCAN/CHIP Only)

Molina Healthcare of Mississippi continues to strive to better serve our members and work efficiently with providers. Effective 5/1/21, no Prior Authorization is needed on file before claims submission for routine deliveries that are not complicated and do not exceed the routine timeframes (three days for vaginal or five days for C-Section) for the claim to pay.

Molina will continue to require authorizations to determine medical necessity on OB delivery stays that are non-routine or complicated.

Providers should wait to file a claim for the below stays until receiving a determination letter:

- Scheduled deliveries before 39 weeks gestation
- Delivery stays that are none-routine or complicated (e.g. O10-O16, O20-O29, O30-O48, O60-O77, O85-O92, O94 -O9A, O09, O00-O08)
- Delivery stays that exceed routine time frames (notification to be filed no later than day 4 for vaginal/ day 6 for C-Section)
- Sick newborns (Sick Baby revenue codes that required an auth regardless the length of stay, e.g. 172, 173, 174)
- Newborns who require services other than normal newborn care (stay beyond 5 days)

Note: The Division of Medicaid (DOM) will continue to require providers to submit newborn enrollment forms. Molina will continue to generate an authorization from the form.

If you have any questions or concerns, please contact our Utilization Management department at **(844) 826-4335**.

UnitedHealthcare® Community Plan

Access and Availability Standards

As a reminder, primary care providers (PCPs) and obstetricians must be available to members by phone 24 hours a day, 7 days a week, or have arrangements for telephone coverage by another UnitedHealthcare participating PCP or obstetrician. Any coverage arrangements that deviate from this requirement must be approved by a UnitedHealthcare medical director or physician reviewer.

Standards for Timely Appointment Scheduling:

Emergency Care Immediately upon the member's presentation at a service delivery site.

Primary Care

- Urgent, symptomatic office visits must be available from the member's PCP or another care provider within 24 hours. This would involve the presentation of medical symptoms that require immediate attention but are not life-threatening.
- Routine office visits or non-urgent, symptomatic visits must be available from the PCP or another care provider within 7 calendar days. A non-urgent, symptomatic office visit would involve medical symptoms that don't require immediate attention.
- Non-symptomatic office visits must be available from the member's PCP or another care provider within 30 calendar days. This type of visit could include wellness and preventive care such as physical examinations, annual gynecological examinations, child and adult immunizations or other services.

Specialty Care

- Specialists and specialty clinics should arrange appointments within 45 days.

Behavioral Health (Mental Health and Substance Abuse)

Behavioral health care providers should arrange appointments for:

- Emergency care (non-dangerous to self or others) immediately upon presentation

COORDINATED CARE NEWS

- Urgent problems within 24 hours of the member's request
- Post Discharge from an acute psychiatric hospital within 7 days
- Routine Non-urgent issues within 21 days of the member's request

Understanding HEDIS® Measures: Statin Therapy for Patients with Diabetes (SPD)

Healthcare Effectiveness Data and Information Set (HEDIS) measures can help enhance quality of care by identifying ways to support preventive care. By working with UnitedHealthcare on HEDIS medical record collection, your efforts can have a direct impact on better patient outcomes – from improved medication adherence to closing clinical care gaps to deeper member engagement in their own well-being.

We realize some of you have questions on specific measures. To help you improve performance for the Statin Therapy for Patients with Diabetes (SPD), we've shared tips and recommendations. Adherence for the SPD measure is determined by the member remaining on their prescribed high or low intensity statin medication for 80% of their treatment period. This is determined by pharmacy claims data (captured each time the member fills the script). The measure is defined below:

Percentage of members ages 40–75 during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria:

- Received statin therapy – Members who were dispensed at least one statin medication of any intensity during the measurement year
- Statin adherence 80 percent – Members who remained on a statin medication of any intensity for at least 80 percent of the treatment period

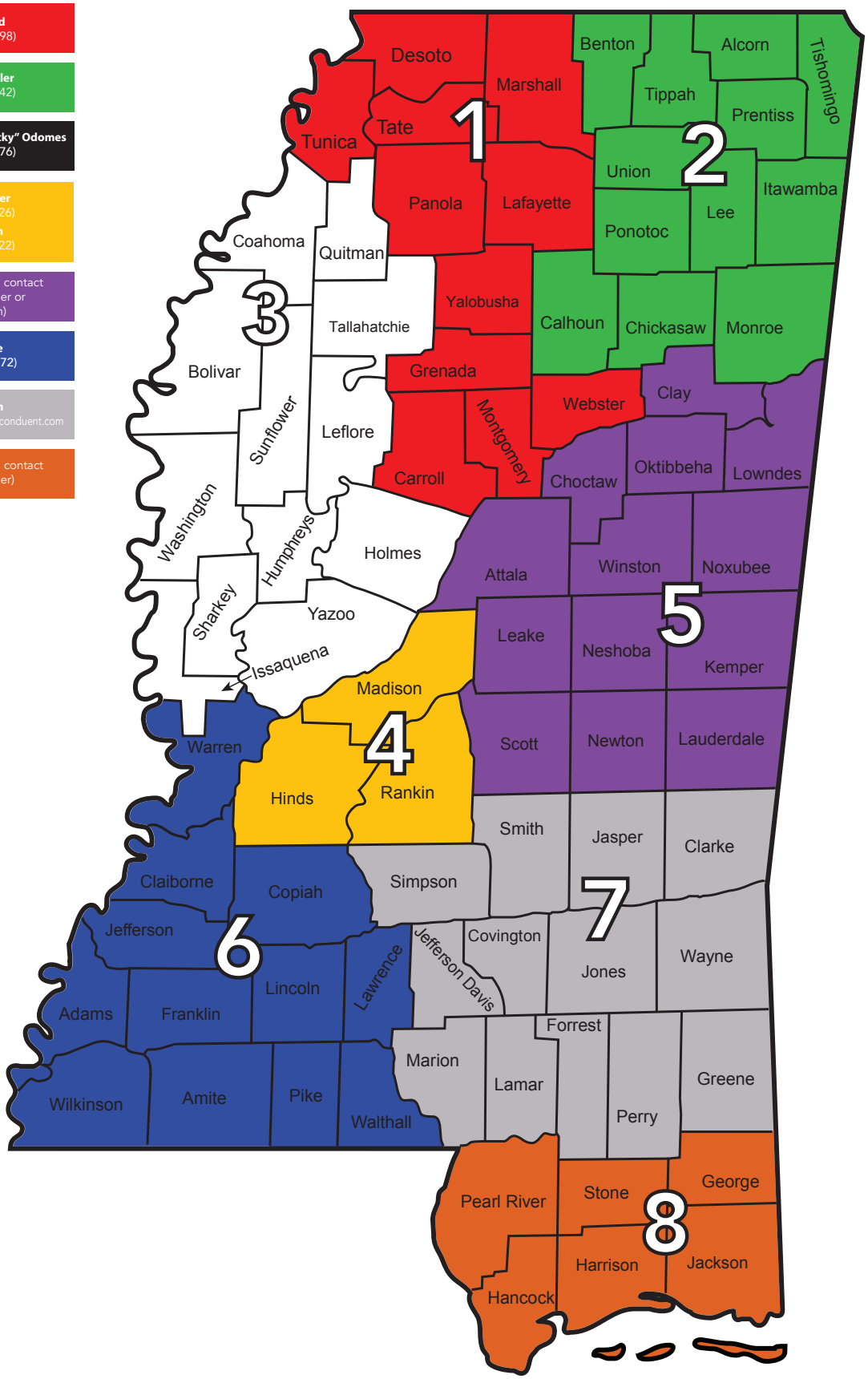
To comply with this measure, one of the following medications must have been dispensed:

Drug Category	Medications	
High-intensity statin therapy	• Amlodipine-atorvastatin 40–80 mg* • Atorvastatin 40–80 mg • Ezetimibe-simvastatin 80 mg**	• Rosuvastatin 20–40 mg • Simvastatin 80 mg
Moderate-intensity statin therapy	• Amlodipine-atorvastatin 10–20 mg* • Atorvastatin 10–20 mg • Ezetimibe-simvastatin 20–40 mg** • Fluvastatin 40-80 mg • Lovastatin 40 mg	• Pitavastatin 1–4 mg • Pravastatin 40–80 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg
Low-intensity statin therapy	• Ezetimibe-simvastatin 10 mg** • Fluvastatin 20 mg • Lovastatin 10–20 mg	• Pravastatin 10–20 mg • Simvastatin 5–10 mg

Important note: The treatment period is defined as the earliest prescription dispensing date in the measurement year for any statin medication at any intensity through the last day of the measurement year. Tips for improving medication adherence: develop a med routine with each patient if they are on multiple meds that require them to be taken at different times, advise patients to setup reminders and alarms, utilize pill organizers, and discuss side effects.

FIELD REPRESENTATIVE REGIONAL MAP

1	**Latasha Ford** (601.572.3298)
2	**Prentiss Butler** (601.206.3042)
3	**Claudia "Nicky" Odomes** (601.572.3276)
4	**Randy Ponder** (601.206.3026) **Justin Griffin** (601.206.2922)
5	**TBA** (interim contact Randy Ponder or Justin Griffin)
6	**Latrece Pace** (601-473-5172)
7	**Erica Guyton** erica.guyton@conduent.com
8	**TBA** (interim contact Randy Ponder)



PROVIDER FIELD REPRESENTATIVES

PROVIDER FIELD REPRESENTATIVE AREAS BY COUNTY

AREA 1 Latasha Ford (601.572.3298) Latasha.Ford@conduent.com	AREA 2 Prentiss Butler (601.206.3042) prentiss.butler@conduent.com	AREA 3 Claudia "Nicky" Odomes (601.572.3276) claudia.odomes@conduent.com
County	**County**	**County**
Desoto	Benton	Coahoma
Tunica	Tippah	Quitman
Tate	Alcorn	Bolivar
Panola	Tishomingo	Sunflower
Marshall	Prentiss	Leflore
Lafayette	Union	Tallahatchie
Yalobusha	Lee	Washington
Grenada	Pontotoc	Sharkey
Carroll	Itawamba	Humphreys
Montgomery	Calhoun	Yazoo
Webster	Chickasaw	Holmes
	Monroe	Issaquena
***Memphis**		

AREA 4 Justin Griffin (601.206.2922) justin.griffin@conduent.com Randy Ponder (601.206.3026) randy.ponder@conduent.com	AREA 5 TBA (interim contact Randy Ponder or Justin Griffin)	AREA 6 Latrece Pace (601.473.5172) Latrece.Pace@conduent.com
County	**County**	**County**
Hinds	Clay	Warren
Rankin	Oktibbeha	Claiborne
Madison	Choctaw	Jefferson
	Attala	Adams
	Leake	Franklin
	Scott	Wilkinson
	Lowndes	Amite
	Winston	Copiah
	Noxubee	Lincoln
	Neshoba	Pike
	Kemper	Lawrence
	Newton	Walthall
	Lauderdale	

AREA 7 Erica Guyton erica.guyton@conduent.com		AREA 8 TBA (interim contact Randy Ponder 601.206.3026) randy.ponder@conduent.com
County		**County**
Simpson		Pearl River
Jefferson Davis		Stone
Marion		George
Lamar		Hancock
Covington		Harrison
Smith		Jackson
Jasper		
Jones		**Slidell, LA**
Forrest		**Mobile, AL**
Perry		
Greene		
Wayne		
Clarke		

OUT OF STATE PROVIDERS	**Justin Griffin (601.206.2922)** justin.griffin@conduent.com **Randy Ponder (601.206.3026)** randy.ponder@conduent.com

CONDUENT
P.O. BOX 23078
JACKSON, MS 39225

If you have any questions related to the topics in this bulletin, please contact Conduent at 800 - 884 -3222

Mississippi Medicaid Administrative Code and Billing Handbook are on the Web
www.medicaid.ms.gov

Medicaid Provider Bulletins are located on the Web Portal
www.ms-medicaid.com

DECEMBER 2021

THURS, DEC 2	EDI Cut Off – 5:00 p.m.
MON, DEC 6	Checkwrite
THURS, DEC 9	EDI Cut Off – 5:00 p.m.
MON, DEC 13	Checkwrite
THURS, DEC 16	EDI Cut Off – 5:00 p.m.
MON, DEC 20	Checkwrite
THURS, DEC 23	DOM Closed
FRI, DEC 24	DOM Closed
MON, DEC 27	Checkwrite
THURS, DEC 30	EDI Cut Off – 5:00 p.m.
FRI, DEC 31	DOM Closed

JANUARY 2022

MON, JAN 3	Checkwrite
THURS, JAN 6	EDI Cut Off – 5:00 p.m.
MON, JAN 10	Checkwrite
THURS, JAN 13	EDI Cut Off – 5:00 p.m.
MON, JAN 17	Martin Luther King, Jr. Day DOM Closed
THURS, JAN 20	EDI Cut Off – 5:00 p.m.
MON, JAN 24	Checkwrite
THURS, JAN 27	EDI Cut Off – 5:00 p.m.
MON, JAN 31	Checkwrite

FEBRUARY 2022

THURS, FEB 3	EDI Cut Off – 5:00 p.m.
MON, FEB 7	Checkwrite
THURS, FEB 10	EDI Cut Off – 5:00 p.m.
MON, FEB 14	Checkwrite
THURS, FEB 17	EDI Cut Off – 5:00 p.m.
MON, FEB 21	President's Day DOM Closed
THURS, FEB 24	EDI Cut Off – 5:00 p.m.
MON, FEB 28	Checkwrite

Checkwrites and Remittance Advices are dated every Monday. Provider Remittance Advice is available for download each Monday morning at www.ms-medicaid.com. Funds are not transferred until the following Thursday.