

## C.17 Provider Services

### REQUIREMENT: RFP Section 60.7.C.17

#### 17. Provider Services (Section 27 Provider Services)

- a. Summarize the Vendor's overall approach to Provider Services, including initiatives and processes for providing effective services to providers to support the Kentucky Medicaid program. In the response, address the following at a minimum:
  - i. A description of how provider representatives engage with providers initially and on an ongoing basis, including level of local presence and onsite visits to provider locations.
  - ii. Description of formal committees, workgroups, or other forums, if any, in which Providers can receive updates and instruction from the Vendor and offer input about the overall program and Vendor initiatives.
  - iii. Methods and metrics used to collect provider feedback and to measure overall provider satisfaction, including frequency of doing so.
  - iv. Methods the Vendor will use to minimize provider complaints and escalations to the Department.
- b. Describe the Vendor's proposed Provider Services call center, including an overview of the following at a minimum:
  - i. Approach to assuring the call center is fully staffed during required timeframes.
  - ii. Location of proposed operations.
  - iii. How the Vendor will meet and monitor call center standards, and how the Vendor will use monitoring results to adjust operations, as needed.
- c. Provide an overview of the Vendor's proposed provider website, including examples of information that will be provided through the website and any functionality that will be included to communicate with providers.  
Provide sample screenshots of provider websites currently maintained by the Vendor.
- d. Provide a proposed table of contents for the Provider Manual and a brief description of the type of information the Vendor will communicate via the manual.
- e. Provide the Vendor's proposed approach to provider orientation and education.
- f. Describe the Vendor's support of providers in Medicaid enrollment and credentialing, including the following:
  - i. Methods for assisting providers who are not enrolled in Medicaid with the enrollment process.
  - ii. Proposed process for conduct of credentialing until such time that a Credentialing Verification Organization (CVO) is contracted by the Department.
  - iii. Proposed process for transitioning credentialing activities to and coordinating with the Department's contracted CVO(s) to educate and assist Providers in completing the credentialing process with the CVO(s).
  - iv. Approach for a timely contracting determination of providers upon receipt of information from a CVO that a provider's credentialing is complete, specifying timeframe for uploading a credentialed and contracted provider into the claims payment system to allow for payment of adjudicated claims.Include copies of the Vendor's proposed credentialing policies and procedures, and procedures for coordination with the CVO(s).
- g. Provide the Vendor's proposed approach for processing provider grievances and appeals. Include at a minimum:
  - i. The overall process to include description of interaction with providers, required correspondence and timeframes for acknowledging and resolving grievances and appeals.
  - ii. Process for tracking reasons for grievances and appeals to identify trends, and how the Vendor will use this information to improve internal operations, provider relations, and provider satisfaction.
  - iii. Process for ensuring transparency to DMS of grievance and appeal types, resolutions, and any Vendor actions to decrease such grievances or appeals in the future.

**Our provider services approach drives proactive engagement, education, collaboration, and transparency while minimizing provider abrasion and maximizing satisfaction and retention.**

Transparency is the cornerstone of our approach as we interact with both the provider community and Department. Molina views our providers as critical partners in transforming the Kentucky Medicaid Program. We developed our provider services approach to meet the specific needs of the Commonwealth based on established relationships and on the ground conversations in Kentucky. *As an MCO focused solely on providing services to government-insured Enrollees, we know firsthand that in order for a Medicaid Managed Care program to be successful it is essential to work in close collaboration with providers, the Department, Enrollees, and other stakeholders, including other Kentucky MCOs.*

We share a common interest with the Department in supporting providers so they are empowered to offer effective and efficient care. This is especially true within a population health environment, which places critical importance on the delivery of high-quality preventive and ongoing care to improve health outcomes. Our experience is that providers must be supported by an MCO that both invests in and mentors them to successfully transform the care delivery system. *Our approach will reduce provider*

***abrasion and increase provider satisfaction by ensuring providers can focus on serving Enrollees rather than administrative issues.***

Molina conducted a series of targeted focus groups and meetings with Kentucky providers who serve Medicaid beneficiaries in 2019. Some of the feedback we received about their interactions with the current MCOs included claims processing frustrations based on a high rate of denials and difficulties with prompt claims adjudication and payment; challenging credentialing process that can take up to three months; cumbersome and inefficient prior authorization and peer review processes; short appeals timeframes and challenges scheduling calls with the MCO to discuss appeals; and a lack of engagement with health plan provider services staff.



Molina affiliated health plans serve members in more than 600 rural counties across the country, and we understand provider needs vary based on location.

**Our proposed Kentucky Provider Services Approach includes:**

- A hands-on, nimble approach to provider services developed specifically for Kentucky
- Six Molina One-Stop Help Centers across the Commonwealth that offer immediate, face-to-face provider support
- Assigned provider services representatives based in the local community
- A Louisville-based Call Center offering telephonic support
- A fully integrated physical and behavioral health network
- Ongoing provider collaboration resulting in reduced provider abrasion and increased satisfaction
- Transparency between Molina and both our provider network and the Department
- Proven processes such as credentialing and claims payment that historically exceed Medicaid performance standards for timeliness
- An MCO focused solely on providing services to government-insured individuals

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We have listened to providers and considered the needs of the Commonwealth in developing our approach to serving the Kentucky Medicaid program. ***Our approach is supported by a continuum of value-based models that promotes the transformation of care delivery and performance from a historically volume-based model to one focused on a clear value-based, long-term population health management strategy that improves the overall quality of healthcare and lowers costs.***

**Molina's six One-Stop Help Centers will be strategically located across the Commonwealth addressing rural needs and historically underserved communities.** These Centers will be located in easily accessible locations in Louisville, Covington, Bowling Green, Hazard, Lexington, and Owensboro, and will offer providers a place for face-to-face assistance, provider meetings and training sessions.

Our provider services representatives will know their local providers and meet face-to-face with physical and behavioral health providers to build trust, foster open communication, and develop collaborative relationships. They will travel to provider locations to meet providers prior to go-live and continue ongoing face-to-face contact with providers after implementation. Provider services representatives will also meet face-to-face with local provider associations and present at regional provider conferences.

Within the remainder of this section, we describe our proposed approach to meet the needs of Kentucky Medicaid providers and proposed strategies to deliver a comprehensive provider services program designed to increase provider satisfaction while simultaneously decreasing provider abrasion and administrative burden. Our provider services program complies with all requirements in Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 27, Provider Services.

## **a. OVERALL APPROACH TO PROVIDER SERVICES**

**Molina is committed to local, high-touch provider services and support for our integrated physical and behavioral health network providers. Our provider services team will be regionally based within the Commonwealth.** Every provider will be assigned a specific provider services representative as their first of point of contact. Each representative will support a specific category of provider (PCPs, behavioral health, specialists, or facilities).

We know delivering prompt and accurate claims payment and quick resolution of issues is essential to minimizing provider abrasion. Our approach includes a dedicated claims support team for providers. Molina is proud of our ability to process claims and consistently exceed service levels. ***Across all our health plans in 2019, we average 10.6 days from receipt of a claim to payment, including claims that require secondary quality review.***

Molina is proud of our approach to finding progressive ways to build strong, positive provider relations. Our flexible and adaptable approach meets the needs of providers no matter where they are located. For example, we will establish self-service tools and multiple interactive training platforms to enhance communication with physical and behavioral health provider offices. This allows providers and their staff to select a modality that best fits their needs and assures all providers receive training that meets their specific needs. This will especially benefit smaller practices or providers located in rural areas that may prefer to complete training from their office.

Our approach to serving providers also varies by provider type. For example, for large provider groups and health systems we will conduct regularly scheduled joint operating committee meetings. The assigned provider services representative will schedule regular joint operating committee meetings to discuss the current status of operations such as claims submission and payment, utilization management, quality, contract questions, and changes in Kentucky's Medicaid program. Joint operating committee meetings provide an additional opportunity for providers to offer feedback and have questions answered. In addition, our dedicated Provider Engagement Team is another critical resource to help our provider partners with value-based payment (VBP) contracts achieve their performance goals.

**Molina's Preferred Provider PA Program.** During our focus groups, we heard frustrations from providers around prior authorization requirements. We understand and are sensitive to the administrative burden placed on hospital systems and provider groups, particularly as it relates to prior authorization. As a manner of practice, Molina systematically reviews its approach to prior authorization codes to discern the utilization, approval rates, and impact on both quality and cost. Molina regularly performs an extensive review of all codes that require prior authorization to identify those that we may be able to build into our VBP programs to relax, or in some instances, eliminate the requirements of prior authorization to remove barriers to Enrollee care and to improve provider relationships.

Molina will incorporate a Preferred Provider PA Program in partnership with Kentucky's highest functioning health systems and provider groups that have demonstrated quality outcomes in identifying certain codes that create administrative burden. We will develop a collaborative approach to relax or eliminate the need for prior authorization of those codes. Subsequent to implementation with these selected Preferred Providers, Molina and the providers will hold quarterly joint operating committee meetings to review utilization, quality, and cost metrics to determine if adjustments to the Program are warranted, which can be made at Molina's sole discretion if necessary.

**This enhanced level of service for large provider groups, health systems, and providers with VBP contracts assures open and effective communication, creating a collaborative partnership focused on improving outcomes and eliminating potential operational issues.** Molina's comprehensive approach to provider services meets providers on their playing field. Additional highlights of our approach include:

**Provider Collaboration.** Our commitment to excellent provider service reduces provider abrasion and voluntary turnover while helping Enrollees sustain lasting provider relationships. Provider services representatives manage provider issue resolution from beginning to end by coordinating with key health plan resources and departments, meeting with providers one-on-one to coordinate solutions, and sharing best practices to continuously refine our provider issue resolution processes.



Providers are happy with Molina. This is evidenced by the **voluntary provider turnover rate of less than 1% at one of our affiliate health plans from November, 2018 through April, 2019.**

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**Training and Onboarding.** Effective training and onboarding, which includes new provider orientation and Molina provider portal training for both physical and behavioral health providers, ensures that providers have the tools and knowledge to participate in the program and meet the needs of Enrollees. Molina's comprehensive provider services training program, which includes provider portal education and links to free external Continuing Medical Education credit opportunities, will equip our providers to meet the needs of Enrollees and understand all contract requirements including, policies, procedures, and scope of services. ***We will also provide an annual Behavioral Health Toolkit for providers which includes education, best practices, and support around common behavioral health issues as well as ongoing education and resources around behavioral health and pain safety.***

**Contracting and Credentialing.** Molina's comprehensive credentialing and recredentialing program will ensure that our Kentucky Medicaid provider network comprises quality practitioners and facilities, meeting clearly defined criteria and quality standards for the services our Enrollees require. ***Over the past year, the average turnaround time across all Molina health plans for completing credentialing activities was 17.5 calendar days from receipt of a credentialing application.***

**Transparency.** During our focus groups, Kentucky Medicaid providers told us that they are not informed about correct coding edits and are frustrated when they do not know what edits are being applied. Our Ohio affiliate health plan maintains a grid on the provider portal that shows all correct coding edits currently in use. We will maintain a similar grid for our Kentucky providers, just another example of how we will encourage transparency with our provider partners.

Our high-touch approach to provider services played a critical role in the success of Molina's recent Mississippi Coordinated Access Network (MississippiCAN) Medicaid program implementation and continues to impact ongoing program operations. Throughout this section we highlight experience from Molina's Mississippi implementation as the covered population, demographics, population health, and rural access challenges are similar to those found in Kentucky. Exhibit C.17-1 provides a summary of the successful provider services approach employed during program implementation.

Utilizing Molina's proven approach tailored to the needs of the state, our Mississippi health plan team was able to stand up a new program while meeting all Medicaid contract requirements. We will leverage this experience to help ensure a positive experience for providers as they begin to deliver care to Kentucky Medicaid Enrollees as part of Molina's provider network.

## Exceeding Expectations and Delighting Providers – Molina's Mississippi Implementation

Preparing our Mississippi Provider Services Team to meet the needs of network providers began well in advance of the go live date:



### Preparing Provider Services Representatives (PSRs) for provider orientation.

The Mississippi health plan utilizes a slide presentation to conduct provider orientation within 30 days of the provider joining Molina's network. Prior to go live, all PSRs had a chance to practice presenting provider orientation material. Multiple practice sessions were held with PSRs presenting a different portion of the orientation at each session. This allowed the entire staff to practice their delivery of the entire provider orientation presentation, respond to questions, and to receive feedback from their peers.



**Mock Provider Meetings.** PSRs participated in mock provider meetings prior to go live. This gave the team an opportunity to hone their meeting facilitation skills and better understand what to expect during a provider meeting. This helped to provide a consistent experience for Mississippi providers as the entire team was serving providers utilizing a unified approach



**Training Guide.** A guide was developed that offered PSRs tips on how to handle different situations so time spent with each provider was meaningful. For example, the guide includes information about what to take to the provider location based on meeting and provider type and effective meeting facilitation.



**Feet on the Street Prior to Go Live.** PSRs went into the field approximately a month prior to go live. This allowed PSRs the opportunity to meet providers and begin to establish relationships.

### Ongoing support for Providers includes:

**Staffing.** PSRs are assigned regionally and 80% of the team is field-based. A small group of PSRs remains in-house to respond to providers who contact the health plan via telephone and to maintain the dedicated provider services email box. They also respond to inquiries from other departments and assist out-of-state providers.

While the majority of PSRs are assigned regionally, one PSR is assigned to meet the needs of FQHCs and another PSR assists BH providers statewide. Assigning by region or provider type allows our PSRs to be intimately familiar with the needs of their assigned providers and their region.

For example, the Delta area is very rural and the ratio of providers to Enrollees is low. It is difficult to transition providers to electronic methods of claims submission and information sharing and many providers do not have access to the internet. In addition, in very rural areas it is often hard to get Enrollees to see the providers and it requires provider relations to partner with the Health Care Services team to develop solutions. The dedicated PSR for this region understands these rural issues as well as how to best assist the providers.

**Visit Documentation.** PSRs are required to document each visit and track all follow-up items related to the visit. The provider is required to sign the documentation report. Documentation reports are submitted weekly. This allows for continuity in the case of a staffing change or unexpected absence.

**Weekly Summary Report.** PSRs complete a weekly summary report which is submitted to leadership. This allows leaders to get a sense of what is happening in the field and respond proactively. The health plan finds this tool allows for timely issue resolution and limits the escalation of issues to the Department. Included in the summary report is provider information such as name, phone, email and identification of any issues. Collecting email addresses also allows the health plan to continually build the contact list for delivery of the provider newsletter.

**Ongoing Communication.** Bi-weekly PSR meetings are held to discuss important news and process changes. PSRs also attend quarterly training. Leadership created a department SharePoint site which has resources grouped by topic including information pulled from the state Medicaid and CMS websites. PSRs also receive links via email related to topics of interest.

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### Exhibit C.17-1. Molina's Successful Mississippi Provider Services Approach



## a.i. PROVIDER ENGAGEMENT

### Initial Engagement

We recognize that as a new plan, the responsibility to build relationships lies with us, not the provider community. Our provider services representatives, Provider Engagement team, contracting and credentialing staff, Community Engagement representatives, and plan leadership will be active throughout the Commonwealth in advance of the go-live date to introduce ourselves and let providers know what they can expect from us.

Exhibit C.17-2 describes an early initiative we took when our Ohio affiliate began operations in 2014.

### It Matters to Molina

Shortly after Molina Healthcare of Ohio began operations, a provider approached their director of provider services. “I made a suggestion to my provider services representative, and you actually took it!” the provider said. The comment was heartening but somewhat surprising. Collaborative problem-solving is part of the Molina culture, but we soon learned that providers in Ohio hadn’t received that level of commitment from previous contractors.

In response, our organization created “**It Matters to Molina**” for use in all Molina affiliated health plans. We distribute comment cards for providers to evaluate us and suggest improvements. We know the importance—to all stakeholders—of meeting provider needs. “It Matters to Molina” reinforces that connection and often reaffirms what we’re doing right.

Providers have been quick to praise us for service that goes above and beyond their expectations, including in the areas of greatest interest to the Department:

#### Delivering high-quality client service

“ Molina has been a good payer and hassle-FREE. ”

Mercer County Health Department

#### Collaborating to solve problems

“ For the past several weeks, we went through very hard times trying to get answers concerning billing, rates, codes, and billing methods. After voluminous attempts to get our questions answered, I finally received a phone call from [one of Molina’s provider services representatives]. Within minutes, she not only resolved our problem but provided us with all answers. I really appreciate her help and wanted to thank you for employees like her. She is amazing! ”

Senior care provider

#### Sharing knowledge

“ [Molina’s provider services representative] held a Webinar that was the BEST, most informative, and instructional and beneficial Webinar I have ever attended ... “She not only did an awesome job but has gone above and beyond to help our agency receive our QMPO number. If everyone at Molina is as wonderful as she is, it will be wonderful working with you. ”

Home services provider

#### Being proactive, adaptable, and innovative

“ I just wanted to take a few moments to let you know how helpful [one of your provider services representatives] has been with me. I am a behavioral health provider, and I have been having some issues in navigating the portal and billing systems with Molina. I have been amazed with how prompt she is in returning emails/calls ... I have really appreciated her assistance, and I have her on my speed dial!!! ”

Behavioral health provider

#### Engaging stakeholders to build strong partnerships and trust

“ Quarterly meetings are wonderful! Always organized and friendly. Keep up the great work. ”

Kettering Health Network

Exhibit C.17-2. “It Matters to Molina”

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This approach proved immediately successful in receiving actionable feedback (in simplifying claims submissions, for instance) and showing providers that we want to incorporate their ideas into our practices and procedures. For Kentucky, we will conduct an “It Matters To Molina” campaign that includes not only comment cards but a dedicated email inbox, a link on the Provider Portal, and a monthly webinar that will allow providers in remote locations to participate and ask questions directly.

As we establish our presence in the Commonwealth, our focus will shift from a large-scale introduction of ourselves to meeting and recruiting those qualified providers who have not yet joined our network. Two teams are responsible for this effort:

**Provider Contracting Team.** Our Provider Contracting staff is responsible for the initial engagement, recruitment, and contracting of physical and behavioral health providers. Our Provider Contracting Team began reaching out to Kentucky Medicaid providers in March 2019. Prior to executing a provider agreement, Molina’s contracting staff is available to respond to any questions and further outline requirements via telephone and email. Once a provider has an executed contract, a Molina provider services representative will conduct a formal orientation within 30 days of the contract’s effective date to explain key information and answer any questions.

**Provider Services Team.** Our high-touch provider services approach begins with early engagement of our provider services staff. Provider services representatives will be on-boarded approximately four to six months prior to program go-live. This will allow the team to receive extensive training on Molina’s provider services approach and provider training materials as well experience in providing the training to provider offices. Most importantly, this will also allow provider services representatives to spend time in the field prior to go-live. They will be able to meet their Kentucky providers face-to-face and begin forging the foundation for a long-time, collaborative partnership which is key to our high touch approach.

## Ongoing Engagement

**Provider Service Representatives.** *Our Provider services representatives are our feet-on-the-street and faces in our providers’ offices. Each provider services representative is required to complete a minimum number of provider visits each week.* While we encourage provider services representatives to schedule appointments for provider visits, our approach is designed to be nimble and allows us to respond immediately if a provider requests assistance. *Providers will also have access to provider services representative support at any of our Molina One-Stop Help Centers across the Commonwealth.*

Provider services representatives are champions for provider training and education, in alignment with Molina’s overall mission, core values, and strategic plan and in compliance with all relevant federal, Commonwealth, and local regulations. Provider services representatives will be the primary point of contact between Molina and our network providers. They will be responsible for provider training, end-to-end issue resolution, and ensuring knowledge of and compliance with Molina policies and procedures while providing high level customer service. They will respond to provider requests and inquiries within two business days. Some of the ways our provider services representatives will provide support include:

- Assisting providers with enrollment status questions
- Assisting providers with prior authorization and referral procedures
- Assisting providers with claims submissions and payments
- Explaining to providers their rights and responsibilities as a participant in our network

### Listening to Providers, Improving Our Processes

Molina Healthcare of Ohio heard a consistent complaint: Because our provider services representatives were traveling so often, email responses were delayed. The team responded by creating shared email buckets by provider type (e.g., hospital, physician, behavioral health) and assigned a subject matter expert to answer all emails from their area of knowledge. Providers receive an initial response within 48 hours and a resolution within 30 days. Provider satisfaction increased, and email responsiveness is now part of the monthly quality audit.

- Responding to providers' questions related to filing grievances and appeals
- Developing, conducting, and assuring provider orientation/training
- Communicating Medicaid policies and procedures, including Commonwealth and federal mandates and any new policies and procedures
- Providing technical support to providers who experience unique problems with Enrollees
- Assisting our Healthcare Services or Care Management staff as they help providers in coordinating care for child and adult Enrollees with complex and/or chronic conditions

Molina's provider services staff will be available Monday through Friday 8:00 am – 6:00 pm Eastern Time, at a minimum. Team members will be available to speak with Kentucky Medicaid providers any time during those hours. Molina will also offer provider support until 9:00 p.m. Eastern Time from our affiliates provider services Call Centers located in other time zones. Providers also have access to self-service functionality 24 hours a day, 7 days a week. Our Call Center will meet all Department standards as described in Section 27.2, Provider Services Call Center, of the Draft Contract.

**Provider Engagement Team.** Our dedicated Provider Engagement Team will be a critical resource in helping our provider partners with VBP contracts achieve their performance goals. The Provider Engagement Team is a cross-functional group that works in collaboration to engage our network providers, especially those serving Enrollees under VBP arrangements, to improve quality outcomes and promote efficiencies through implementation and support of new programs/initiatives. The Provider Engagement Team supports providers by accessing and evaluating comprehensive cost, utilization, and quality data, and identifying and proposing performance improvement opportunities and related resources. The team will work closely with our providers to achieve the following goals:

- Improve healthcare outcomes and HEDIS scoring
- Secure Enrollees with certain medical needs into care management programs
- Implement Patient Centered Medical Homes in PCP offices, making the PCP function a more attractive and important component of the healthcare delivery model
- Increase provider satisfaction by targeting/assisting providers with billing/coding deficiencies

Exhibit C.17-3 summarizes how our Provider Engagement Team collaborates with providers with VBP contracts by providing additional support to help them achieve targeted metrics.



Additional Data and Reporting Support	Implementation Support Resources	Improvement Initiatives/ Best Practices
<ul style="list-style-type: none"> <li>• VBP metrics over time and compared with benchmarks</li> <li>• High cost Enrollee list</li> <li>• Quality/ HEDIS missing service list</li> </ul>	<ul style="list-style-type: none"> <li>• Quality Improvement Team</li> <li>• Healthcare Services Team</li> <li>• Care Management, Disease Management</li> <li>• Health Homes</li> <li>• Community Health Workers</li> <li>• ED Diversion &amp; Transition of Care Support</li> </ul>	<ul style="list-style-type: none"> <li>• Shared best practices</li> <li>• New technologies</li> </ul>

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### Exhibit C.17-3. Additional Support Offered by our Provider Engagement Team

Molina Healthcare of Illinois created a new Provider Engagement Team initiative in 2018 to respond to issues facing large providers. This outreach effort targeted the highest-volume facilities with an increased focus on education, data-driven initiatives, and quality measures. The goal was to improve the quality of care their members received while reducing costs.



Illinois providers have embraced the idea of partnership through the Provider Engagement Team, and their willingness to share information and ideas has helped our affiliate improve the program for the entire group's benefit by:

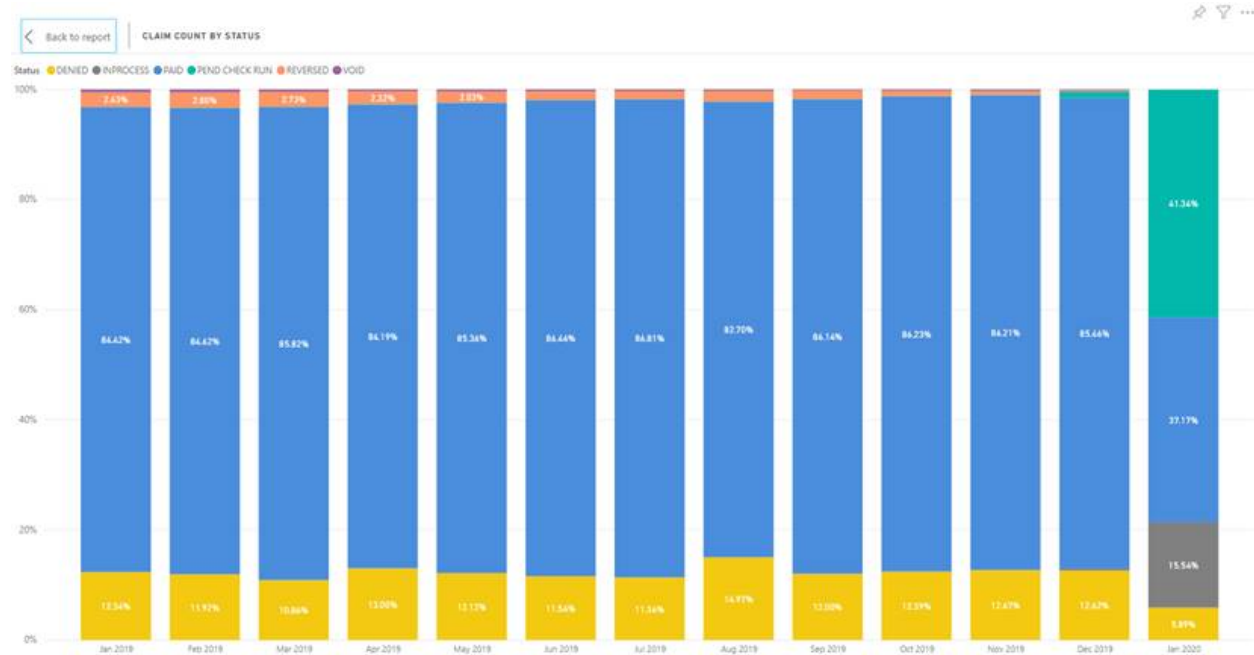
- Sharing an ED opioid-reduction tool with all participating facilities.
- Promoting best practices to hospitals for an organized and successful discharge planning process for behavioral health patients.
- Reviewing vaccine promotion strategies at each facility and offering suggestions for improving the process. This led to improved vaccination rates.

The most visible function of the Provider Engagement Team is provider education. In addition to quarterly meetings with each participant, our affiliate health plan facilitated 18 monthly webinars during 2018 on topics such as website and portal registration, claim submission through the portal, appeals and grievances, transitions of care, and managing behavioral health conditions in a PCP office.

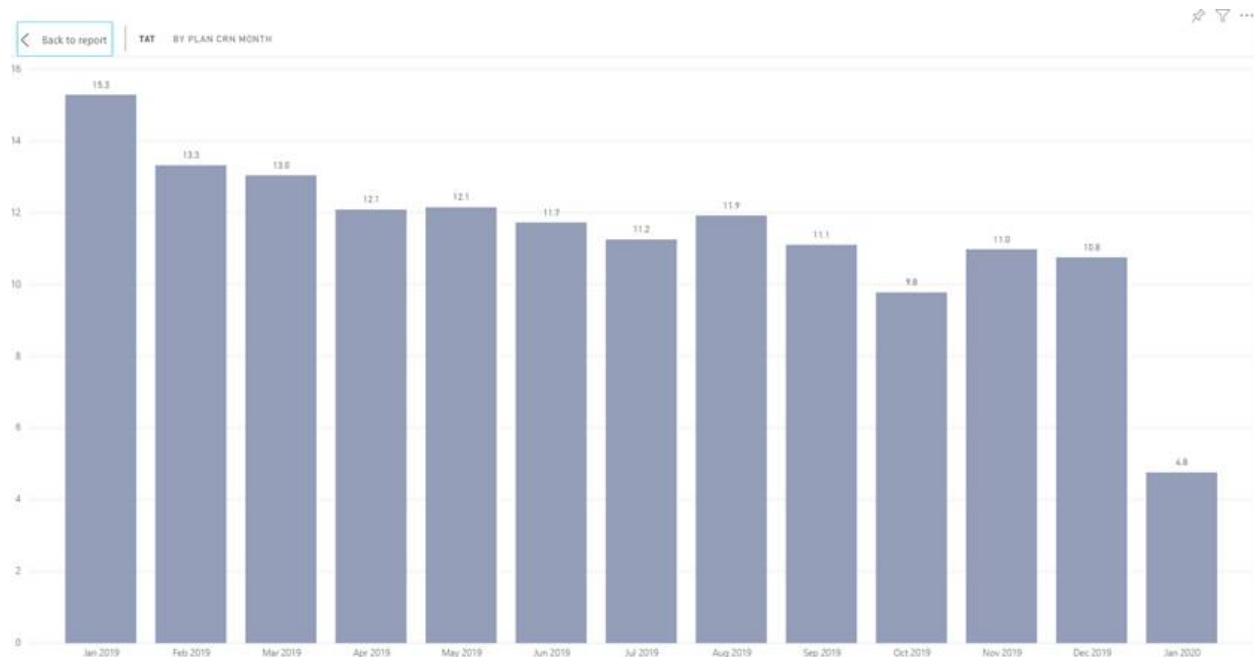
Meanwhile, Molina Healthcare of Ohio developed a strong Core Team approach with their behavioral health providers. This internal team is comprised of a Provider Engagement Team member, the behavioral health medical director and a quality improvement representative who is a licensed mental health clinician. Their focus is to develop strategies to support the needs of our Enrollees by working with identified providers and review dashboard analytics with them to share the provider's current standing in the network related to behavioral health-related measures.



**Increased Transparency.** Not only do we deliver information to providers about their performance, but we enable them to track ours as well. We track and share with providers our monthly claims status and turnaround time, as shown in Exhibits C.17-4 and C.17-5. Providers can see trends in claims and the results of our efforts to improve our operations and pay providers more quickly.



**Exhibit C.17-4. Monthly Claims Status**



**Exhibit C.17-5. Monthly Turnaround Time**

## a.ii. PROVIDER COMMITTEES

**Providers matter to Molina.** We continually look for opportunities to update providers on new opportunities to improve healthcare of Enrollees and include provider input in program operations. Below we describe how providers receive updates from Molina and will have a voice in program operations through participation in the Provider Advisory Workgroup and the Quality Improvement Committee.

## Provider Advisory Workgroup

Molina's Provider Advisory Workgroup is a team of a cross-section of network providers who meet quarterly to provide feedback to Molina on programs and initiatives. The Provider Advisory Workgroup also provides an opportunity for providers to receive updates and instruction from the provider services staff and other Molina subject matter experts. Workgroup meetings provide a forum for open dialogue on issues related to the relationships and interactions between, and among, providers and our staff as well as provider input and suggestions.

The Provider Advisory Workgroup is facilitated by provider services representatives and includes our participating physical and behavioral health network providers and reflects their geographical distribution and diversified representation. We will solicit participation from providers in each of Kentucky's eight regions. Meeting minutes from Provider Advisory Workgroup are shared with the Enrollee Provider Satisfaction Workgroup, which then develops strategies to improve performance.

### ***Provider Advisory Group: Provider Selection***

Molina will use a variety of criteria to seek provider participation in the Provider Advisory Workgroup. This includes soliciting feedback from our Healthcare Services, Pharmacy, Quality, Enrollee Services, and Provider Services departments on potential candidates. We also review Enrollee panel size for PCPs and claims volume for specialists to ensure we are inviting providers who provide care to a sufficient number of our Enrollees and can provide valuable feedback on our processes.

We also encourage providers to volunteer for participation through notifications in the Provider Bulletin and provider portal. To ensure diverse membership, we look to include a representative mix of PCPs, pharmacy providers, high-volume specialists, and ancillary providers. We will encourage regional representation across Kentucky, participation of providers with expertise in population health and social determinants of health, and providers who engage with critical Commonwealth Medicaid committees. We request providers to commit to the group for one full year. Membership is evaluated annually, and new providers are solicited to obtain new perspectives.

## Molina-Led Provider Forums

Molina will seek unique ways to engage providers and build positive relationships. We will use operations in other states as a guide. For example:

- **Molina Healthcare of Texas** hosts a series of "Molina on the Spot" quarterly meetings in each of six service regions. These meetings serve as an educational series, but we also have representatives in attendance to answer questions about utilization management, contracting, and claims.
- **Molina Healthcare of Ohio** created a clinical joint operating committee to create a bridge between providers and their Utilization Management department, who were having difficulty with communication regarding authorizations. The Provider Services department collaborated with key provider networks. Our Ohio affiliate identified key staff from the health plan and providers to attend the meetings, presented the clinical joint operating committee plan during existing provider meetings, and reached an agreement to move forward with the joint operating committee. The joint operating committee meetings are now regularly scheduled, with a written agenda of clinical and collaborative priorities to address at each meeting.

We plan to begin these meetings in advance of go-live. The subjects will depend on which areas are of most interest and help to Kentucky providers, based on their advance input.

## Professional Review Committee

Molina designates a Professional Review Committee to make recommendations regarding credentialing decisions using a peer review process. We work with the committee to ensure that network providers are competent and qualified to provide continuous quality care to our Enrollees. The committee reviews and approves credentialing policies and procedures.

## Provider Participation in Quality Improvement

Kentucky providers will be active members of Molina's Kentucky Quality Improvement Committee. Co-chaired by the medical director and quality improvement director, our Quality Improvement Committee will reflect a diverse array of expertise, including our CEO and leaders from the quality, healthcare services, behavioral health, network, provider services, compliance, and community and Enrollee engagement teams. Community physical and behavioral health provider participation will promote a community-based approach to our quality program. Meeting quarterly, our Quality Improvement Committee will be responsible for designing, approving, implementing, monitoring, and modifying the activities within our Quality Assurance and Performance Improvement (QAPI) Program.

The QIC will recommend policy decisions, analyze and evaluate the progress and results of all QAPI activities, institute necessary action, and ensure follow-up. Subcommittees will continuously monitor data, identify areas for improvement, track interventions and performance, review performance improvement project results, and report to the Quality Improvement Committee. Through committee activity, participating providers may review and provide feedback on proposed clinical practice guidelines, performance measure results, clinical protocols, QAPI study designs and interventions, and plans to improve levels of care and service.

### Quality Improvement Committee in Ohio

To illustrate the important role of the Quality Improvement Committee in influencing QAPI efforts, last year the Quality Improvement Committee in our Ohio affiliate was brainstorming ideas for improving the health plan's HEDIS rate for Timely Postpartum Care. During the discussion, a network provider on the Quality Improvement Committee expressed concern about the lack of available resources within his county for referral of Members who screened positive for postpartum depression. The Quality Improvement Committee then explored opportunities to educate providers about available resources in that county. After the meeting, the Molina team located resources. As a follow-up, the Quality Improvement Committee reviewed the resources and initiated training of providers in that county through the Provider Engagement Team.

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## a.iii. COLLECTING PROVIDER FEEDBACK AND MEASURING PROVIDER SATISFACTION

Molina has a history of enhancing provider satisfaction by emphasizing transparent communication and executing fair processes for our providers. Our approach addresses the needs of our provider community while embracing the importance of continually seeking feedback from our provider partners. We will maintain an Enrollee Provider Satisfaction Workgroup to facilitate continuous process improvement with our participating providers.

The Enrollee Provider Satisfaction Workgroup develops action plans that address opportunities for improvement while our Quality Improvement Committee ensures their inclusion within our Quality Improvement plan. The Enrollee Provider Satisfaction Workgroup includes staff from provider services, network development, medical management, quality improvement, operations, and community and Enrollee engagement. The Enrollee Provider Satisfaction Workgroup will meet monthly to develop, review, implement, and analyze data and provider feedback received through the tools outlined in Table C.17-1.

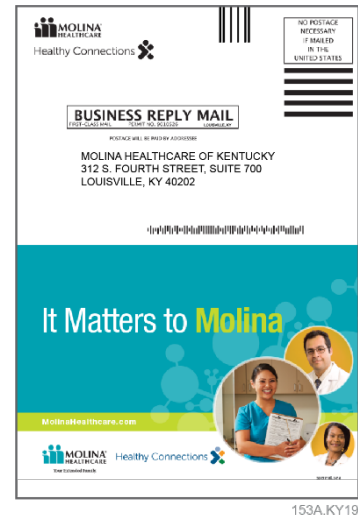
**Table C.17-1. Tools, Frequency and Responsible Parties – Provider Satisfaction**

Tools	Frequency	Responsible Department
It Matters to Molina	Continuous	Provider Services
Provider Services Feedback	Continuous	Provider Services
Performance Metrics	Continuous	Provider Services
Provider Advisory Workgroup	Quarterly	Provider Services

Tools	Frequency	Responsible Department
Provider Grievances and Appeals	Quarterly	Provider Grievances and Appeals
Provider Satisfaction Survey (Questions, Methodology, and Results)	Annually	Provider Services and Quality Improvement

## It Matters to Molina

We will deploy our innovative “It Matters to Molina” provider outreach program in Kentucky. ***“It Matters to Molina” offers several easy ways for providers to give feedback***, including a postage-paid card that provider services representatives make available at provider offices, a dedicated “It Matters to Molina” email box, soliciting feedback during face-to-face meetings/training sessions, a link on our provider portal, seminars, and association meetings. We will leverage this feedback from providers to inform strategies to enhance and improve the provider experience. Molina tracks, monitors, and reports back on the provider feedback we receive through these cards. We receive a great deal of feedback, especially during provider visits as well as conferences, sponsorships, and community events. Our affiliate health plans have implemented several improvements based on the feedback received from providers, including enhancements to our provider portal and eligibility documents. ***This enhanced commitment to excellent service and collaboration helps ensure provider retention and the stability of our network.***



153A.KY19

We will host “It Matters to Molina” Provider Forums monthly. Our forums are modeled on the “Banana Phone” concept that used to be in place during rain delays at Cincinnati Reds games. The Cincinnati Reds radio announcers would open the “Banana Phone” line and invite fans to call in to talk about anything and everything—and if you ever listened in—you know the fans rose to the occasion! The Reds radio announcers found a unique way to connect with fans; similarly, ***Molina is always looking for unique ways to make ourselves accessible to our provider partners.*** Our forums utilize Webinar technology as it allows providers to attend the session from their office location, expanding the number of providers that can participate in each forum.

## It Matters to Molina

Our “It Matters to Molina” program is the result of an encounter between a provider and a member of Molina’s leadership team. At a conference in Cincinnati, a provider stepped up to the Molina booth and wanted to share her experience with Molina and one of our PSRs. The provider said “I just wanted you to know that I made a suggestion to my PSR and you took it!” Our leadership team member thanked her for her suggestion, told her how glad Molina was that the provider was pleased with our response, and then expressed concern that the provider was so surprised by our response and the implementation of her idea.

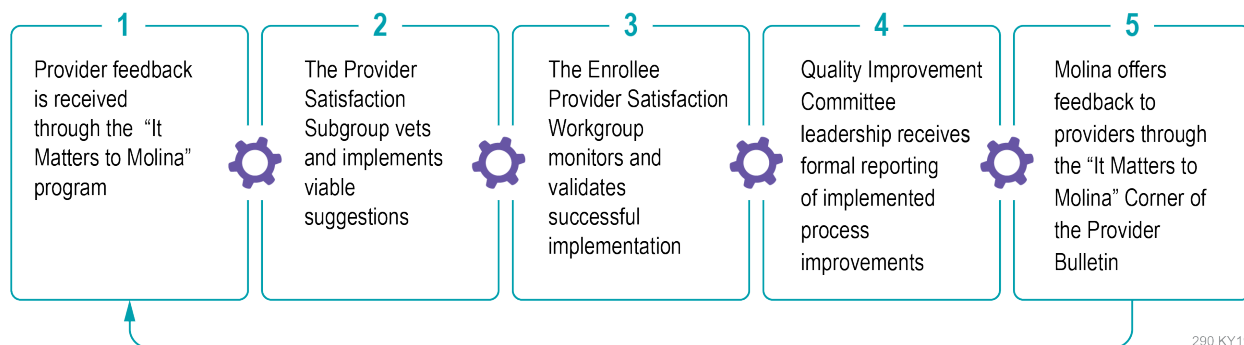
The provider responded by saying “None of the other plans care what providers have to say”. Our leadership team member told her that listening to our providers is one of the things that make Molina different and explained that Molina was founded by a physician (a Medi-Cal provider) and that it matters to us what providers think and say. As she spoke “providers matter....it matters to Molina” captured her attention. And that is how the “It Matters to Molina” program got its start.

153.KY19

The “It Matters to Molina Forum” offers another way to connect with providers and allow them to speak directly with Provider Services and staff from other departments. There is no need for providers to walk through phone prompts or wait on hold; we are available at a set time to answer their questions. This is a great option for our rural providers who often find travel from a remote location difficult. These forums




also provide Molina an opportunity to respond to and discuss comments that have been received via the “It Matters to Molina” program. Our feedback loop (Exhibit C.17-6) includes documentation of suggestions, vetting and implementation of viable ideas, and feedback to providers.




290.KY19

**Exhibit C.17-6. “It Matters to Molina” Provider Feedback Loop**

We use our Provider Bulletin to share information with providers in the “It Matters to Molina” Corner as shown in an excerpt from our Ohio affiliate’s July bulletin included in Exhibit C.17-7.



**MOLINA<sup>®</sup>**  
HEALTHCARE



**PROVIDER BULLETIN**  
A bulletin for the Molina Healthcare of Ohio provider networks

**“It Matters to Molina” Corner**

Molina Healthcare of Ohio is now offering the opportunity for your office to be entered into a monthly drawing for a prize! To enter, follow the “It Matters to Molina” Corner article instructions. Each month will be a new and exciting opportunity to enter that can include:

- Responding to a question posed by Molina about a previous Provider Bulletin article
- Attending one of our Provider Training Sessions and/or It Matters to Molina Provider Forums
- Responding to a Molina survey

And more!

July Question: In a previous Molina Provider Bulletin we discussed the Authorization Reconsideration process. If you receive a denial for a prior authorization request, you can submit a reconsideration of the authorization denial on which form?

- a. Claim Reconsideration Request Form
- b. Authorization Reconsideration Request Form

Please email your answer and contact information by July 15, 2019 to [OHProviderBulletin@MolinaHealthcare.com](mailto:OHProviderBulletin@MolinaHealthcare.com) to be entered into the July “It Matters to Molina” drawing. The correct answer and drawing winner will be announced in the Aug. Provider Bulletin.

360.KY19

**Exhibit C.17-7. “It Matters to Molina Corner” in our Provider Bulletin**

## Provider Relations Feedback

Provider services representatives meet face-to-face with providers on a regular basis, which allows them to discuss and address any questions, concerns or issues. Provider services representatives respond to provider inquiries with a final resolution or timeline for resolution in two business days or less and report issues and trends to the Enrollee Provider Satisfaction Workgroup for review.

**Collaborating with other MCOs to Streamline Processes.** Molina brings experience collaborating with other MCOs to reduce administrative requirements for providers. We will leverage best practices from our affiliate health plans to help facilitate successful collaboration with other MCOs in Kentucky. Below we highlight experience from our affiliate health plan in Illinois, where they took a leadership role in collaborating with other MCOs to simplify processes for providers through the development of a universal provider enrollment roster form.

## Simplifying Procedures for Providers in Illinois

Illinois providers expressed frustration they were required to complete different enrollment forms to be credentialed by each of the nine Illinois MCOs. The use of multiple forms and providing differing information resulted in billing errors and Enrollees receiving outdated information. In addition, the rosters did not contain information about office hours, ADA accessibility, and other vital answers to questions about access.

### In 2018, Molina took a leadership role to create a universal roster.

From January to May, Molina worked with one other health plan to develop the roster. Molina sought feedback from providers to understand the inconsistencies between the required forms. As the new template was created, Molina added fields to meet federal and State regulations as well as the operational needs of all MCOs.

All MCOs approved the new roster and it was introduced in June 2018. Before providers shifted to the new form, Molina completed three training and feedback sessions to demonstrate how to use the new document and answer any questions. Molina created written training materials that emphasized that the process is standardized across plans in instructions, format, and data entry requirements. In addition, a Molina representative demonstrated the new roster during a statewide provider meeting.

Initially, providers were resistant to the new process. But they quickly realized that the new system eased their administrative burden and streamlined the process for MCOs. The primary advantage is that the only documentation requirement for credentialing is to register with the Illinois Department of Healthcare and Family Services' IMPACT website using the universal roster form. Although plans and providers still must reach their own contractual agreements, a provider is credentialed as soon as the Illinois Department of Healthcare and Family Services approves the application.



**The time for loading providers into the system decreased from 60 days to 30 in the first six months post implementation of the universal roster.**



**Providers report high levels of satisfaction and a reduction in billing errors.**

161.KY19

We know that implementing a new Medicaid program is challenging for all stakeholders, but that it can be especially troublesome for providers. New Enrollee benefits, covered services, processing requirements and other changes can lead to increased provider abrasion. Experience has taught us that the six months leading up to the program's launch and the six months after are the most critical for effectively educating all providers about new requirements.

Molina finds that the best way to do this is through collaborative provider education: in-person and Web-based seminars and materials developed jointly with the Department and other MCOs. Providers are more likely to understand and comply with new requirements when they hear a unified message, with the added weight of a joint presentation.

While there are always MCO-specific requirements that will need to be presented solely by the individual MCOs, the vast majority of new requirements and procedures can be presented through collaborative education. These joint activities also serve to augment Department notices and updates and can help ensure compliance with Department needs.

Throughout the course of the program, as new requirements, services, and contractual obligations are developed, new opportunities for joint education inevitably present themselves. MCOs should remain willing to collaborate on these opportunities and can evaluate them through monthly or quarterly meetings between the Department and the MCOs. These meetings should look at any new requirements as well as feedback solicited from providers about existing procedures.

We also know from experience that providers want MCOs to align where possible to provide administrative simplification. Lessons learned from our experience include the importance of giving each MCO ample time to review and revise documentation and procedures, identifying areas of agreement and areas where additional elements were required for business processes. Regular meetings, with specific deliverables from each MCO between meetings, help to make sure the process stays on track.

## Provider Portal Feedback

Our provider portal offers the ability of providers to give instant feedback on demographic data. Where this was previously something we corrected quarterly, feedback now goes directly to our Provider Data Management team and is updated on our core systems as part of a daily process.

In addition, our portal has poll questions, and we pass this information to our Provider Services team, which uses this feedback to enhance the portal.

## Performance Metrics

We monitor performance metrics daily, weekly, monthly, quarterly, and annually (as applicable) that can relate to provider satisfaction. This includes claims payment, credentialing timeliness, denials, Enrollee appeals and grievances trending/timeliness, and authorization timeliness. These performance metrics are shared with the Enrollee Provider Satisfaction Workgroup to identify areas for improvement and ensure an action plan is developed and implemented to meet the expectations of our network providers.

## Provider Advisory Workgroup

Molina also invites feedback from providers through ongoing Provider Advisory Workgroup meetings. We provide details about the Provider Advisory Workgroup in our response to Section II above.

## Grievances and Appeals

We will apply a formal provider grievance and appeals process to the Kentucky Medicaid program that provides for the timely, effective resolution of any disputes between Molina and our providers. We will resolve provider grievances or appeals and provide written notification of the resolution that is received by the provider within 30 days. We provide detailed information below about our Grievance and Appeals process in response to Requirement 17.g.

## Annual Provider Satisfaction Survey

Molina conducts an annual Provider Satisfaction Survey measuring satisfaction levels with numerous health plan functions and services, including the value and effectiveness of our provider education and communication materials and how well we support providers in delivering care. We contract with an external survey vendor to offer a confidential mechanism by which providers report on their experience with our health plan. Provider services lets our providers know when the survey is available. We use blast emails (or blasts faxes for those providers we cannot reach via email), email signature tag lines, reminders during office visits, and other methods to encourage them to respond.

The survey asks providers to rate our performance in a number of activities including but not limited to, claims processing, providing timely authorizations, responsiveness of provider services representatives, usefulness of communications, network adequacy for referrals, and coordination of care. Upon conclusion of the survey, the results and analysis, including industry benchmarks, comparisons to previous performance, statistical analysis and recommendations as well as detailed data, are reviewed by our Enrollee Provider Satisfaction Workgroup, which develops and implements appropriate action plans. Results are also reviewed by the Quality Improvement Committee.

We will file our provider satisfaction survey results and subsequent action plans with the Department at least 90 calendar days following the completion of the survey and no later than December 1st for the current calendar year. Additionally, we share the results with our providers via the Provider Bulletin, advisory workgroup meetings, provider portal, and site visits.



In a 2018 provider survey, Molina providers at our affiliate health plan in Texas indicated they would recommend Molina to others:

**87.8%** of providers would recommend Molina to other patients

**86.3%** of providers would recommend Molina to other Providers/Physicians

Our affiliates conduct annual provider satisfaction surveys, and we will implement similar protocols in Kentucky. Table C.17-2 summarizes provider satisfaction survey results from our Ohio affiliate health plan over the last three years. By applying a series of solutions described below, the health plan achieved more than an 11% improvement between 2016 and 2018 across the indicators that are most reflective of provider satisfaction Molina.

**Table C.17-2. Demonstrating Strong Provider Satisfaction in our Ohio Affiliate Health Plan**

Year	Recommend Molina to Other Patients	Overall Satisfaction with Molina
2016	74.4%	73.7%
2017	76.4%	72.9%
2018	88.7% 19% gain over 2016	81.9% 11% gain over 2016

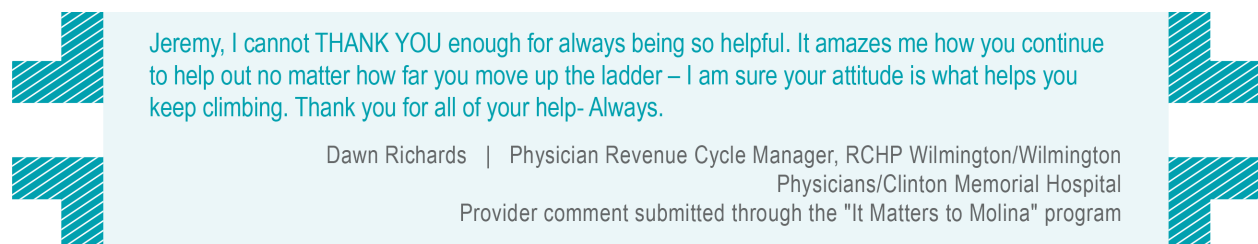
In a 2018 Provider Survey, performed by an external CMS-certified vendor, 90% of providers expressed their satisfaction with one of our affiliate health plans by indicating they would recommend us to other providers.

#### **a.iv. MINIMIZING PROVIDER COMPLAINTS AND ESCALATIONS**

Providers matter to Molina. We designed our approach to meet the needs of providers with the goal of increasing provider satisfaction and minimizing provider abrasion. We actively seek to incorporate the voice of the provider into program operations.

Our goal in Kentucky will be to minimize provider complaints and escalations to the Department. One of the benefits of our high-touch provider services model is that issues are resolved quickly. Provider services representatives follow a provider issue from beginning to end and facilitate prompt resolution of issues. We have found this to be an effective way to meet the needs of providers and will leverage this approach in Kentucky to minimize provider complaints and escalations to the Department. Our ongoing education activities also help to minimize provider complaints. Our goal is to make sure that providers have easy access to the resources they need. We also offer ongoing training to reinforce important topics.

Our Call Center tracks high-volume calls from providers and gives this information to our Provider Services department, which conducts root-cause analysis to determine the reason for the calls and if it is affecting other providers as well. This has led to a number of internal improvements in claims processing.



Our Ohio affiliate recognized inefficiency in the process for providers to submit claims reconsiderations. The portal allowed such submissions; however, attachment size capacity was limited, and many providers were forced to send their reconsideration requests by fax. This created a burden because faxing is time-consuming and does not allow providers to confirm that Molina had received the submission. In addition, our affiliate had to convert faxes to electronic files and upload them into our system.

Based on provider feedback, our affiliate increased the attachment size capacity so most documents could be submitted through the portal. However, despite notice of this improvement in Provider Bulletins and through other methods, many hospital systems continued to submit by fax. The provider services team reached out to these facilities individually to show them the benefits of this increased capacity. Eight of these 12 facilities now use the portal for claims reconsiderations.

All methods we describe throughout our response combine to deliver an exceptional experience for our providers. Relying on the development of trusting provider relationships, absolute transparency, ongoing provider education and outreach, incorporating provider feedback into program operations, surveys, and focused data analysis will increase provider satisfaction.

## **b. PROVIDER SERVICES CALL CENTER**

Call Center representatives will be locally recruited and located in our Louisville-based provider services Call Center and available Monday through Friday from 8:00 am to 6:00 pm, Eastern Time. Molina will also offer provider services support until 9:00 pm, Eastern Time, from our Call Centers located in other time zones. Providers also have access to self-service functionality, which is available 24/7. Our Provider Services Call Center will meet all Department standards as described in Section 27.2, Provider Services Call Center, of the Draft Contract.

Representatives will help providers access a full range of information including eligibility, claims, authorization information, interpreter services, and contracting and credentialing status. Representatives focus on first-call resolution of provider questions, issues, and concerns or help to facilitate a viable resolution. They are essential to our commitment to establish a collaborative relationship with providers, so they can focus on offering high-quality and efficient service to Enrollees.

Molina analyzes provider call volume, patterns, and reported issues. High-volume callers or repeat calls for the same issue are identified by the call center. Provider services representatives will then proactively reach out to providers who appear to be experiencing service-related issues and offer training and technical support.

### **b.i. APPROACH TO CALL CENTER STAFFING**

We continually monitor Call Center performance to ensure effective staffing levels are in place to meet and exceed contractual performance standards. Using our state-of-the-art Verint workforce management system, key performance indicators are monitored real-time by our dedicated Workforce Management Team and Call Center operations leadership to enable intraday adjustments to staff levels, in 30-minute increments.

Through use of cross-trained agents, leads, supervisors and back-up staff in eight locations in time zones throughout the United States, we can nimbly adjust staffing levels to address volume spikes that are part of typical call arrival patterns as well as those that may occur unexpectedly. Daily, weekly and monthly review of overall staffing needs are conducted to determine longer-term staffing needs based on a staffing ratio proportionate to the number of Enrollees, call volume, call arrival patterns, average call handle time, staff utilization and other advanced staffing analysis metrics. We also monitor after-hour call volumes to ensure our hours of operation meet the needs of our providers, adjusting our operations when necessary to deliver the optimal support. Through our capabilities to create a virtual unified call center connecting all of our call center sites, we enhance our ability to flex our staffing levels, as well as mitigate risk of service interruptions caused by weather or other external events. Our initial staffing assessment is based on historical call trends in similar markets and adjusted accordingly to Kentucky Medicaid established norms and needs.



**Located in Louisville, our Provider Services call center** will deliver efficient and personalized services to providers through specially trained Kentucky-based staff who understand Kentucky Medicaid program requirements and the needs of our Kentucky provider network



**Our HIPAA-compliant, Cisco-based Interactive Voice Response (IVR) phone system is available 24/7 and allows providers to access self-services options over the phone, including eligibility verification, claim status, and authorization status.** Providers may also leave voicemail messages, which are returned the next business day. In addition, our secure provider portal allows providers to conduct Enrollee eligibility inquiries; search for other contracted providers; submit authorization requests, conduct referral follow-up, view authorization requests, and obtain real-time approvals; submit, review status of, and adjust claims; generate a listing of Enrollee panels; and view HEDIS services reports. The portal is accessible to authorized users and providers in accordance with HIPAA privacy and security guidelines and Commonwealth laws.

Additionally, our Nurse Advice Line and Behavioral Health Services Hotline are available 24/7 to providers for referrals and other after-hours clinical support, including helping to make arrangements to support emergency issues such as middle-of-the-night prescription requests.

## Developing Provider Call Center Scripts

For common topics, Molina will develop scripts for use by Call Center staff in providing consistent responses to provider inquiries. Molina develops detailed job aids and scripting for agents to assist with the depth and breadth of issues on which providers may call. The Molina Agent Resource Center is populated with relevant content and is easily accessed by agents to locate reference materials pertinent to each topic. The robust search and filtering capabilities put key information at the representatives' fingertips. Entering a keyword into the search field provides the job aids and reference materials designed to ensure accurate and consistent information is delivered to our providers. We include Molina Agent Resource Center screen shots in Exhibit C.17-8 and Exhibit C.17-9.

Name	Summary of Change	Line of business	State	Modified Date
National In-Office Approved Laboratory Testing	Updated Naming Convention from "National POLT Approved List" to "National In-Office Approved Laboratory Testing"	Claims, Medicaid, Medicare, MMP, Duals, Marketplace	CA, FL, ID, IL, MI, MS, NM, NY, OH, PR, SC, TX, UT, WA, WI	06/04/2019
Out of Network Providers- WI	Providers may call to verify if a specific provider is in network with Molina Healthcare, this article explains how to handle those inquiries.	Medicaid	WI	06/04/2019
Out of Network Providers- WA	Providers may call to verify if a specific provider is in network with Molina Healthcare, this article explains how to handle those inquiries.	Medicaid	WA	06/04/2019
Out of Network Providers- FL	Providers may call to verify if a specific provider is in network with Molina Healthcare, this article explains how to handle those inquiries.	Medicaid	FL	06/04/2019

**Exhibit C.17-8. MARC Agent Screen**

Agents are provided step-by-step details on handling requests, along with talking points to address both current needs as well as educating providers to avoid future questions.

Microsoft Word Web App

[Back to top](#)

## What do I do – Approved Status?

Follow the steps below when assisting a member or provider with an approved PA request.

Step	Action
1	Once you confirm there is a PA on file and it's been approved, inform the caller of the approval.
2	<p>Provide the following approval details:</p> <ul style="list-style-type: none"> <li>• Authorization number</li> <li>• Approval start date</li> <li>• Approval end date</li> <li>• Name of the provider that requested the Authorization</li> <li>• Review each individual line to identify approved and/or denied services</li> </ul> <p><b>NOTE:</b> If assisting a provider, you can also provide the number of units approved and number of units used (if applicable).</p>
3	Set clear expectations for any future PA requests by educating the caller on the PA process.

Step	Action										
	<p>Include:</p> <ul style="list-style-type: none"> <li>• Turn-around time frames</li> <li>• When and how the member and/or provider will receive notification of a decision</li> <li>• Molina's UM department is in charge of reviewing PA requests for approval</li> <li>• The member's PCP or Specialist needs to submit any/all PA requests</li> <li>• PA should have supporting information as to why the request is medically necessary</li> </ul>										
4	<table> <tr> <th>IF</th><th>THEN</th></tr> <tr> <td>The member is calling and requires further clarification beyond your scope of knowledge/practice.</td><td> <ul style="list-style-type: none"> <li>• Review the <b>Authorization</b> notes.</li> <li>• Consult with UM department for assistance.</li> <li>• Refer member to the requesting physician for further assistance with their questions.</li> <li>• Assist with any further questions and/or inquiries.</li> <li>• Close the call.</li> </ul> </td></tr> <tr> <td>The provider is calling and requires further clarification beyond your scope of knowledge/practice.</td><td> <ul style="list-style-type: none"> <li>• Warm transfer to UM department for assistance.</li> </ul> </td></tr> <tr> <td>The member is calling and understands the approval and has no further questions.</td><td> <ul style="list-style-type: none"> <li>• Refer the member to the approved Specialist on the PA to set up an appointment.</li> <li>• Assist with any further questions and/or inquiries.</li> <li>• Close the call.</li> </ul> </td></tr> <tr> <td>The provider is calling and understands the approval and has no further questions.</td><td> <ul style="list-style-type: none"> <li>• Close the call.</li> </ul> </td></tr> </table>	IF	THEN	The member is calling and requires further clarification beyond your scope of knowledge/practice.	<ul style="list-style-type: none"> <li>• Review the <b>Authorization</b> notes.</li> <li>• Consult with UM department for assistance.</li> <li>• Refer member to the requesting physician for further assistance with their questions.</li> <li>• Assist with any further questions and/or inquiries.</li> <li>• Close the call.</li> </ul>	The provider is calling and requires further clarification beyond your scope of knowledge/practice.	<ul style="list-style-type: none"> <li>• Warm transfer to UM department for assistance.</li> </ul>	The member is calling and understands the approval and has no further questions.	<ul style="list-style-type: none"> <li>• Refer the member to the approved Specialist on the PA to set up an appointment.</li> <li>• Assist with any further questions and/or inquiries.</li> <li>• Close the call.</li> </ul>	The provider is calling and understands the approval and has no further questions.	<ul style="list-style-type: none"> <li>• Close the call.</li> </ul>
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The provider is calling and understands the approval and has no further questions.	<ul style="list-style-type: none"> <li>• Close the call.</li> </ul>										

## Exhibit C.17-9. Screens Guide Provider Services Representatives During Interactions with Providers

In addition to our Molina Agent Resource Center tools, front-line agents are also supported by highly trained and experienced Lead Agents and Supervisors who provide support for complex or unique situations and issues.

## **b.ii. LOCATION OF PROPOSED OPERATIONS**

**Our provider services Call Center will be located in Louisville.** Molina representatives, Kentucky residents familiar with the local landscape, will offer our providers a unique level of knowledge and understanding of the local community. Call Center overflow operations are available through our multiple call centers nationwide. Although our Call Center capacity is highly scalable, during an emergency or event of overflow, we can seamlessly route calls to continue serving providers.

During the winter of 2018-19, for example, our parent company, Molina Healthcare, Inc. (MHI) had several weather-related impacts to Call Centers in Washington, Ohio, New Mexico, Mississippi, and Texas resulting in closures. For each event, the Call Center was able to continue taking calls at alternate locations to minimize impact to the providers.

## **b.iii. MEETING AND MONITORING CALL CENTER STANDARDS**

We will meet or exceed all Kentucky Medicaid Call Center performance standards as defined in the Draft Contract. We will also monitor average speed of answer, calls handled, and services level against our own internally developed performance standards. We will make sure that voice messages left during non-business hours are returned within one business day.

We will use information from our Customer Relationship Management system, proprietary call tracking, and Cisco Unified Intelligence Center software integrated with the call center phone system to track call performance metrics for internal operational performance management and for external reporting to the Department.

Our Call Center Workforce Management Reporting Team produces applicable reports to ensure timely and accurate performance reporting. Performance measures include average speed of answer, abandonment rate, call volume, calls handled, services level, and call quality from our internal quality monitoring program. As demonstrated by our results shown in Table C.17-3, we consistently meet or exceed Kentucky program requirements, throughout our affiliated Medicaid plans, including Medicare and duals.

**Table C.17-3. Provider Call Center Performance Metrics**

Performance Measure	Kentucky Performance Standard	Molina 2019 Performance Results
Call Abandonment Rate	Less than 5%	1.77%
Service Level Percentage (live answer by customer services representative)	Greater than 80% of calls are answered within 30 seconds	85.34%
Blocked Call Rate	Less than 1%	<1% Molina does not block calls. Our approach is to ensure sufficient trunk line capacity to avoid any blocked calls. Any blocked calls we experience are due to rare and random events with the carriers and their network lines.
Call Center Accuracy	Accurate response to call center phone inquiries by call center representatives is 90% or higher	93.7%
Resolution of Inquiries	100% percent of call center open inquiries are resolved within (72 hours	93.8%

Performance Measure	Kentucky Performance Standard	Molina 2019 Performance Results
Additional Call Center Metrics Regularly Tracked by Molina and Not Required by the Draft Contract		
Average Speed of Answer	Not required	26 seconds
Average Length of Call	Not required	5:52 Our Call Center does not impose limitations on the time our agents require to fully address a provider's issues. Our goal is first call resolution of issues to ensure both a high caller satisfaction with our service delivery and to avoid needless return calls for the same issue.

## Using Monitoring Results to Adjust Operations

Performance results are monitored by Call Center management real-time, daily, weekly, monthly, and quarterly to ensure we comply with performance standards. Our Call Center Operations and Workforce Management Teams work closely, using data from our Cisco and Verint call center applications to monitor performance. We provide a screen shot from our Verint application in Exhibit C.17-10.

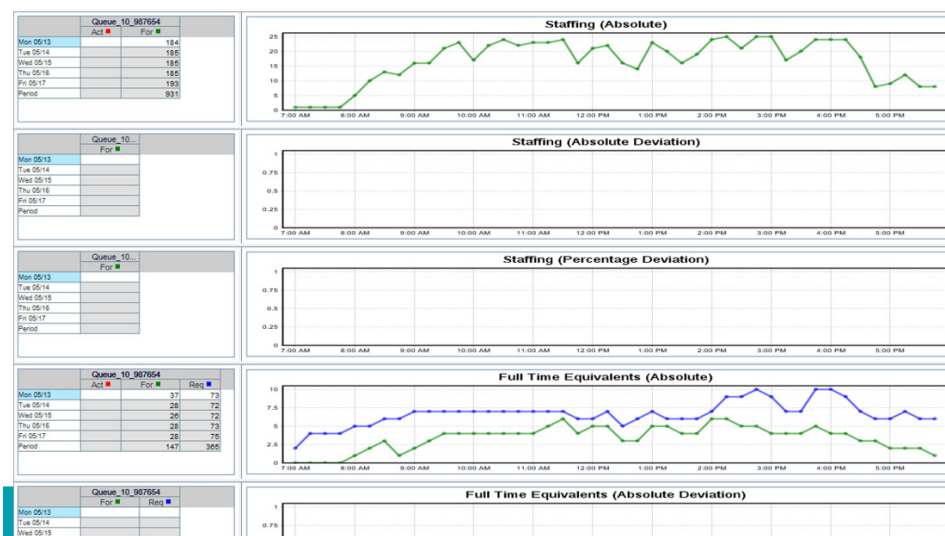


Exhibit C.17-10. Verint Application


Performance concerns are addressed real-time via group chats and conference calls. If non-compliance is identified, we take appropriate corrective actions for resolution by addressing schedule, attendance or adherence issues. We document and maintain all calls and interaction notes in our CRM and core information technology management (core IT) systems, enabling us to monitor and report on provider interactions.

We also uphold high standards by monitoring representatives to identify training and coaching opportunities. We assess each representative's performance weekly through side-by-side and remote call monitoring, live monitoring of calls, adhering to processes based on the type of call received, and by documenting all inquiries.

The quality monitoring process provides agents and their managers with their call audit results and call recordings, which are reviewed with agents during monthly one-on-one coaching sessions. In line with

our overall Molina performance management approach, coaching is conducted promptly to address improvement opportunities. Continued substandard performance is handled through disciplinary action, up to and including termination.

Representative performance is documented in their monthly scorecards, which are reviewed with them by their supervisor in monthly one-on-one coaching and feedback meetings. We provide a sample representative scorecard in Exhibit C.17-11.

 <b>1:1 Monthly Operational Worksheet (MSR)</b>			
<b>Month Evaluated 2018:</b> _____		<b>Date:</b> MM/DD/YYYY	
<b>Employee:</b> Agent 1 Smith		<b>Supervisor:</b> Supervisor 1 Porter	
<b>Business Unit/Plan:</b> Member & Provider Contact Center			
<b>Scorecard/Metric Review</b> (Discuss Scorecard in order of importance)			
	Scorecard Metric	Actual	Rating
1	<b>Quality Monitor Score (40% Weighted Factor)</b> <ul style="list-style-type: none"> <li>Outstanding – 96% and above</li> <li>Commendable – 94% - 95.9%</li> <li>Satisfactory – 90% - 93.9%</li> <li>Area of Opportunity – Below 90%</li> </ul>		
2	<b>Schedule Adherence (20% Weighted Factor)</b> <ul style="list-style-type: none"> <li>Commendable/Outstanding – 94% and above</li> <li>Satisfactory – 90% - 93.9%</li> <li>Area of Opportunity – Below 90%</li> </ul>		
3	<b>Attendance (25% Weighted Factor)</b> <ul style="list-style-type: none"> <li>Outstanding – Perfect</li> <li>Commendable – 8 hrs. or one work day or less UPTO and/or &lt; 2 tardies (5 min)</li> <li>Satisfactory – Meeting Guidelines</li> <li>Area of Opportunity – Not Meeting Guidelines</li> </ul>		
4	<b>HEDIS Requirements – 99% (No Weighted Factor)</b>		NA
5	<b>I&amp;R Elements - attach I&amp;R Scorecard Summary - capture notes specific to I&amp;R results:</b>		
6	<b>Open area for site specific or LOB specific topics:</b>		

**Exhibit C.17-11. Sample Representative Scorecard**

Overall call quality performance trends and opportunities are reviewed by the Quality Assurance Team during weekly meetings as shown in Exhibit C.17-12.

QA Monthly Scores - Inbound									
Call Origin	Month <input type="checkbox"/>		11/1/2018		12/1/2018		Total Avg Score		Total QA Status
	Avg Score	Sample	Avg Score	Sample	Avg Score	Sample			
Medicaid	92.9	4377	93.9	5047	93.4	3252	93.4	12676	
CA	92.0	652	94.1	813	94.2	481	93.4	1946	
FL	93.3	658	92.9	772	95.1	407	93.5	1837	
ID			98.7	10	98.2	7	98.5	17	
IL	95.0	292	96.5	368	94.3	246	95.4	906	
MI	94.4	448	93.6	518	93.3	286	93.8	1252	

**Exhibit C.17-12. Group QA Performance Report**

### Call Center Employees Training Program

Table C.17-4 details the extensive training we provide to our representatives to prepare them to deliver optimal customer service. Training includes a four-week program encompassing Kentucky Medicaid program information and includes classroom training. Upon completion of the classroom training, we place agents in a nesting location with additional dedicated supervisory and lead resources co-located with them.

Additional training will be provided based on new initiatives, policy or procedural updates, and special needs as identified. Emerging issues, program, policy or procedure changes as well as system enhancements are promptly addressed by our training team or supervisors. We will conduct refresher training on a regular basis, with monthly training focused on issues and opportunities identified through our call center Quality Assurance program. Annual refresher training will focus on priority concerns such



as PHI and HIPAA, and all employees receive annual fraud, waste and abuse (FWA) training to make them aware of the detection, prevention, review, and reporting of illegal activities

To proactively address specific challenges faced by behavioral health providers in Kentucky today, we train our representatives to work closely with and successfully connect behavioral health providers with required resources to meet our Enrollees' behavioral health needs. We will further track and report monthly behavioral health hotline calls received and processed by our Call Center and Nurse Advice Line to the Department.

**Table C.17-4. Molina Provider Call Center Staff Training Modules**

Topic	Areas of Training	Hours
New Hire On-boarding	<ul style="list-style-type: none"> <li>Human Resources Orientation</li> <li>Introductions and Job Description</li> <li>Organizational Structure</li> </ul>	7.5
Compliance Training	<p>Molina's compliance training consists of both Instructor lead and online training. Compliance requirements are practiced and applied throughout the training which includes:</p> <ul style="list-style-type: none"> <li>HIPAA Law, HIPAA Criteria, HIPAA Privacy Incidents, PHI, Minor Consent, Fraud, Waste, &amp; Abuse</li> <li>Quality Assurance Call Monitoring</li> </ul>	14
Systems / Applications/ Websites Training	<p>Molina systems training provides representatives with hands-on, navigational experience. Positioned early in the curriculum, it ensures the application of skills reinforced throughout the training. It covers:</p> <ul style="list-style-type: none"> <li>QNXT/CRM System Training, Call Code, Call Routing, Call Documentation</li> <li>FAD / CISCO Phones</li> <li>PBM</li> <li>Molina Public Website and Portal</li> <li>Kentucky State Medicaid Website</li> </ul>	16
Soft Skills	<p>Molina's soft skill training focuses on the tools and skills necessary to provide professional and empathetic service to our providers. Representatives come to understand the importance of human connections and learn how to build rapport through empathy for the many challenges faced by providers. Training includes:</p> <ul style="list-style-type: none"> <li>Service - The Molina Way: Making Human Connections</li> <li>Do the Right Thing – Emphasizing Accountability for Addressing Callers' Needs</li> <li>Phone presence: Call Handling, Irate Calls, and Crisis Calls</li> <li>Probing for understanding: 'The Art of Questioning'</li> <li>Heart of Communication: Building Rapport through Empathy</li> <li>Behavioral Health</li> <li>Special Needs Sensitivity Training: Visual, Auditory, and Kinesthetic Simulation</li> </ul>	20.5

Topic	Areas of Training	Hours
Product Training	<p>Molina's standardized Medicaid content provides representatives with an integrated learning experience applying soft skills, system navigation, product knowledge, and the utilization of critical resources. We include role plays, scenario-based problem solving, demonstration of knowledge, and skills within the adult learning framework. Our comprehensive assessment methodology includes a combination of trainer observation, proficiency demonstration of representative knowledge and skills, and the incorporation of soft skills.</p> <p>Training includes:</p> <ul style="list-style-type: none"> <li>• Medicaid Introduction and Kentucky Medicaid Program specifics including Policies and Procedures</li> <li>• Regional Demographics</li> <li>• Complaints, Grievances and Appeals / Critical Events and Incidents</li> <li>• Training Resource Library</li> <li>• Eligibility Verification</li> <li>• Pharmacy</li> <li>• Covered Services and Benefits</li> <li>• Value Added Services</li> <li>• PCP Change</li> <li>• Authorizations and Referrals</li> <li>• Claims including accessing/reading claims details, claims processing review, handling claims adjustments and reversals</li> <li>• Medicaid Case Management</li> <li>• Crisis Calls</li> <li>• Connecting enrollees to roster of community-based services</li> <li>• Demographic Changes</li> <li>• Material Requests</li> <li>• Medical terminology enhanced training</li> <li>• Connecting providers to translation/interpreter and TTY services</li> <li>• Population Health Management</li> </ul>	30
Role Playing	<p>Molina designed a role play template used throughout training and during the final assessment. It provides CSRs call handling experiences while navigating all resources required to effectively and efficiently addressing the Enrollee's questions, requests, or concerns.</p> <p>Role playing addresses call scenario simulation, problem solving, demonstration of skill, accessing resources, soft skill / call handling, documentation, and peer review.</p>	12
Nesting/Live Call Listening	<p>Upon completion of classroom training, representatives are provided a nesting / on-the-job training experience.</p> <p>Transition to floor nesting area. Supervisor and Subject Matter Expert support</p>	77

Representatives will participate in mandatory company cultural diversity training and receive regular communications that promote an understanding of cultural beliefs and traditions specific to the Kentucky population, including culturally and linguistically appropriate service delivery. Representatives will be equipped to direct providers to resources that meet specific cultural and linguistic needs to care for Enrollees in special population groups.

**Demonstrating our commitment to quality, culturally competent service delivery, the majority of our affiliate health plans have achieved NCQA's Multicultural Health Care Distinction.** We also plan to pursue the NCQA Multicultural Healthcare Distinction for the Kentucky Medicaid program.

## **c. PROVIDER WEBSITE**

Ensuring all providers have 24/7 access to health plan information is key to quality health plan operations. Through our public website, secure provider portal, and provider online directory we provide secure immediate self-serve access to required program information in compliance with applicable RFP requirements, Commonwealth and federal regulations regarding access and dissemination of such information. We customize our website, provider portal, and mobile application to meet specific program requirements.

All Molina affiliate plans are moving to the Availity provider portal in 2020, through our MHI vendor, and we will build our systems in Kentucky to feature this portal. This is the widely preferred tool among Kentucky providers. Among other benefits, it allows providers to submit claims online with standard SNIP Level 1-7 edits and streamlined prior authorization submission pages.

Users of our Web portal can:

- Submit claims
- Check Enrollee eligibility verification and history
- View Coordination of Benefits (COB) information
- Update the provider profile
- View/download PCP Enrollee rosters
- Submit online service/prior authorization requests
- Submit a claim status inquiry
- View Nurse Advice Line call reports for Enrollees
- View HEDIS missed service alerts for Enrollees
- Check status of authorization requests

**In affiliate plans, we have recently begun sharing data via with approved providers that have capabilities to receive such data formats.** Our provider portal currently has ***over 400,000 active accounts and supports more than 6.1 million monthly transactions*** across the enterprise.

### **WEBSITE EXPERIENCE AND CAPABILITY**

**Our Molina public website ([www.molinahealthcare.com](http://www.molinahealthcare.com))** contains written materials to help providers access needed information and resources. Our website is fully compliant with HIPAA and is available in English and Spanish via hyperlink to select the appropriate language. Our Kentucky Medicaid provider website features will include:

- Searchable Provider Manuals
- Contact information for Enrollee Services, Nurse Advice Line, and Behavioral Health Services Hotline
- Searchable Provider Online Directory
- Prior authorization criteria as well as current/archived prior authorization codified lists
- Pharmacy Preferred Drug List (PDL) and pharmacy conditions for coverage and utilization limits
- Enrollee Rights and Responsibilities, including complaints, appeals, grievances and the fair hearing process
- Information about KHIE
- What's New Updates and Provider Bulletin archives
- Links to other websites such as CHFS, DMS, and the CVO(s)
- Link to the provider portal
- Health and wellness materials (including topics on behavioral health)
- Transportation service information
- Premiums and cost sharing, including any conditions and limitations

- Provider complaints and appeals processes
- Our Notice of Privacy Practices
- Contact information for Provider Services
- Announcements for upcoming training sessions, town hall meetings and It Matters to Molina Provider Forums
- Coding Edits grid (transparency/visibility to correct coding requirements)
- Contracting and Credentialing information

Molina is committed to supplying our providers and Enrollees a comprehensive list of our in-network providers. Our website hosts our Provider Online Directory, which is available 24/7 and is updated weekly to ensure the most up to date listing of providers available. In addition to our online searchable directory, we provide a PDF of the printed version for Enrollees and providers to download.

We developed and maintain our website to allow providers to access important information quickly and self-sufficiently. However, we also understand that providers encounter situations that require a hands-on approach. Contact information on our public website and our portals direct them to the correct department for timely resolution. For example, we provide information on the following:

- Provider call center number including the hours of operation and information on the purpose of this number and what information it can provide
- Enrollee Services call center number in English and Spanish including hours of operation, how to access all covered services, what to do in an emergency or crisis, the availability of interpreter services, and the TTY Line for hearing impaired
- Behavioral Health Hotline number in English and Spanish including its 24/7 availability, how to access services, what to do in an emergency or crisis, the availability of interpreter services, and how to access SUD services
- 24 Hour Nurse Advice Line in English and Spanish including its 24/7 availability, information on how the number can be used, the availability of interpreter services, and the TTY Line for hearing impaired
- Enrollee Advocates to obtain information about their rights and responsibilities as well as assistance with the complaint or appeal process
- Fair Hearing Contact Information including the toll-free number to request an appeal and information on assistance that can be received by calling this number
- Subcontractors, including contact information for our PBM, dental, and vision services

In addition, we also maintain a pharmacy section on our website, and the link to this website is shared with the Vendor Drug Program. The website includes a list of our implemented clinical edits for covered drugs. For each clinical edit, we outline prior authorization requirements and criteria, publication history and any relevant clinical publications or sources, including our policies.

Our Management Information System regularly monitors the Molina public website using industry-leading metrics-monitoring systems to ensure expected performance and optimal user experience. This monitoring includes the analysis of download and wait times in addition to overall web experience to ensure the website is operating on sufficient bandwidth with quick upload that requires a small amount of memory.

## **SECURE PROVIDER PORTAL**

We will maintain a secure online provider portal (accessible via login), customized for Kentucky Medicaid, that offers 24/7 access and a repository of customized information and functionality for providers. The no-cost provider portal offers general and up-to-date information (including tutorials)

including information on submitting claims, checking claim status, submitting appeals, checking Enrollee eligibility, as well as missing services information for PCPs.

The provider portal meets all Draft Contract requirements and provides a secure exchange of clinical data and other relevant documentation between the provider and Molina. The portal supports online claims processing, both single claims and batch processing. The portal also provides access to common functions, including:

- Capabilities for providers to submit inquiries and receive responses within one business day of receipt
- Capabilities for providers to file grievances, appeals, and supporting documentation electronically in an encrypted format that complies with federal and Commonwealth law and allows a Medicaid provider to review the current status of a matter relating to a grievance or appeal filed concerning a submitted claim
- Other portals, as determined by Molina (e.g., for processing claims)
- Search for Enrollee eligibility and benefit details
- Submit single or batch claims and print/review current claims
- Check the status on a claim
- Create, submit, and review service requests and authorizations ***with streamlined online authorizations processes making electronic submission much more attractive than faxing***
- Upload medical records and required documents
- View HEDIS score and compare to national benchmarks
- Authorize additional users, third party billers, update account and profile information
- Create and export reports on submitted claims
- View Explanation of Payment (EOP) PDFs for claims in a finalized (paid/denied) status

Designed with ease of use in mind, Molina's provider portal home page offers access to the most important and most used features via the "My Favorites" section. Providers can easily navigate to those sections with one click of the mouse, as shown in Exhibit C.17-13.



Exhibit C.17-13. Availity Provider Portal Home Page

Our providers are interested in viewing up-to-date information on their Enrollees to facilitate access to preventive health care. PCPs can view their HEDIS profiles and quickly identify Enrollees with missing services, as shown in Exhibit C.17-14. This feature allows providers to proactively reach out to those Enrollees and bring them in for services.

The performance rates are based on claim/encounter data received as of 04/30/2019

Medicaid measures	Your Current 2019 Measurement Year Performance				2017 Measurement Year Performance*		2018 NCOA Nat'l Percentiles*			
	Total # Patients in Measures	# Patients Completed Services	# Patients with Missing Services	% of Patients with Missing Services	Your Performance	Health Plan Performance**	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Adolescent Well Care Visit (AHC) (V)	1	0	1	100%	100.00%	82.48%	40.88%	48.41%	57.88%	85.94%
Adult Access to Preventive/Infectious Health Services-AI years (AAP) (V)	31	21	10	32.3%	100.00%	84.62%	77.24%	82.10%	85.50%	87.58%
Adult BMI Assessment - AI (ABA) (V)	25	23	2	8.00%	100.00%	97.14%	77.13%	84.54%	89.35%	92.54%
Annual Monitoring for People on Persistent Medications Combined Rate - AI (MPM) (V)	1	1	0	0%	100.00%	97.23%	85.19%	87.23%	89.98%	91.94%
Avoid Treatment of Adults with Acute Bronchitis - AI (AAB) (V)	2	2	0	0%	100.00%	38.19%	22.12%	26.17%	32.91%	38.91%
Cervical Cancer Screening - AI (CCS) (V)	18	14	4	22.2%	100.00%	85.89%	48.19%	55.84%	65.88%	69.90%
Children and Adolescents' Access to Primary Care Practitioners (CAP) - AI Members (V)	1	1	0	0%	100.00%	0.00%	79.00%	79.00%	79.00%	79.00%
Oral Hygiene Screening (OHS) Total (V)	1	0	1	100%	100.00%	89.22%	48.83%	55.16%	61.83%	66.62%
Diabetes HbA1c < 8.0% (CDC) (V)	4	2	2	50%	100.00%	88.73%	58.80%	48.70%	52.55%	58.30%
Diabetes HbA1c Test (CDC) (V)	4	3	1	25%	100.00%	87.64%	82.99%	85.90%	89.42%	92.88%
Diabetes Nephropathy Test (CDC) (V)	4	2	2	50%	100.00%	90.73%	85.00%	89.00%	90.00%	97.00%
Diabetes Retinal Eye Exam (CDC) (V)	4	3	1	25%	100.00%	82.00%	44.53%	53.28%	61.50%	66.11%
Pneumonia Care PFC (PFC) (V)	1	1	0	0%	0.00%	79.80%	55.47%	50.88%	67.63%	73.81%
Prenatal Care Timeliness - TOPC (PFC) (V)	1	1	0	0%	0.00%	83.33%	74.21%	82.25%	87.88%	91.00%

Legend:  
■ Your rate is at or above 90% NCOA benchmark  
■ Your rate is at or above 75% NCOA benchmark  
■ Your rate is below the 75% NCOA benchmark

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\* Higher than Performance includes data from claim/encounter data as well as medical records for sampled members in particular measures.  
 \*\* This is the current 2019 NCOA National Percentiles are displayed. The data are updated annually with the NCOA August benchmark as of July/August.  
 \*\*\* The current 2019 NCOA National Percentiles are displayed. The data are updated annually with the NCOA August benchmark as of July/August.  
 \*\*\*\* Measurement Year Performance data will be updated by 2019 Measurement Year performance with the final NCOA August data as of July/August.

Exhibit C.17-14. HEDIS Profile Page

Molina also encourages our providers to use our Links and Forms sections, as we provide valuable provider education and materials on topics such as a Quick Reference Guide for Portal Use, updated information on prior authorizations, how to enroll in electronic funds transfer, and information on cultural competency.

### Data Transfer

It has been our experience that by working closely with our provider community and government agencies, ***we are able to train and implement electronic (Web portal or clearinghouse) submission practices 98% of the time***, ensuring faster claims receipt and processing. The portal allows providers to submit corrected claims electronically and if necessary, to upload required documentation and information with the claim.

We also offer electronic funds transfer and remittance advice (EFT/ERA) for faster and safer payment and explanation of payment. Providers also have the convenience of accessing their remittance advice at any time for any date of payment through the provider portal via the claim status inquiry pages.

### Securing Protected Health Information

Molina has many ways to ensure security of protected health information (PHI) across our health plan and throughout our web portals. This includes PHI in written word, spoken word, or in a computer system. Provider Services incorporates training related to PHI in both orientation and ongoing training activities. Below are ways we protect and secure PHI:

- Molina has policies and rules to protect PHI
- Molina limits who may see PHI; only Molina staff with a need to know PHI may use it
- Molina staff is trained on how to protect and secure PHI
- Molina staff must agree in writing to follow the rules and policies that protect and secure PHI
- Molina secures PHI in our Management Information Systems network. PHI in our Management Information Systems is kept private by using encryption, passwords, and firewalls
- Annual audits are conducted to ensure Molina is compliance with all Commonwealth and federal regulations

We use our Provider Bulletin to share information about the provider portal as shown in an excerpt from our July bulletin included in Exhibit C.17-15.



## PROVIDER BULLETIN

A bulletin for the Molina Healthcare of Ohio provider networks

### Molina Provider Portal

The Molina Provider Portal is an easy-to-use online tool designed to meet provider needs. All our providers can register and use the following features:

- Online claim submission
- Check claim status
- Online claim reconsiderations
- Correct claims
- Enrollee eligibility
- Submit prior authorization (PA) requests
- Check claim status
- And more!

Registration is easy, just visit <https://Provider.MolinaHealthcare.com>, click on “Register now,” and follow the instructions.

For more information view the Provider Web Portal Quick Reference Guide on our website, under the “Manual” tab, or join us for one of the upcoming monthly Provider Portal training sessions available:

- Tues., July 23, 2 to 3 p.m. meeting number 806 047 762
- Thurs., Aug. 22, 2 to 3 p.m. meeting number 805 406 661

Molina offers provider training sessions on a variety of topics including the Provider Portal, Claims Training, It Matters to Molina forums and Provider Orientations. For additional training topics and times, view our Provider Training Sessions in the side panel of this Provider Bulletin.

360A.KY19

### Exhibit C.17-15. Provider Portal Education Via Our Provider Bulletin

#### d. PROVIDER MANUAL

The basic building block of our training program and reference documents for our network providers is the Provider Manual. A proposed Table of Contents is included within Attachments to C.17, Proposed Kentucky Provider Manual Table of Contents.

The manual and updates serve as a source of information to providers regarding covered services, Molina’s policies and procedures, and provider credentialing and recredentialing, Enrollee grievances and appeals, claims submission requirements, reporting fraud, waste and abuse, prior authorization procedures, Medicaid laws and regulations, telephone access, the QAPI program, standards for preventive health services, and other requirements when identified by Molina.

The Provider Manual includes easy-to-reach information and is broken down into sections including:

- Contact information for the Molina Call Center as well as for specialty departments such as Healthcare Services, Quality, Behavioral Health, and Claims

Proposed Table of Contents	
1.	Contact Information for Providers .....
	Provider Services Department .....
	Enrollee Services Department .....
	Claims Department .....
	Claims Recovery Department .....
	Compliance and Fraud Alert Line .....
	Credentialing Department .....
	Nurse Advice Line .....
	Healthcare Services (HCS) Department .....
	Health Management .....
	Behavioral Health .....
	Pharmacy Department .....
	Quality Department .....
	Molina Healthcare of Kentucky, Inc. Service Area .....
2.	Provider Rights and Responsibilities .....
	Provider Rights .....
	Nondiscrimination of Healthcare Service Delivery .....
	Section 1557 Investigations .....
	Facilities, Equipment and Personnel .....
	Provider Data Accuracy and Validation .....
	Molina Electronic Solutions Requirements .....
	Electronic Solutions/Tools Available to Providers .....
	Electronic Claims Submission .....
	Electronic Payment (EFT/ERA) .....
	Provider Portal .....
	Balance Billing .....
	Enrollee Rights and Responsibilities .....
	Enrollee Information and Marketing .....
	Enrollee Eligibility Verification .....
	Enrollee Cost Share .....
	Healthcare Services (Utilization Management and Case Management) .....
	In Office Laboratory Tests .....
	Referrals .....
	Admissions .....
	Participation in Utilization Review and Care Management Programs .....
	Continuity and Coordination of Provider Communication .....
	Treatment Alternatives and Communication with Enrollees .....
	Pregnancy Notification Process .....
	Prescriptions .....
	Pain Safety Initiative (PSI) Resources .....
	Participation in Quality Programs .....
	Access to Care Standards .....
	Site and Medical Record-Keeping Practice Reviews .....
	Delivery of Patient Care Information .....
	Compliance .....
	Confidentiality of Enrollee Health Information and HIPAA Transactions .....
	Participation in Grievance and Appeals Programs .....
	Participation in Credentialing .....
	Delegation .....
	Policies and Procedures .....

- Provider Rights and Responsibilities
- Cultural Competency and Linguistic Services
- Benefits and Covered Services
- Healthcare Services (including Medical Necessity Review and Prior Authorization procedures)
- Quality
- Compliance
- Claims and Compensation

The manual is reviewed and updated at least annually to ensure accuracy of the content. As the healthcare landscape changes, we add sections as needed for subjects on which providers might need further education and assistance. For instance, our section on cultural competency and linguistic services advises providers that we offer training through a variety of methods, including written materials, onsite cultural competency training, online cultural competency training, and integration of cultural competency concepts and nondiscrimination of service delivery into provider communications.

During new provider orientation, we will educate providers on the contents of the manual and how to access it. The manual provides comprehensive information needed to verify that providers operate in full compliance with all applicable contractual, regulatory, and statutory requirements, including our submission processes for provider grievances and appeals.

Upon contracting with Molina, providers will be directed to the Provider Manual that is published on the website. Providers will have 24/7 access to the Provider Manual via our provider website. We will prepare and issue provider communications as necessary to inform providers about Molina policies, initiatives or other information. Molina will submit to the Department for approval the Provider Manual, including any manuals provided by a Subcontractor for direct services, and any updates to the Provider Manual, prior to publication and distribution to Providers.

## **e. PROVIDER ORIENTATION AND EDUCATION**

**Molina views our network providers as partners in improving health outcomes in Kentucky.** For providers to succeed in Kentucky Medicaid, they must thoroughly understand how the program operates; where to get questions answered; how to respond to programmatic changes; and how to help Enrollees access covered services, value-added services (VAS), and other community-based programs. We will support providers with comprehensive training (including individual training at provider practice locations when requested or required) and easily accessible technical assistance. ***We have designed our training program to meet providers where they are and offer training via multiple modalities to help reduce administrative burden, allowing providers to focus on improving Enrollee health.***

Molina will develop and submit to the Department a provider orientation and education plan that includes methods, topics, and dates for completion of activities and workshops or other types of training sessions. We will submit the plan to the Department within 60 days of contract execution, when material changes are made and annually.

Our educational offerings include orientations for newly contracted providers within 30 days of completing credentialing. For new and current providers, we offer training programs by telephone, one-on-one, via WebEx, or in group settings. Trainings address core topics applicable to all network providers and are supplemented with specialty topics. All providers can also access ongoing training on contract requirements, policy updates, and Enrollees' special needs through scheduled in-person office visits, group training at conference sites, or Webinars. Our provider manual also serves as an excellent resource for provider reference.

We will ensure that all providers receive initial orientation and ongoing training and education in full compliance with the requirements in Section 27.5, Provider Orientation and Education, of the Draft Contract. We will participate in Provider Educational Forums, as required in Draft Contract Section 27.6, and will meet all applicable federal requirements.

Molina will conduct initial orientation for all providers within 30 days after placing a newly contracted provider on an active status. We will use reasonable efforts to ensure that all providers receive targeted education for specific issues identified by the Department.

We know providers want user-friendly educational opportunities and easy access to educational resources where and when they need them. ***Our track record nationally demonstrates our ability to deliver effective training programs that meet our contracted providers' specific needs.***

### **Provider Educational Forums**

Molina will participate in any Medicaid Provider Educational Forums designated by the Department to be held throughout the Commonwealth as enhanced education efforts related to Medicaid managed care. Molina will remit to the Department \$20,000 at the start of each fiscal year required by the Contract to support this outreach effort.

Our affiliate health plans all participate in Provider Forums. For example, our Ohio affiliate health plan participated in 16 Behavioral Health Provider Forums held across the state during 2018 and 2019. The health plan's provider services representative dedicated to behavioral health providers attended all sessions, and their behavioral health director participated and presented at many of the sessions. Each session included:

- Information tables from each MCO with subject matter experts (from behavioral health Provider Services, Contracting and behavioral health Operations) available to answer providers' questions and included information on how to find upcoming Molina training opportunities specifically for behavioral health providers and how to sign up for Molina's general Provider Bulletin and targeted behavioral health Provider Bulletin. Our affiliate was able to answer question/resolve provider issues at the time of the forum, rather than taking questions back for investigation and later follow-up
- Presentation on updates from the Ohio Department of Medicaid and a combined MCO presentation (with presenters rotating among the plans for each session)
- Open Q&A sessions
- All sessions were recorded and materials were available on Ohio Department of Medicaid's website

Participants included:

- Community Behavioral Health Providers
- MCO subject matter experts in behavioral health (including Provider Services, Behavioral Health Operations, and Contracting)
- Ohio Department of Medicaid
- Ohio Department of Mental Health and Addiction Services
- Provider billing agencies and EDI vendors
- The Ohio Council of Behavioral Health & Family Services Providers

Operational efficiencies were identified and implemented based on providers' feedback at these forums. Collaboration occurred between MCOs and providers to develop consistent processes (one example is the universal provider roster that all MCOs accept now from the behavioral health providers). Our Ohio affiliate took feedback directly from the Provider Forums and leveraged the information to enhance behavioral health Provider Bulletins and inform ongoing training and Q&A sessions offered to providers.





Hi Molina team! Thank you again for participating in the summer Medicare & Medicaid meetings. We know our members benefit from meeting with you in their home towns, and getting these updates. I hope you find them helpful as well in enhancing your relationship with your providers.

Mary Whitacre | Director, Educational Development & Services, Ohio State Medical Association



## **Molina's Approach to Provider Training**

Our approach to provider training, education, and technical assistance begins with our provider services representatives. These individuals provide a local presence and will work in communities across Kentucky to train providers to easily navigate administrative processes and facilitate care for all Enrollees, including those in rural regions. Provider services representatives will provide ongoing support and refresher training as needed.

Each provider will be assigned a specific provider services representative who will serve as their first of point of contact. Provider services representatives will each manage a specific category of provider (PCPs, specialists or facilities). Our full-time staff will work throughout Kentucky and be Kentucky-based and located both centrally in Louisville and regionally in our Molina One-Stop Help Centers across the Commonwealth.

Across the country, we develop and implement innovative training approaches and educational opportunities for our providers that supplement our standard training program. Training will highlight Commonwealth program goals, as well as incorporate Molina's internal goals, operational and policy updates, new service approaches, and evidence-based and promising practices.

We will maximize participation in Kentucky Medicaid training sessions by offering group and individualized training at multiple times in multiple venues and via Webinar. Notices of upcoming training sessions are posted to the Molina website within 30 days of training dates. Provider services representatives are also available to schedule individual training sessions if a provider is unable to attend a scheduled training session or requires additional training.

We will also record training sessions and post them on the provider website, allowing providers to review at their convenience. To maximize provider participation in program operations, we will encourage providers to participate in our "It Matters to Molina" program during training and education sessions.

## **Training Programs**

Our provider training programs are based on adult learning theory, including task-oriented instruction with multiple opportunities and modalities for learning targeted material. To accommodate providers' schedules and preferences, we will offer Kentucky Medicaid training programs by telephone, one-on-one, via Webinar, or in group settings. Training addresses core topics applicable to all network providers and is supplemented with specialty topics. These presentations are our core orientation training tools and are available 24/7 on the provider portal, enabling providers to access training at their convenience.

Besides simply attending the training session, we want to ensure providers are actively engaged in learning the material. To this end, the programs are designed to be engaging and interactive training presentations. We use frequent fact checks and provide opportunities to ask questions and seek clarification. Recognizing that individuals have different learning styles, we present information visually as well as orally and can provide translation if requested.

## Provider Orientation

Newly contracted providers and their staff will receive new provider orientation within 30 days of completing the contracting process. New provider orientation is facilitated by the provider's assigned provider services representative. Orientation sessions include provider-specific information by provider type; for example, pediatricians learn about covered well-child services, PCPs learn about their obligations, and OB/GYNs learn about continuity of care for pregnant Enrollees.

We will offer orientation via Webinar on multiple days and times each month to accommodate the schedules of all providers and their office staff. Upon request, provider services representatives will provide one-on-one orientation at the provider's locations as well as offering health system group sessions and presentations at regional office staff meetings. Molina tracks successful completion of orientation, and additional follow-up is required for providers who do not participate in the orientation session within the expected timeframes. Retraining is also required on a case-by-case basis for providers as part of corrective action plans. Orientation sessions are also made available to provider sites for newly added staff.

During implementation of the Kentucky Medicaid program, we plan to host town hall meetings before go-live to meet the needs of providers in each of the eight regions of Kentucky. Proposed locations for town halls/orientation include hospital conference facilities, meeting rooms, and rented meeting spaces if necessary. A copy of the provider orientation will be posted online so that providers have access to the material for new staff members or to use as a point of reference whenever needed.

## Ongoing Provider Training Program

Providers can also access ongoing training on contract requirements, policy updates, and Enrollees' special needs through scheduled in-person office visits, group training at public conference sites, town halls, and Webinars. Depending on the training being offered, providers can receive Continuing Medical Education credits for participating. During registration, we provide printed educational materials related to presented topics as well as other applicable participant information.

Thank you all for taking the time to present for our group today. The informational materials and presentation was excellent. We greatly appreciate you sponsoring our lunches. Thank you for the time and effort you all dedicated to travel and support of our network. We look forward to our continued partnership. Best regards,

CHP PR Team | Caroline Garrigan, Manager Provider Relations  
Community Health Partners. Naples, Florida  
Provider comment submitted through the "It Matters to Molina" program

In addition, we keep providers up to date with program updates through ongoing provider education and communication that includes operational and policy-related updates. We accomplish this through:

- Regional provider and/or association meetings
- Face-to-face provider visits
- Joint Operational Committees with our health systems, hospital and large provider groups
- Provider Bulletins and blast email/fax publications
- Provider Manual updates
- Announcements on our provider website landing page

Molina's Mississippi Provider Services team began orienting new providers in September 2018. During September, they facilitated new provider orientations to 99 provider groups. The team also met with 340 provider groups via webinar. They successfully met all Contract requirements and Molina Mississippi Network providers were ready to serve members as of go live.

As of February 2019, the team completed more than 530 on-site provider visits.

As we develop our partnerships with the Department and our providers, we will look to share new service approaches and promising evidence-based practices gathered from other providers and our experiences in the market as well as our other programs nationally.

### **Covered Topics**

We will design our provider orientation and training sessions to cover all topics necessary to effectively participate as a network provider. The orientation sessions will include an overview of Molina and Kentucky Medicaid processes, requirements and responsibilities, provider-specific information by provider type, and important information relevant to the Enrollee population served by the provider such as how to access the roster of community-based resources and partners. Training will also encompass topics specific to the Commonwealth's population, such as cost-sharing, copayment information, and eligibility. All contracted physicians and their office staff, regardless of specialty, will be invited to attend all our training sessions.

Molina provider education will include at a minimum:

- Molina coverage requirements for Medicaid services, including information about prior authorization requirements, EPSDT preventive health screening services, and EPSDT special services
- Molina policies and procedures, Molina administrative clinical practices, and updated information when modifications to existing services occur
- Medicaid policies and procedures, including Commonwealth and federal mandates and any new policies and procedures
- How to report suspected Fraud, Waste and Abuse, and annually addressing Fraud, Waste and Abuse with Providers
- Medicaid populations and eligibility
- Standards for preventive health services
- Telehealth services
- Enrollment of PCPs in the Department for Public Health and the Department for Medicaid Services Vaccines for Children Program
- Special needs of Enrollees in general that affect access to and delivery of services
- Advance Medical Directives
- Claims submission and payment requirements
- Special health/care management programs in which Enrollees may participate
- Provider role in Population Health Management program
- Cultural competency
- Responding to needs of Enrollees with behavioral health, developmental, intellectual and physical disabilities
- Integrated healthcare, addressing social determinants of health, and population health management initiatives
- Reporting of communicable disease
- Molina's QAPI program, the external quality review organization (EQRO), and the provider's role in impacting quality and healthcare outcomes, including ongoing education about QAPI program findings and interpretation of data when deemed necessary by Molina or the Department

- Medical records review
- Value-based payment

We will educate our pharmacy providers and provider community on access to covered drugs. Our educational programs for the Kentucky Medicaid pharmacy provider community will meet the requirements of the Draft Contract, Section 27.5, Provider Orientation and Education. Materials include but are not limited to:

- **Provider Letters and Bulletins.** We will supply providers with relevant information and important changes through quarterly newsletters. We will also use fax blasts to convey urgent and important information and bulletins.
- **PDL Drug Changes and Distribution.** We will post a searchable full PDL and any updates to our provider portal and provide updates in quarterly provider newsletters.
- **Point-of-sale (POS) Messaging.** We leverage extensive POS messaging to ensure clear and transparent communication to pharmacies and prescribing providers. This will assist pharmacists in performing thorough prospective DUR (drug-to-drug interaction, age precautions, therapeutic duplication, excessive duration, early refills, or suboptimal dosing). POS messaging also provides the dispensing pharmacist with information on other prescriptions paid by Molina to other pharmacies that may otherwise be unknown during the dispensing process. The formulary status of medications and possible alternatives is also conveyed through POS messaging to provide dispensing pharmacists with proactive and relevant benefit information to promote collaboration with prescribers as part of the multi-disciplinary team. This extensive messaging will provide a high level of actionable information for our pharmacist partners to ensure access to care and high-quality service for Enrollees.
- **Training.** We will fully support all training sessions, webinars, quarterly newsletters, and other training activities as requested by the Department. Molina's in-house pharmacy staff undergoes quarterly inter-rater reliability testing to ensure consistent review and processing of pharmacy prior authorization requests. We will send targeted letters to providers around specific PDL initiatives and PDL changes. Molina provider services representatives will personally engage with network providers on pharmacy benefits impacting specific Enrollees and other relevant changes to services.
- **Billing Instructions and Claim Resolution.** The PBM has dedicated staff who are available 24/7 to address all billing and claim issues, concerns, and inquiries.
- **Website Postings of the PDL.** Molina's provider website will include an electronic copy of the PDL, including the status (preferred, non-preferred), an indication if prior authorization is required, information necessary to initiate a request for prior authorization or access to a non-preferred drug, and quantity limits.
- **Prior Authorization Processes and Procedures.** We will educate pharmacy providers on prior authorization processes and procedures. This includes educating them on providing Enrollees a 72-hour emergency supply of medications when a prescription is awaiting prior authorization and Molina is unable to reach the prescribing physician and the dispensing pharmacist deems the prescription necessary to avoid imminent harm or injury to the Enrollee.

Our provider website will include an electronic copy of the PDL including the PDL status (preferred, non-preferred), an indication if prior authorization is required, information necessary to initiate a request for prior authorization or access to a non-preferred drug, and quantity limits.

Hi Shaun,  
Thank you so much for being such an amazing presenter at our Summer/Fall Fest, it is truly a pleasure to watch you engage with our providers. Hope to see you again next year!! Keep up the fantastic work! Best regards,

Natasha Marcelin | Provider Relations Representative  
Community Health Partners, Naples, Florida  
Provider comment submitted through the "It Matters to Molina" program

## Behavioral Health Education for PCPs

PCPs play a key role in detecting depression and other behavioral health symptoms, as they are generally the first contact for Enrollees with these conditions. Moreover, due to an Enrollee's cultural background, they may prefer to see a trusted PCP versus a behavioral health specialist.

Our behavioral health department supports and educates PCPs about behavioral health conditions, including screening, treatment, referral opportunities and collaboration with specialists, facilities, and community-based organizations. We encourage PCPs and behavioral health providers to integrate behavioral health and primary care services to produce the best outcomes and provide support to Enrollees on their road to recovery.

### *Educating PCPs on Behavioral Health Treatment Referrals*

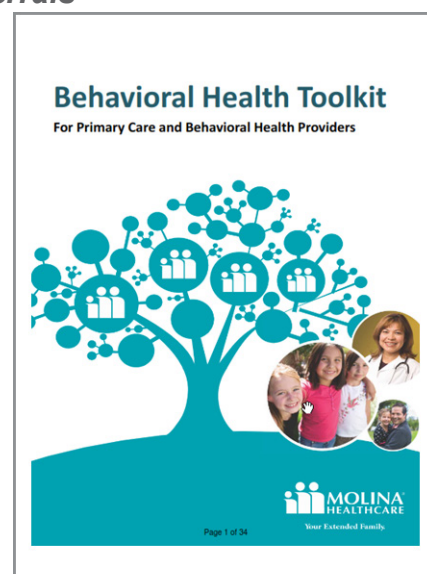
Our behavioral health team, led by our medical director, provides Behavioral Health Toolkits for PCPs and specialists. The toolkits are designed to assist providers in their efforts to assess and treat behavioral health conditions in the primary care setting and to provide guidance regarding when to refer an Enrollee to a behavioral health provider.

Each toolkit includes screening tools, diagnostic criteria, clinical guidelines and interventions, and links to additional clinical resources. For example, the toolkit's clinical guidelines for Enrollees with moderate risk of clinical depression promote medication review, evaluation of social supports, referral to our Care Management department, referral to a provider, assistance with locating a provider and scheduling, and coordination with the provider. PCPs can also discuss Enrollees with complex conditions with a health plan psychiatrist or specialist.

We also educate our providers on how to refer an Enrollee when they determine medically necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals. We encourage PCPs to refer to the most appropriate level of care.

We require providers to exchange information between the PCP and behavioral health provider to coordinate care of the patient and ensure continuity of care. Providers are required to document referrals made in the Enrollee's medical record. Documentation includes the specialty, services requested, and diagnosis for which the referral is being made. To further facilitate integration of care, providers are required to refer Enrollees to behavioral health providers that are contracted and credentialed with us, except in the case of emergency services.

Our behavioral health care managers are on-call for our contracted PCPs, and they can be contacted if PCPs have any questions about how or when to refer an Enrollee. For higher acuity Enrollees in our Care Management program, our staff often collaborates with an Enrollee's provider(s) in the community to assess and secure resources needed to meet the Enrollee's specific needs. Our Nurse Advice Line, which

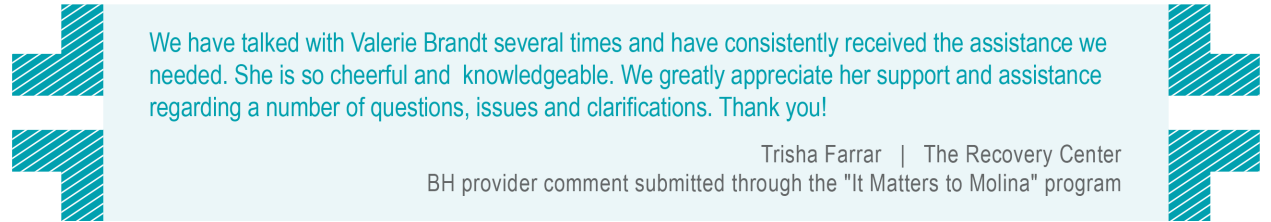


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is staffed by registered nurses with behavioral health training, is also available 24/7 to provide referrals, verify network providers, and other needed clinical support.

We also make behavioral health claims data available to contracted PCPs and behavioral health providers via our secure provider portal. In total, this program results in providers working together, along with our care managers, to schedule appointments and transportation, identify missed appointments, and share data to make sure their assigned Enrollees receive needed services.



We have talked with Valerie Brandt several times and have consistently received the assistance we needed. She is so cheerful and knowledgeable. We greatly appreciate her support and assistance regarding a number of questions, issues and clarifications. Thank you!

Trisha Farrar | The Recovery Center  
BH provider comment submitted through the "It Matters to Molina" program

### ***Addressing the Opioid Crisis***

Central to Molina's efforts to support its providers in addressing the opioid epidemic in Kentucky and other states are enhanced educational offerings to improve guideline-compliant provider prescribing behavior. We offer provider education on pain management based on the CDC 2016 prescribing guidelines, buprenorphine prescribing, as well as co-prescribing Naloxone for patients on daily opioids.

Molina's Pain Safety Initiative offers a variety of platforms to engage our providers such as offering CME webinars, tutorials, and other media from nationally recognized sources addressing all the relevant Opioid Use Disorder topics. We also have made available to providers (and Enrollees) the CDC smartphone app and website, which has an online tutorial of the CDC prescribing guidelines as well as additional information.

Molina's provider website contains Opioid Safety Guidelines posted on the Health Resources tab for easy provider access. Additionally, our national Medical Director for Substance Use Disorders has been providing Molina-wide virtual and in-person trainings, as well as presenting at provider summits in multiple affiliate health plan states.

### ***Additional Support for PCPs***

Our model of care includes behavioral health care managers supporting PCPs and ensuring collaboration among providers, leading to greater efficiency and effectiveness of care delivery and better health outcomes. We train care managers to understand complex medical conditions and associated self-management interventions, and offer expert communication skills, community-based resource knowledge, and care management experience to our PCPs and other providers. For example, care managers ensure their contact information is easily accessible when a PCP meets with an Enrollee. If the PCP diagnoses an Enrollee at high risk for depression, the PCP knows to call the care manager to identify a behavioral health provider that can meet the Enrollee's needs, immediately engage a behavioral health specialist, and, if needed, initiate visits with the provider.

To increase behavioral health service access, we encourage the use of telemedicine by providing reimbursement incentives to provider groups interested in establishing a telehealth platform and/or designating clinic space for Enrollee consultation through a quarterly bonus to providers serving four or more Enrollees via telehealth.

### ***Internal Feedback Drives Provider Training***

As part of our overall provider education strategy, provider services solicits provider-specific or process-specific feedback from other internal departments. We can leverage that information as part of individualized outreach to one or more providers. For example, we may hear from utilization management staff that a provider group has an unusually high prior authorization denial rate due to frequently leaving out a certain piece of information on prior authorization requests that is required to fully review for

medical necessity. Or we may trend pain-points/process issues experienced by multiple providers, and provider services can leverage that information for a broad training session and/or communication on the specific process in the Provider Bulletin.

### **Ongoing Provider Communication**

We make use of various methods to assure our providers always have the latest information. Our provider website, Provider Bulletin, and blast emails all communicate important information to network providers. We also incorporate messages printed on the remittance advices (Explanation of Benefits) to convey important information such as reminding providers to respond to the Provider Satisfaction Survey or to update their demographic information. We have the opportunity to partner with our Provider Services call center for specific initiatives ending each provider call with a certain message, reminder, or question. We also have the capability to send notices to the announcements box of the provider portal to communicate with providers as needed. Our staff is also able to include informational taglines on their emails to providers.

## **f. MEDICAID ENROLLMENT AND CREDENTIALING**

Molina's efficient credentialing and recredentialing process for Kentucky Medicaid providers will minimize issues related to denied claims, administrative hassles, and reduced access that occur when processes are improperly administered. Our comprehensive credentialing program is designed to ensure that our network consists of quality practitioners and facilities meeting clearly defined criteria and standards vital to maintaining the service quality necessary to meet our Enrollees' diverse needs.

Molina's high-touch approach to enrollment and credentialing played a critical role in the success of the recent Mississippi Medicaid and current Mississippi CHIP program implementations and continues to impact ongoing provider satisfaction as summarized in Exhibit C.17-16.

## Exceeding Expectations and Delighting Providers – Molina's Mississippi Implementation

Molina managed a successful network development effort during the recent implementation of the Mississippi program. This included:



**Meeting Targets.** All contracting and credentialing requirements were successfully met prior to go live. During focus groups, Molina heard from providers that credentialing was often a frustrating experience with turn around times often exceeded 90 days. Utilizing a thoughtful strategy and focused effort **our Mississippi affiliate has decreased current turnaround time to 14 days**. The key to this success has been a high touch approach where Molina works with providers on the front end to ensure the submission of a complete and accurate credentialing application. The result of our approach is that providers are credentialed and enrolled in less than 30 days.



**Network Adequacy.** Molina's Mississippi network met all adequacy requirements prior to go live. Ongoing network development continues and in the four months post-implementation **Molina's Mississippi network has doubled in size**. The Mississippi network includes key health care providers such as the University of Mississippi Medical Center and Ochsner Health system.



**Rural Strategy.** A focus on partnering with FQHCs is critical to delivering service in rural areas. Molina is contracted with the FQHC Association for 19 of 21 Mississippi FQHCs and maintains separate contracts with the other two FQHCs.



**School Based Health Clinics.** Mississippi FQHCs manage almost all of the school based health clinics in the state. Molina also hold contracts independently with a few clinics. Provider Services maintains strong relationships with the FQHCs and they participate in community outreach activities such as back to school events.



**Workforce Shortages.** Workforce shortages have proven to be a challenge especially in the rural areas of Mississippi. One of Molina's strategies has been to **engage a large number of nurse practitioners**. Molina's Mississippi Network Development team is constantly reaching out to new nurse practitioners entering the state. Other innovative solutions include contracting with Fast Pace Urgent Care. Fast Pace operates a network of urgent care clinics. One goal of this partnership is to reduce the number of preventable emergency department visits.

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### Exhibit C.17-16. Successful Network Development Approach in Mississippi

Our provider services representatives will be active in meeting with providers early during the implementation period, and one of our main goals is to help reduce their administrative burden. Through individual outreach and at provider fairs and other community events, we will introduce ourselves and offer our assistance in helping them meet state requirements.

#### f.i. ASSISTING PROVIDERS WITH THE MEDICAID ENROLLMENT PROCESS

Before the credentialing process begins, Molina explains to providers that by law, they must be enrolled in the Kentucky Medicaid program in order to be contracted. This information is available on our website, and our Contracting team further emphasizes the need. We also make a point of highlighting this requirement as we host or attend provider forums and other events throughout the Commonwealth. In addition to explaining the requirement, we give providers directions on how to enroll and what paperwork they will need to complete the process.

Exhibit C.17-17 shows an example of one such notice our Illinois affiliated distributed to providers.



June 11, 2018

## Provider Memorandum

Providers may log into IMPACT by visiting <https://www.illinois.gov/hfs/impact/pages/default.aspx>. To make sure your enrollment experience is as quick and efficient as possible, please investigate whether you need to complete any of these prerequisite steps before you attempt to enroll or revalidate in the IMPACT system.

- Obtain an application ID number sent via postal mail
- Ensure a Certified W-9 is on file
- Renew any professional certifications or licensures
- Ensure the appropriate web access
- Obtain a National Provider Identifier (NPI) Number

If you have any questions, please contact your Provider Network Manager or you may contact the Provider Network Management Department via email at [MHILProviderNetworkManagement@MolinaHealthcare.com](mailto:MHILProviderNetworkManagement@MolinaHealthcare.com)

Providers who need help locating their respective Provider Network Manager, please visit Molina's Service Area page at <http://www.molinahealthcare.com/providers/il/medicaid/contacts/Pages/servicearea.aspx>.

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### Exhibit C.17-17. Provider Memorandum

#### f.ii. PROPOSED CREDENTIALING PROCESS

When the provider is ready to begin the credentialing process, Molina's Contracting and Credentialing departments work together to create a smooth process for the provider. Contracting staff ensures that the provider has collected the proper documents (IRS Form W-9, Council for Affordable Healthcare Quality ID, etc.). Because these documents can take time for the provider to collect – for instance, the turnaround time for a CAQH ID is 2-3 business days – the Contracting department works with the provider until verifying that all paperwork is collected, then sends the packet to the Credentialing Department. The results of this advance work are evident in our turnaround times (TATs) both enterprise-wide and by state.

Our credentialing program has been developed in accordance with the NCQA and meets federal, Commonwealth, and Department requirements. Our approach eliminates potential discrimination against providers serving high-risk populations or specializing in conditions requiring costly treatment. We offer delegated credentialing to qualified provider groups, which results in expedited credentialing for their providers. Copies of MHI's proposed credentialing policies and procedures, and procedures for coordination with the Credentialing Verification Organization(s) are included within Attachments to C.17. These documents include the MHI Credentialing Program Policy, the MHI Assessment of Organizational Providers Policy, the MHI Fair Hearing Plan Policy, and the MHI Credentialing Verification Organization Procedures.



Average TAT for all Molina health plans over the past year is 17.5 days

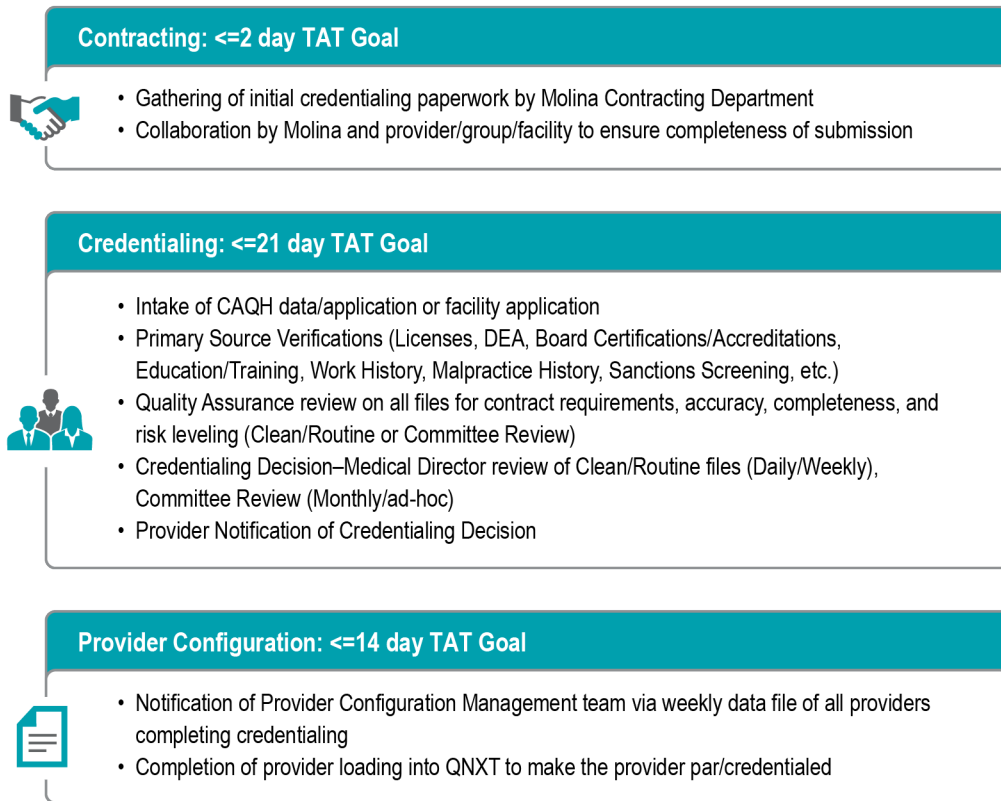
Individual average health plan TATs over the last year include:

South Carolina: 11.3 days

Ohio: 13 days

Mississippi: 19.4 days

Exhibit C.17-18 offers a high-level view of our credentialing process and turnaround times (TATs).



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### Exhibit C.17-18. Credentialing Process and Expected Turnaround Times

We continually monitor our credentialing turnaround times including receiving feedback from providers regarding the timeliness and effectiveness of our credentialing process.

For Kentucky Medicaid, we will rely on our current credentialing and recredentialing process, which has proven successful in our affiliate plans. We will complete the credentialing or recredentialing of a provider within 90 days of receipt of all relative information from the provider, or within 45 days if the provider is providing substance use disorder services, as required by the Draft Contract, Section 27.7, Provider Credentialing and Recredentialing. ***Our credentialing process across all Molina health plans currently averages 17.5 days to complete from the time we receive a complete application.*** At the time of initial credentialing and recredentialing, the provider or facility must complete an application with information necessary to perform a comprehensive review of their credentials. We utilize the CAQH's online credentialing application process, which supports our administrative simplification and paper reduction efforts as well as the accuracy and integrity of our provider database.

We will work with Kentucky providers to make sure their credentialing application is complete prior to submission. This approach has allowed our affiliate health plans to maintain contracting and credentialing turnaround time performance that exceeds the requirements of their state partners. For example, Molina's South Carolina health plan has developed a checklist to make sure that all required information is collected prior to submission of the credentialing application. They also make use of a tracking log to monitor progress of the application to make sure there are no delays in the process.

Once we receive a completed application, we log it into our credentialing system based on receipt date, allowing us to track the application, monitor turnaround times, adjust staffing to accommodate large influxes of applications, and meet our deadlines. We create an electronic credentialing file for each



provider applicant. This file contains all copies of documentation received plus verifications and a signed attestation statement, in accordance with NCQA and Department requirements. We will make at least three outreach attempts to resolve missing or expired information issues when we receive an incomplete credentialing application.

We recredential all providers within 36 months of the previous credentialing decision, in accordance with NCQA standards. This includes a re-verification of licensures and certifications as well as essential monitoring and review of any sanctions. Enrollee grievances, Enrollee satisfaction, and information from quality improvement and medical management activities are included, when available.

Individual providers and provider groups with whom Molina contracts must be credentialed prior to joining the provider network. We credential a wide range of acute care and other provider types, including but not limited to:

- Acupuncturists
- Addition medicine specialists
- Audiologists
- Behavioral health practitioners licensed, certified or registered by the Commonwealth to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Psychologists
- Speech and Language Pathologists
- Telemedicine Practitioners
- Optometrists

Providers must meet established criteria to be eligible to participate in the Molina network. We rely heavily on CAQH at both credentialing and recredentialing for individual providers in order to minimize the administrative burden by fostering an online paperless process. We provide details about established criteria by provider type in MHI's Credentialing Program Policy included within Attachments to C.17.

### Ongoing Monitoring of Provider Sanctions

We monitor practitioner sanctions between recredentialing cycles for all practitioner types and take appropriate action against practitioners when occurrences of poor quality are identified. We monitor provider sanctions as described below in Table C.17-5 and in our MHI Credentialing Program Policy included in Attachments to Section C.17.


**Table C.17-5. Provider Monitoring**

Ongoing	Every 30 Days
Sanctions or Limitations on Licensure	OIG Sanctions
National Practitioner Data Bank (NPDB) Continuous Query Reports	Department Sanctions
Adverse Events	Social Security Administration Master Death File
Enrollee Grievances and Appeals	System for Award Management Sanctions
System for Award Management Sanctions	All State Medicaid Exclusions Databases
DEA Administrative Actions	OIG Most Wanted
NPPES Registry	Provider Services Feedback and Survey Tools

Molina utilizes National Practitioner Data Bank (NPDB) continuous query to monitor our credentialed providers for any license actions, or Medicare or Medicaid sanctions reported to the NPDB. We receive notification within 24 hours of a report being submitted to the NPDB. Additionally, we monitor the entire contracted and non-contracted/ network every 30 days against all Medicare and Medicaid sanction databases.


Our Credentialing Committee's decision to accept or deny an applicant is based on primary source verification, and additional information as required. Our Kentucky medical director will chair the committee, which will meet monthly (or as often as needed) and includes a variety of participating Kentucky-based providers, including PCPs, specialists, behavioral health, and other providers.

The committee applies NCQA-approved processes to review and render decisions regarding initial and continued network participation. The committee recommends approving, denying, terminating, approving on watch status, placing on corrective action, or deferring decisions pending additional information. In addition, our medical director will approve clean files on a weekly basis to expedite the process. We will notify the Department within 10 calendar days of any denial of a provider credentialing or recredentialing application either for program integrity-related reasons, or our decision not to allow a provider to participate in our network.



I just attended the Columbus MCO BH Provider Forum and was very impressed with how knowledgeable and helpful Valerie was. She answered all questions I had about contracting/credentialing and even called her supervisor to ensure her responses were accurate. Great customer service!

Debbie Cline | Freedom Center of Knox County CMHC  
BH provider comment submitted through the "It Matters to Molina" program



### f.iii. TRANSITIONING TO A CVO

Molina is experienced in successfully transitioning credentialing and recredentialing activities to a Credentialing Verification Organization (CVO). We know from experience the use of the CVO saves time by eliminating duplicative efforts and processes for providers who credential separately with multiple MCOs, and it reduces administrative costs for providers and MCOs.

We also know this process can lead to questions from providers, who often don't initially understand the benefits of reduced administrative burden. When Texas transitioned to a CVO, our Molina affiliate distributed an FAQ sheet that explained what will and will not change for providers and that the contracting process remains the same – i.e., agreements with each MCO individually. If Kentucky chooses to follow this path, Molina will prioritize a similar education campaign for all of our providers.

***MHI's national vendor, Aperture Credentialing, LLC, is a Louisville-based CVO.*** A copy of MHI's Credentialing Verification Organization Procedures for coordination with the CVO are included within Attachments to C.17. Among the benefits to providers of this agreement is that Aperture has partnered with Availity, an MHI vendor that supplies our Provider Portal platform, to create an online portal for providers to complete the credentialing application, submit document, and verify completion.

In Mississippi, our affiliate is currently working with the Mississippi Division of Medicaid and other MCOs to consolidate credentialing. As we successfully accomplished in our affiliate health plans, we look forward to collaborating with the Department and other MCOs to share best practices and lessons learned.

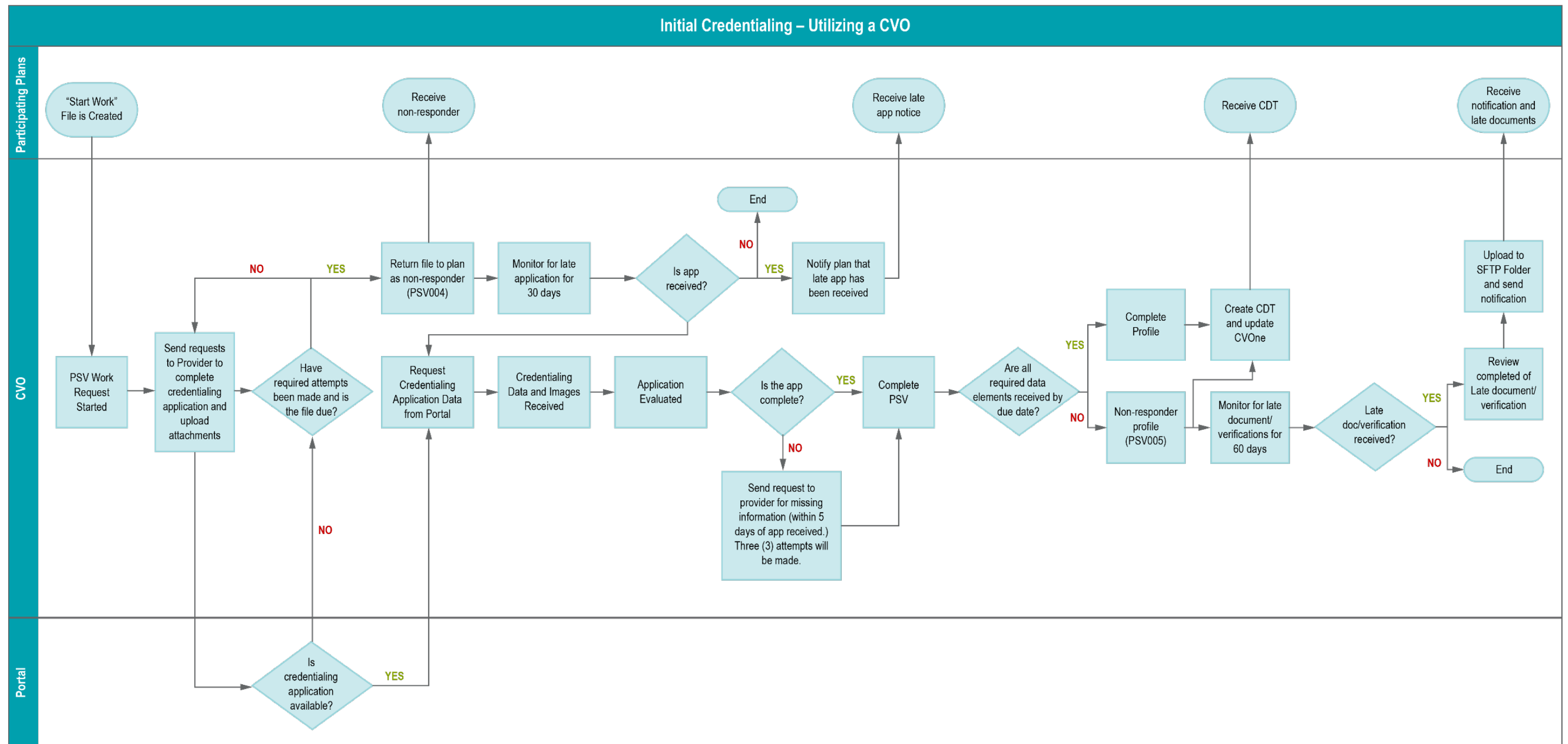
We have established internal processes to make the transition as easy as possible for our providers. Our provider services representatives will educate our providers on the new CVO policies and we will also use our Provider Website, Provider Bulletin, and email blasts to keep providers informed.

For example, our affiliate executed a contract with the Texas Association of Health Plans (TAHP) in collaboration with the Texas Medical Association and Medicaid MCOs, and with Aperture to develop a Texas Centralized Credentialing Verification Organization (CVO) process for credentialing verifications for non-delegated provider organizations. The collaborative joint effort helps reduce credentialing burdens for all Texas providers including physicians, allied health practitioners, hospitals, facilities and all types of ancillary providers.

Our Texas affiliate health plan uses the CVO to obtain primary source verification directly from issuing entities, including professional license, board certification or residency/fellowship completion, Drug Enforcement Agency (DEA) certificates, and verification of education and training. The CVO also queries the NDPB, SAM, and the OIG through primary source verification to identify any history of liability issues and potential sanctions, and the appropriate Texas licensing agency for board orders. Secondary sources or visual inspection are reviewed to help verify malpractice insurance, five-year work history, history of loss of licensure or felony convictions, history of loss of privileges, or disciplinary sanctions. The application must indicate admitting privileges at a contracted facility or another physician able to admit patients on the provider's behalf, and willingness to accept new patients.

Our Texas affiliate health plan retains responsibility for reviewing and auditing policies and procedures for all provider organizations they delegate credentialing to. To ensure that each delegate complies with NCQA and TDI standards, they conduct a pre-delegation and annual oversight audit. The Delegation Oversight Committee reviews audit results and determines if the entity qualifies for delegated credentialing activities. Following approval, the delegate submits routine reports regarding changes to its network. Should a delegate fail to meet standards, our Texas affiliate requests submission of a corrective action plan to the Delegation Oversight Committee. If the delegated group fails to meet the requirements of the corrective action plan, Molina will take additional corrective action up to and including termination.

Exhibit C.17-19 shows a high-level workflow outlining the credentialing process between Molina and a CVO.



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**Exhibit C.17-19. Initial Credentialing Utilizing a CVO**

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#### f.iv. Approach to Timely Contracting

Our medical director reviews and approves clean credentialing files weekly, which expedites the contracting and credentialing process. Our Credentialing Committee meets monthly (or more often as necessary) and uses a peer review process to make credentialing decisions on more complex files. We outperform Draft Contract requirements to complete credentialing activities within 90 calendar days of application receipt for non-behavioral health providers and within 45 calendar days of application receipt for behavioral health providers.

***Our credentialing process across all Molina health plans currently averages 17.5 days to complete from the time we receive a complete application.*** We send a letter to every provider with notification of our medical director's or Credentialing Committee's decision on their network participation.

***We load all information for contracted and credentialed providers into QNXT, our claims management and processing platform, within 14 calendar days of contract approval.*** Their participation becomes effective upon the date of clean file medical director approval or approval by the Credentialing committee if required.

A copy of MHI's Credentialing Verification Organization Procedures for coordination with the CVO are included within Attachments to C.17.



In 2017, one of our affiliate health plans added resources and streamlined its provider grievances and appeals processes, dramatically decreasing the percent of total provider disputes received

Provider disputes received < 60 days

Quarter 1	Quarter 4
72.5%	0%

#### g. GRIEVANCES AND APPEALS

We will apply a formal provider grievance and appeal process providing timely, effective resolution of disputes between our health plan and both network and non-network providers. We document and track all grievances and appeals whether received by phone, email, fax, provider services representatives, or at meetings. All provider grievance and appeals information is housed in Molina's Appeals and Grievance System.

Molina's Appeals and Grievance System's reporting capabilities provide data on volume and turnaround-time metrics for each case (as well as averages). In addition to any Commonwealth reporting requirements, the Appeals and Grievance System provides root cause detail for internal tracking and trending. Root cause analysis assists in process improvement and enables our representatives and PSC to take appropriate action to reduce or eliminate future occurrences.

#### g.i. GRIEVANCE AND APPEALS PROCESS

As an NCQA-accredited health organization, our provider grievance and appeals processes have been audited and determined to meet or exceed industry standards. Our formal provider grievance and appeals process provides for the timely and effective resolution of any disputes between our health plan and our providers. We will submit our Provider Grievances and Appeals Policy and Procedures to the Department for review 90 days after Contract execution. We will also submit changes to the policy and procedures for Department review prior to implementation of changes.

Our first and most effective strategy to reduce grievances and appeals is to proactively prevent them. We leverage data analytics to identify issues that are common to many providers, and we develop an action plan to address the issue. Our provider services representatives maintain frequent contact with the provider assigned to them, and we have email and phone support to address other issues. At our Molina One-Stop Help Centers, we can meet with providers in person to discuss issues and possibly mitigate the need for an appeal. When we do receive grievances and appeals, we perform root-cause analysis and



barrier assessments provide insight into issues that may have contributed to the causes and performance gaps in achieving established goals.

Our Appeals and Grievance System is a workforce tool the Provider Resolution Team accesses while resolving grievances and appeals. Our system is time-tested, proven, and reliable and is used successfully at our 14 affiliated Medicaid health plans to collect, store, access, track, and analyze provider grievances and appeals information in support of our affiliate's Medicaid programs. The system has the capability of storing related documents, routing a "case" to another department to work (e.g., route an appeal to a clinical department for medical review or a claim to the Claims Adjustment department to adjust a claims-related dispute or appeal). The Appeals and Grievance System also generates required correspondence and keeps track of the timeframe for any open case to ensure compliance with regulatory timeframes.

### Ensuring Providers Receive Information about the Grievance and Appeal Process

When providers enter into a contract with Molina, Provider Services works closely with each contracted provider to ensure they have a complete understanding of the grievance and appeals processes required for network participation. A thorough description of the process is included in the Provider Manual, which is published on the public portion of the Molina website. During the contracting process, providers are encouraged to carefully review the Provider Manual which is incorporated by reference in the provider contract.

We understand the Department will provide a standard Provider Grievance Form to be used to initiate the provider grievance process. Molina will use this form to capture information regardless of the point of origin of the provider grievance. Molina will provide information specified in 42 C.F.R. 438.10(g)(2)(XI) about the Appeals and Grievance System to all service providers and subcontractors at the time they enter into a contract.

Prior to executing a contract, the provider has access to Molina's contracting staff to respond to any questions and further outline requirements via telephone and email. Once a provider has an executed contract, a Molina provider services representative conducts a formal orientation within 30 days of the contract's effective date to explain key information, including a full overview of the grievance and appeals process and a detailed description on the submission of a grievance or an appeal through the use of both electronic (Provider Portal and Right Fax) and non-electronic (telephone and hard copy mail) options. In the event a provider has questions about grievances or appeals, they can contact their assigned provider services representative or our provider Call Center to receive updated information regarding their dispute along with an estimated time frame for completion.

### Provider Grievance and Appeals

Under our process, providers may file a grievance or appeal orally, electronically or in writing, within 30 calendar days from the date of the event causing the provider's dissatisfaction. ***To help our providers ease their administrative burden, providers may include up to 25 claims with their appeal request if the appeal involves the same or similar payment or coverage issues.***

Regardless of submission method, all grievances and appeals are automatically "mapped" to our Appeals and Grievance System, which creates a unique case number. The Provider Resolution Team coordinators work out of the system and can route cases to other appropriate Molina departments as needed. The Appeals and Grievance System data is used for internal tracking and trending as well as any regulatory state reports.

Elements tracked will include date filed, grievance/appeal type, identification of the provider filing the grievance or appeal, identification of the individual recording the grievance or appeal, disposition of the grievance or appeal, a summary of any action taken to resolve the issue, and the resolution date. The Appeals and Grievance System can drill down to multiple tiers of specificity related to root cause. This specificity provides valuable data to be used to identify opportunities for improvement.

We will configure the Appeals and Grievance System to capture all pertinent information needed for the timely review and ultimate resolution within all applicable contractual and statutory requirements and timeframes. The system interfaces daily with our core IT system (QNXT), which maintains all provider demographic information, performs claims adjudication, and is the source data for all claim inquiries. Select information recorded in our Appeals and Grievance System is also reflected in QNXT.

For provider grievances, we confirm receipt of the grievance. All grievances and appeals are resolved, and written notification is provided within 30 calendar days. Molina will allow providers the right to file an internal appeal regarding Denial of the following:

- A health care service
- Claim for reimbursement
- Provider payment
- Contractual issues

We understand that appeals received from providers that are on the Enrollee's behalf for denied services with requisite consent of the Enrollee are considered Enrollee appeals.

Our Appeals process will include:

- A committee to review and make decisions on provider appeals. The committee will consist of at least three qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to appeal
- Written notification to the provider regarding a denial
- Right to request an external third-party review of Contractor decisions after the internal process has been exhausted

If the grievance or appeal is not resolved within 30 days, Molina will request a 14-day extension from the provider. If the provider requests the extension, Molina will approve the extension.

We will ensure that there is no discrimination against a provider solely on the grounds the provider filed an appeal or is making an informal grievance. Molina will monitor and evaluate provider grievances and appeals. We will submit monthly reports to the Department regarding the number, type and outcomes including final denials of provider grievances and appeals as required in the Draft Contract, Appendix D, Reporting Requirements and Reporting Deliverables.

### **Molina's Grievance and Appeals Staff**

Our designated Provider Resolution Team will include clinical reviewers with various levels of expertise and backgrounds, and our assignment process ensures that disputes and appeals are reviewed by staff with the appropriate experience based on the provider type and/or the nature of the dispute. For example, cases related to CPT and HCPCS coding are reviewed by certified coders, while hospital and professional claims are reviewed by claim examiners familiar with Medicaid benefits and contract interpretations for the respective provider type. Our staff considers all supporting documentation submitted with the requests and conducts research of all available health plan databases (i.e. prior claims, calls to the health plan, and prior issues) to ensure that all relevant information is included in the review.

When a request requires input from another department, the case will be routed through our Appeals and Grievance System. If a request related to a post-service claim requires a medical necessity review, the claim will be routed to the clinical reviewer (nurse) for review. A summary is provided along with a recommendation based on documentation, benefit, and/or medical necessity guidelines.

Once complete, the case is routed to our Medical Affairs department to be reviewed by a medical director. The medical director will review the documentation and the summary and provide a decision. If it is a denial for Enrollee ineligibility, the claim will go to our Enrollment department for review. Departments

involved in review of a case enter their findings into the core system, which is integrated with the Appeals and Grievance System, so all staff involved in working the case can view certain information even if they are not working directly in the Appeals and Grievance System.

When the execution of the case decision requires a QNXT update (i.e., eligibility update and provider contract correction), grievance and appeals staff will engage the appropriate department to execute the update and ensure prompt and accurate resolution is submitted to the provider. Notes are added to the case throughout the process to keep the case status updated and ensure adequate documentation. Once resolved, we will close the case in the Appeals and Grievance System and select appropriate root cause categories (multiple tiers of specificity) to ensure accurate root cause analysis.

### **Elevating Grievances and Appeals**

When a decision is favorable to a provider, a coordinator will route the appeal to our Claims Adjustment team. The coordinator and claims adjuster will coordinate to assure the adjustment is processed in accordance with the decision and required timeframes, or as specified by the Department or final order issued by an independent review entity.

In instances where an appeal approaches the 25-day mark, the claims adjustment will be escalated to a high-priority level to ensure it is processed timely. This escalation process will also be used for all disputes received from the Department and final orders issued by an independent review entity. Once the final review is complete, grievance and appeals staff will generate a determination letter, which will be mailed to the provider.

A provider who has exhausted Molina's grievance and appeals process will have a right to appeal a final denial, in whole or in part, by Molina to an external independent third party in accordance with applicable Commonwealth laws and regulations including denials, in whole or in part, involving emergency care services.

Molina will provide written notification to the provider of their right to file an appeal. A provider will have a right to appeal a final decision by an external independent third party to the Cabinet for Health and Family Services Division of Administrative Hearings for a hearing in accordance with applicable Commonwealth laws and regulation. If the provider prevails, in whole or in part, Molina will comply with any Final Order within 60 days unless the Final Order designates a different timeframe.

### **g.ii. TRACKING GRIEVANCES AND APPEALS AND IMPROVING OPERATIONS**

All grievances and appeals are date stamped, documented, tracked, and stored in the Appeals and Grievance System, allowing for the aggregation and trending of issues as well as the capability to share data with the Department on a monthly basis. In addition, we generate a quarterly summary report that encapsulates this information as well. Ad hoc reports will be provided upon the Department's request.

***Enhanced data analytics enable us to identify opportunities for plan improvement and establish goals and performance thresholds, which ultimately leads to a reduction in grievances and appeals and an increase in provider satisfaction.*** Root-cause analysis and barrier assessments provide insight into issues that may have contributed to the causes and performance gaps in achieving established goals. The analysis and resulting opportunities for improvement will be reviewed by the Provider Advisory Workgroup, Quality Improvement Committee, and Enrollee Provider Satisfaction Workgroup as appropriate. Action plans with associated timelines related to identified opportunities for improvement will be developed and process changes will be implemented by the appropriate department within our health plan.

For example, one of our affiliate Medicaid health plan's quarterly trend analyses indicated an uptick in overturned appeal decisions. The plan's Grievances and Appeals team conducted a root cause analysis and discovered that many of the decisions were overturned after providers submitted additional documentation during the appeal process to support their request. In collaboration with the Healthcare Services department, solutions were designed and implemented to address the issue and consequently

reduce the volume of overturned decisions. This included conducting targeted training to providers on supplying all relevant clinical information with requests for prior authorization at the time of submission. In addition, the Healthcare Services department revised their process to have utilization management nurses make additional attempts to reach providers when clinical information or clarification is needed to render a determination on the service request. The health plan closely monitored overturned decisions following implementation of the targeted training and confirmed a significant decrease in appeals and overturned decisions.

Exhibit C.17-20 shows one analytics tool, which we use internally and share with providers.



**Exhibit C.17-20. Grievance and Appeals Data**

We know from experience that transparency is crucial to reducing provider abrasion and increasing satisfaction. Our provider services team is responsible for ongoing communication with network providers and for sharing the results of analyses and assessments. For individual provider issues, we will meet face-to-face with the provider to offer education and technical assistance. If the issue requires a broader solution that impacts the overall network, provider services will launch a comprehensive network-wide communication and education effort.

We continually monitor our credentialing turnaround times including feedback from providers regarding the timeliness and effectiveness of our operations.

### g.iii. ENSURING TRANSPARENCY

Molina will submit provider grievance and appeals reports as required in Appendix D, "Reporting Requirements and Reporting Deliverables." In addition, Molina will make an online Grievance and Appeals Dashboard available to the Department that acknowledges receipt, in progress or completed status of claims. We will also have a dedicated resource to serve as a point of contact for the department for all grievance and appeals related issues.

Exhibit C.17-21 shows a summary of our grievances and appeals by category (dismissed, duplicate, overturned, partial, unknown, upheld, or withdrawn). In addition to using this tool internally, we make it available to providers as well as the Department.

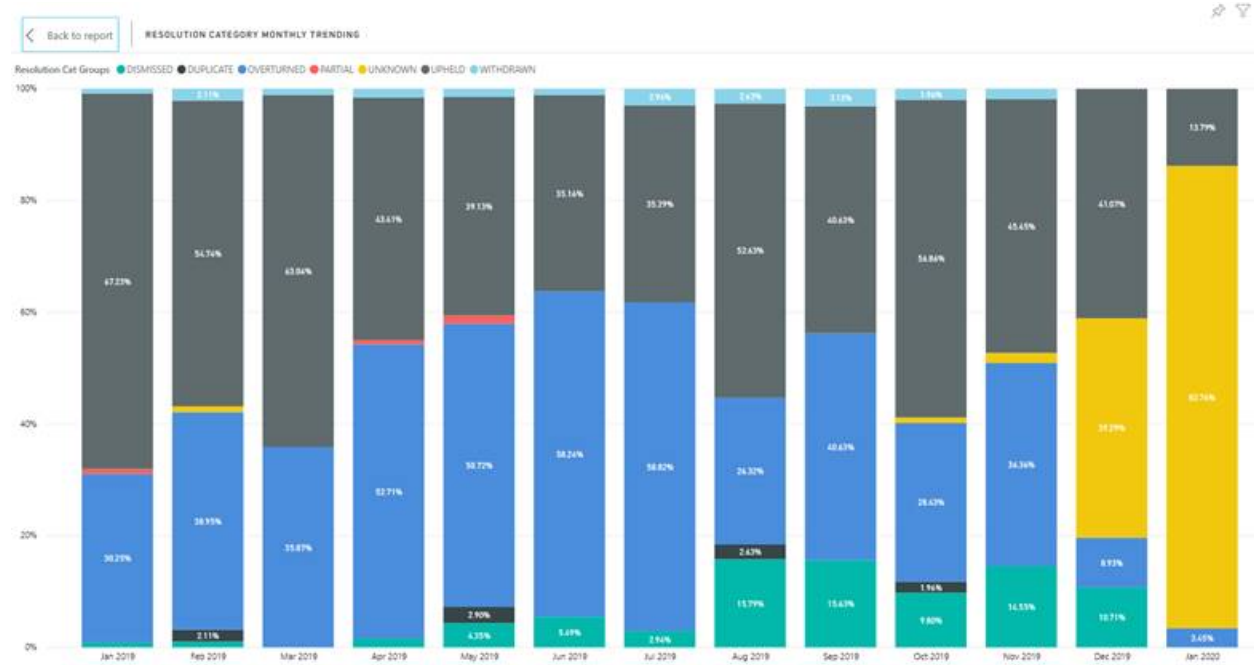


Exhibit C.17-21. Grievance and Appeals Summary