PROVIDER NEWSLETTER

A newsletter for Molina Healthcare Provider Networks

Fourth Quarter 2019

In this Issue

2019-2020 Flu Season

The Advisory Committee on Immunization Practices (ACIP) continues to recommend annual influenza vaccinations for everyone who is at least six months of age and older. It's especially important that certain people get vaccinated, either because they are at high risk of having serious flu-related complications or because they live with or care for people at high risk for developing flu-related complications. A licensed, recommended and age-appropriate vaccine should be used. Inactivated influenza vaccines (IIVs), recombinant influenza vaccine (RIV) and live attenuated influenza vaccine (LAIV) are expected to be available for the 2019–20 season. Standard-dose, unadjuvanted, inactivated influenza vaccines will be available in quadrivalent formulations (IIV4s). High-dose (HD-IIV3) and adjuvanted (aIIV3) inactivated influenza vaccines will be available in trivalent formulations. Recombinant (RIV4) and live attenuated influenza vaccine (LAIV4) will be available in quadrivalent formulations.

Important Update:

The A viral vaccine components have been updated for the 2019-20 flu season and the B viral vaccine component remains the same from the 2018-19 flu season.

The age indication for Afluria Quadrivalent has been expanded from ≥5 years to ≥6 months. The dose volume for Afluria Quadrivalent is 0.25 mL for children aged six through 35 months and 0.5 mL for all persons aged ≥36 months (≥3 years).

The dose volume for Fluzone Quadrivalent for children aged six through 35 months, which was previously 0.25 mL, is now either 0.25 mL or 0.5 mL. The dose volume for Fluzone Quadrivalent is 0.5 mL for all persons aged ≥36 months (≥3 years).

For a complete copy of the ACIP recommendations and updates, or for information on the flu vaccine options for the 2019-2020 flu season, please visit the Centers for Disease Control and Prevention at https://www.cdc.gov/flu/professionals/vaccination/.

Quality Outcomes for Chronic Kidney Disease

Molina Healthcare of Ohio partners closely with our provider network to care for our members with chronic and end-stage kidney disease. Clinical best practice demonstrates that timely referral to a nephrologist and early dialysis preparation are key to achieving quality of care outcomes. Additionally, as recommended by the National Kidney Foundation, for individuals for whom Peritoneal Dialysis is appropriate, members may experience significant health benefits compared to traditional hemodialysis. For additional questions, please reach out to Molina's Healthcare Services Department at (855) 322-4079.

Refer Chronic Kidney Disease (CKD) patients (Glomerular filtration rate [GFR] < 60) to a nephrologist in a timely manner

- Impaired kidney function and proteinuria increase the risk of cardiovascular disease two to four times, even after adjusting for traditional cardiovascular risk factors. (Gansevoort RT et al. Lancet. 2013 Jul;382(9889):339-52)
- Early appointments (beginning six months or more before dialysis) and frequent care (at least one nephrology visit every three months) are associated with 10 percent lower risk for major adverse cardiovascular events (acute MI, acute heart failure, acute stroke or sudden death). (Yang J, et al. Am J Kidney Dis. 2017)

Peritoneal Dialysis Preferred

- Most nephrologists would choose peritoneal dialysis (PD) over hemodialysis (HD) for themselves. "96% of nephrologists surveyed recently would choose PD over HD if they had to go on dialysis themselves." (Merighi, JR et al. Hemodial Int. 2012; 16: 242-251)
- Residual kidney function is maintained longer with PD than HD: In a prospective study, PD patients had an 8.1 percent decline in GFR per month compared to 10.7 percent decline in GFR per month for HD patients. (Jansen M, et al. Kidney Int 2002; 62: 1046-53)
- PD reduces vascular access interventions. In a prospective observational study in Canada between 2007 and 2010, mean number of access interventions was significantly less in PD than HD patients (p =0.005). (Oliver MJ, et al. Nephrol Diol Transplant 2012; 27:810-816)
- Absolute PD contraindications are few: bowel cancer, diverticulitis, colostomy/ileostomy, ischemic bowel and excessive abdominal scarring from prior abdominal surgeries.

Refer patients early to vascular surgeon for PD catheter or fistula/graft to avoid central venous catheter

- Arteriovenous (AV) fistulas or AV grafts result in much better outcomes. Hemodialysis catheter use needs to be avoided or minimized to avoid complications, especially central vein stenosis, which substantially reduces the success of future AV fistulas. In a retrospective review, the cumulative risk of any catheter-related complications was 30 percent at one year and 38 percent at two years. The one-year risk of bacteremia was 9 percent. Central vein stenosis or thrombosis occurred in 1.5 percent of patients. (Poinen K et al. Am J Kidney Dis. 2019;73(4):467)
- To minimize catheter use, all pre-dialysis patients with an expected start of hemodialysis within one year and patients who have initiated hemodialysis urgently with a catheter should be referred to a vascular surgeon to determine eligibility for AV access or PD catheter. Central venous

catheters should be reserved only for those with limited life expectancy (e.g., metastatic cancer) or patients with a very short expected duration of hemodialysis (e.g., pending live-related transplant).

Transplant evaluation

- Patients who are interested in transplantation and who have no known contraindications should be referred to a transplantation program before they even start dialysis, when the estimated glomerular filtration rate (eGFR) is <30 GM mL/min/1.73 m^2. (Bunnapradist S, Danovitch Am J Kidney Dis. 2007;50(5):890)
- Absolute contraindications for transplant include: active substance abuse, active malignancy, active infection, reversible renal failure, uncontrolled psychiatric disease, documented active and ongoing treatment nonadherence, or a significantly shortened life expectancy.

Molina's Special Investigation Unit Partnering with You to Prevent Fraud, Waste and Abuse

The National Healthcare Anti-Fraud Association estimates that least 3 percent of the nation's health care costs, amounting to tens of billions of dollars, is lost to fraud, waste and abuse. That's money that would otherwise cover legitimate care and services for the neediest in our communities. To address the issue, federal and state governments have passed a number of laws to improve overall program integrity, including required audits of medical records against billing practices. Molina, like others in our industry, must comply with these laws and proactively ensure that government funds are used appropriately. Molina's Special Investigation Unit (SIU) aims to safeguard Medicare and Medicaid, along with Marketplace funds.

You and the SIU:

The SIU analyzes providers by using software that identifies questionable coding and/or billing patterns, and to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse along with concerns involving medical necessity. As a result, providers may receive a notice from the SIU if they have been identified as having outliers that require additional review or by random selection. If your practice receives a notice from the SIU, please cooperate with the notice and any instructions, such as providing requested medical records and other supporting documentation. Should you have questions, please contact your Provider Services Representative.

"Molina Healthcare appreciates the partnership it has with providers in caring for the medical needs of our members," explains Scott Campbell, the Molina Associate Vice President who oversees the SIU operations. "Together, we share a responsibility to be prudent stewards of government funds. It's a responsibility that we all should take seriously because it plays an important role in protecting programs like Medicare and Medicaid from fraudulent activity."

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

To report potential fraud, waste and abuse, you ma\y contact the Molina AlertLine toll-free at

(866) 606-3889, 24 hours per day, 7 days per week. In addition, you may use the service's website to make a report at any time at https://MolinaHealthcare.AlertLine.com.

Patient Driven Payment Model

Effective Oct. 1, 2019, the new Patient Driven Payment Model (PDPM) was implemented by the Centers for Medicare and Medicaid Services (CMS) to replace the Resource Utilization Group (RUG), Version IV for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS).

Molina is following CMS Medicare methodology for the PDPM implementation, and has posted a Frequently Asked Questions (FAQ) resource document under the "communications" header on our Medicare page of the Molinahealthcare.com website.

Molina providers reimbursed under the Medicare SNF PPS are subject to the PDPM payment transition starting with dates of service on/after Oct. 1, 2019. The payment transition applies to all lines of business that are contracted/required to pay Medicare allowable rates.

In order to prevent payment disruption, action is required to modify claim billing practices. There was no transition period between RUG-IV and PDPM. RUG-IV billing ended Sept. 30, 2019. PDPM billing began Oct. 1, 2019.

CMS has released resources to help you on the PDPM webpage, including fact sheets, FAQs and training materials. Please visit the CMS website at www.cms.gov, and under the "Medicare" tab find the "Medicare Fee-for-Service Payment" section, then select "Skilled Nursing Facility PPS."

Balance Billing

Providers contracted with Molina cannot bill Molina members for any covered benefits. The provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Molina member be liable to the provider for any sums owed by Molina to the provider. Balance billing a Molina member for services covered by Molina is prohibited. This includes:

- Holding the Molina D-SNP member liable for Medicare Part A and B cost sharing
- Requiring a Molina member to pay the difference between the discounted and negotiated fees, and the provider's usual and customary fees
- Charging a Molina member fees for covered services beyond copayments, deductibles or coinsurance

CGRP Inhibitors for Preventative Migraine Treatment

Three new medications gained Food and Drug Administration (FDA) approval for the prevention of migraines in adults. These medications are humanized monoclonal antibodies that bind to the calcitonin gene-related peptide (CGRP) ligand and blocks its binding to the receptor. A brief overview of each medication is discussed below.

The first CGRP Inhibitor, approved on May 17, 2018, is called Aimovig (erenumab-aooe). Aimovig is given as a 70 mg/mL monthly subcutaneous injection, which may be increased to 140 mg/mL monthly. The efficacy of Aimovig was evaluated in three randomized, double-blind, placebo-controlled studies, with two studies including patients with episodic migraines and one study including patients with chronic migraines.

In all three studies, Aimovig treatment demonstrated statistically significant improvements for mean monthly migraine days and change from baseline in monthly migraine days by the third month of treatment.

The second CGRP Inhibitor, approved on Sept. 14, 2018, is called Ajovy (fremanezumab—vfrm). Ajovy is dosed as a single 225 mg/1.5 mL subcutaneous injection monthly or 675 mg/1.5 mL, administered as three consecutive 225 mg/1.5 mL injections, every three months. The efficacy of Ajovy was evaluated in two multicenter, randomized, three-month, double-blind, placebo-controlled studies in which one study included patients with episodic migraines and the other included patients with a history of chronic migraines. Both studies demonstrated a statistically significant decrease in monthly average number of migraine days during the three-month period from baseline.

The third CGRP Inhibitor, approved on Sept. 27, 2018, is called Emgality (galcanezumab-gnlm). Emgality dosing for migraine prevention requires a loading dose of 240 mg/mL, administered as two consecutive 120 mg/mL subcutaneous injections, followed by monthly doses of 120 mg/ml. The efficacy of Emgality was evaluated in three multicenter, randomized, double-blind, placebo-controlled studies, with one three-month study including patients with chronic migraines and two six-month studies including patients with episodic migraines. In each study, Emgality showed significant reductions in the mean number of monthly migraine headaches from baseline over the three- and six-month periods, respectively.

A common adverse effect for the three medications was injection site reaction. Additionally, Aimovig also reports constipation as a common adverse effect. There is no established data for the use of these medications in special populations, including in pregnancy, breast-feeding, pediatrics and geriatrics patients.

Molina Healthcare, Inc., National Pharmacy and Therapeutics (P&T) Committee approved CGRP antagonist prior authorization criteria during the first quarter of 2019.

References:
Aimovig (erenumab-aooe) [prescribing information]. Thousand Oaks, CA: Amgen Inc; May 2018.
Ajovy [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc: September 2018.
Emgality [package insert]. Indianapolis, IN: Eli Lilly and Company: September 2018.

Model of Care

2019 Model of Care training is happening now.

CMS requires that contracted providers directly or indirectly facilitating or providing Medicare Part C or D benefits for Molina SNP members complete Model of Care training. This quick training will describe how Molina and providers work together to successfully deliver coordinated care and care management to members with both Medicare and Medicaid.

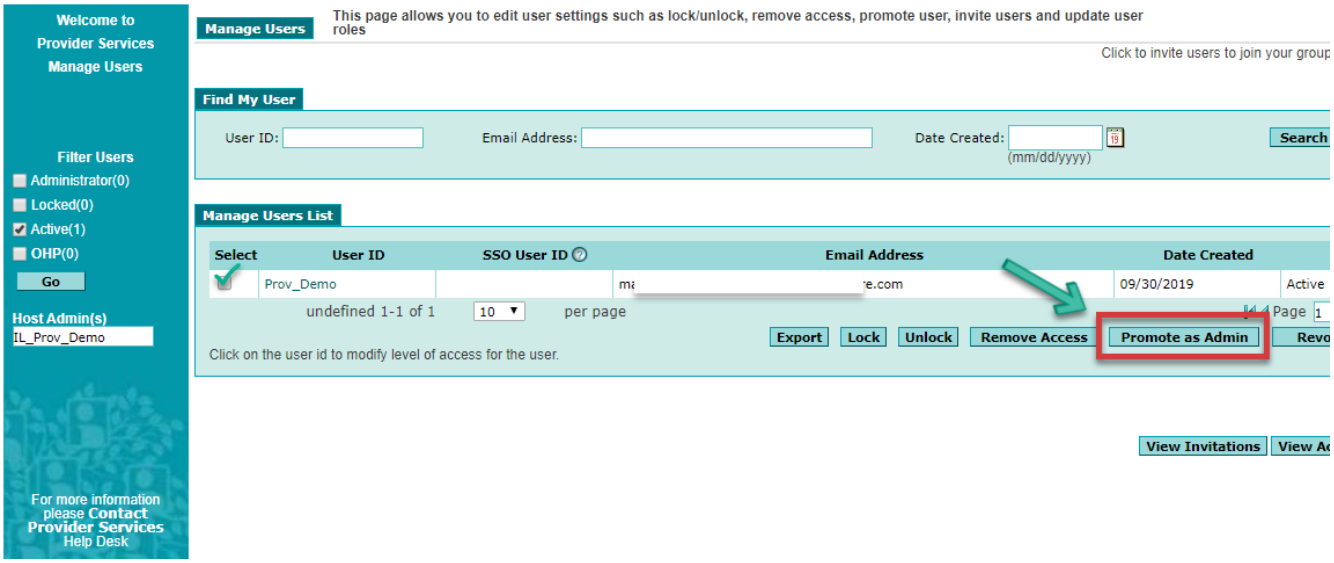
In order to ensure compliance with CMS regulatory requirements, receipt of your completed attestation form is due to Molina by Dec. 31, 2019. If you have any additional questions, please contact your Molina Provider Services Representative at (855) 322-4079.

Provider Portal Corner

If you're the Primary Administrator for your account, you can invite additional users and manage existing users' roles to help you with your day-to-day activities. We highly recommend that you promote at least one other user to Administrator to support your responsibilities.

It's as easy as 1-2-3 to promote a user to an Administrator:

1. Go to Manage Users screen
2. Select the User ID you want to promote
3. Select Promote as Admin button



And voila! The user's status will change to "Admin/Active."

This simple step can assist you in delegating responsibilities and ensuring you always have backup support.

Note: As staff leave or transition into new roles, it is always a good idea to conduct an annual review of all Provider Portal users to determine whether each user should:

- still have access to the Provider Portal
- still have the current level of access on the Provider Portal