Molina Healthcare

Provider Orientation & Training

MOLINA HEALTHCARE

Agenda

1. Welcome, Introductions
2. Molina Healthcare
3. What is MMP?
   - Reminders - EVV & CHAMPS
4. Program Requirements
5. Authorization Process
6. Billing/Claims Instructions
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8. Marketing Practice Guidelines
9. Questions

Molina Healthcare of Michigan

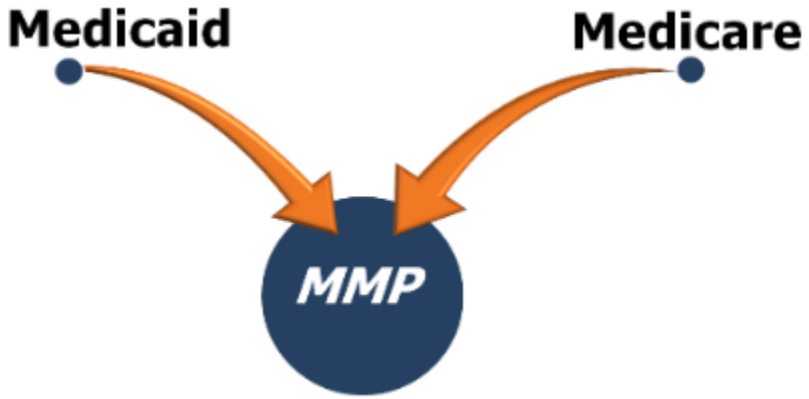
- Molina Healthcare, headquartered in Long Beach, California, is a national managed care company focused on providing health care services to people who receive benefits through government-sponsored programs. Molina is a health plan driven by the belief that each person should be treated like family and deserves quality care.

- C. David Molina, M.D., founded the company in 1980 as a provider organization with a network of primary care clinics in California. As the need to more effectively manage and deliver health care services to low-income populations grew, Molina has grown to be a health plan serving millions of Members across the country.

- Molina Healthcare of Michigan is the 2nd largest Medicaid health plan in Michigan providing health care benefits to over 415,000 members across all of our programs, which include Medicaid, Medicare, Marketplace, and the MI Health Link Program.

What is MI Health Link?

- MMP/ MI Health Link is the demonstration program for persons with Medicare & Medicaid.
- Molina Healthcare of Michigan has been serving MI Health Link members in Wayne and Macomb counties since 2015 and currently has over 12,500 members.
- Molina ranked highest in the 2020 Provider Satisfaction Survey, evidence of our commitment to our providers.
  - Known by other names:
    - Duals Demonstration
    - MI Health Link
    - Integrated Duals
    - Molina Dual Options



Member Eligibility & Enrollment

- Molina currently serves Members in two regions in the State of Michigan.
  - Region 7: Wayne County
  - Region 9: Macomb County
- Members must meet the following requirements:
  - Age 21 or older (65 or older and under 65 if on disability)
  - Eligible for Medicare Parts A and B
  - Eligible for Full Medicaid Benefits
  - Reside in Wayne or Macomb counties
- Enrollment process
  - Member's choice to participate in the demonstration. Members may "opt out" of the program at any time.
  - A **voluntary** Member contacts MI Enrolls and requests enrollment into a participating health plan.
  - A **passive** Member is enrolled by MDHHS and does not opt out.

Welcome to Molina Healthcare of Michigan

We are partnering with Molina, now what?

Following the contracting process

- LTSS Specialist will be assigned and will assist with the following;
  - Prior authorization request/extension
  - Member questions or concerns
- Contracting Manager will assist with the following;
  - Contract and credentialing
  - Monthly Open Forum and Rounding
- Provider Relations Specialist;
  - Claims concerns and issues
  - Portal and Payment questions
- Availity Essentials and ECHO for EFT

BID: Process

- Provider agrees to make a good faith effort to evaluate and consider each bid request based on the scope of work, timeline, and resources available, and
- Provider agrees to respond to all bid requests issued by Health Plan within 14 calendar days of receipt. All communications regarding bid requests, including acceptance or rejection, must be conducted in writing and sent via email to ensure proper documentation and record-keeping, and
- Provider shall provide bid within 30 days; When you are submitting a bid for services, please ensure you are providing detailed information. (Supplies, Labor, Service being performed, Total cost), and
- Make ensure you are providing information that is needed. As far as approvals from the city you may need or permits. Or providing information stating a permit is not needed for that service, and
- Provider is required to apply for a minimum of five (5) bid requests per calendar year. However, if Health Plan does not issue at least five (5) bid requests to the Provider within the calendar year, the Provider will not be penalized for failing to meet the minimum acceptance requirement.

BID Process

- LTSS Specialist will send completed checklist for member
- Provider will bid on each section of the home that is requested to clean
- Provider must submit before pictures of every room that Provider is bidding on with completed checklist to receive winning bid
- Provider must respond even if not bidding
- Provider has 30 days to bid on each bid
- Provider will reach out to their LTSS specialist with difficulties reaching member
- After photos must include photos of every room that you bided on
- Claims will not be paid until member and the CC sign off on checklist.
- If member refuses to sign off, the CC must go to home and review completion

CHAMPS Provider Enrollment

- Providers who serve Michigan Medicaid beneficiaries, including providers participating in a Managed Care Organization's (MCO) provider network, will be required to be enrolled in CHAMPS.

- Providers enrolling in CHAMPS are divided into two categories: typical and atypical.
  - Typical providers are professional health care providers that provide health care services to beneficiaries.
  - Atypical providers provide support services for beneficiaries. These providers generally do not have professional licensure requirements and may not have an NPI.

- MDHHS is awaiting guidance from federal partners regarding the enrollment requirements for atypical providers and will share those updates once available.

- Enrollment in CHAMPS is solely used for the purpose of screening providers participating in Medicaid.

Electronic Visit Verification (EVV)

Why?

As part of the Federal 21st Century Cures Act the Center for Medicare and Medicaid Services (CMS) is requiring states to implement an Electronic Visit Verification (EVV) system for Personal Care and Home Health Care services.

What?

Electronic Visit Verification (EVV) is a validation of the date, time, location, type of personal care or home health care services provided, and individual(s) providing and receiving services. This information helps to ensure that beneficiaries, clients, or participants receive the expected care

Who?

Beneficiaries, Clients, Participants and Providers involved in the Personal Care or Home Health Care programs.

When?

The Michigan Department of Health and Human Services (MDHHS) is currently focused on activities related to COVID-19. A timeline of when EVV will be rolled out in Michigan has not been established yet. MDHHS will continue to keep caregivers, providers, and beneficiaries informed of all EVV updates and changes. No action is required at this time.

Electronic Visit Verification (EVV)

- An Electronic Visit Verification system must verify the following information:
  - Type of service performed
  - Individual receiving the service
  - Date of the service
  - Location of the service
  - Individual providing the service
  - Time the service begins and ends
- EVV does NOT apply to congregate residential settings where 24 hour service is available (such as group homes, assisted living facilities).
- MDHHS entered 5 year contract with HHAeXchange.
- MDHHS will be implementing an "Open Vendor Model." This model allows providers and managed care organizations to use the state EVV system at no cost, or an alternate EVV system of their choosing that directly integrates with the state system.
- https://content.govdelivery.com/attachments/MIDHHS/2023/03/24/file_attachments/2446865/EVV%20Press%20Release%203.23.23.pdf

Michigan Department of Health and Human Services (MDHHS)- HHAeXchange Provider Onboarding

- **In order to complete this onboarding form, you will need the following information regarding your agency:**
- Company name, address, and phone number
- Executive Director in your office (name, email, phone)
- Agency Medicaid ID
- Federal Tax ID
- National Provider Identification (NPI)
- Approximate number of customers your agency services today
- Number of caregivers in your agency
- List of Waivers your program works with/ primary contacts for each waiver at your agency

Michigan Department of Health and Human Services (MDHHS)- HHAeXchange Provider Onboarding Form

Helpful Links for HHAeXchange/ EVV

- HHAeXchange Knowledge Base Home
- Login | HHAeXchange
- Michigan EVV (Electronic Visit Verification) | HHAeXchange
- MDHHS Bulletin MMP (24-34) EVV Personal Care Services
- MDHHS EVV Link
- MDHHS Live-In Caregiver Attestation

Contact information if providers have an issue with the EVV system.

HHAX Contact Information

1-866-576-1179

Client Support Portal - Jira Service Management

Chronic Conditions in the Population

- The MMP population experiences an array of physical and mental health conditions:
  - Physical Conditions such a COPD, Congestive Heart Failure, Diabetes, and paralysis are common.
  - Mental health conditions such as depression, anxiety, substance abuse, bi-polar disorder and schizophrenia are very common
  - Members could also be living with an intellectual disability
  - Any of these conditions may also co-exist for members receiving care

Program Objectives and Requirements

MOLINA HEALTHCARE

Care Coordination & Benefits

- Specialized team of nurses and social workers serve as Care Coordinators for MMP Members.
- Care Coordination is a pivotal role to assure “member centric” care.
- Every member has access to his/her personal Care Coordinator.
- Care Coordinators advise and assist members to receive benefits provided under the demonstration.

- The program provides:
  - All medically necessary clinical services (inpatient, outpatient, physicians)
  - Pharmacy, vision, dental, transportation
  - Long term services & supports (LTSS)

Person Centered Planning

- What does Person-Centered Planning mean?
  - Person-Centered planning means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities.(MCL 330.1700g)
- How does it work for the individuals receiving care?
  - Through Care Planning, the individual will be able to identify their goals, hopes, interests and preferences in their life. The Care Plan will allow that individual to work toward and achieve those goals which includes providing them with the services and supports they require.

Self Determination

- What is Self-Determination?
  - Self-Determination means that you decide what you want to do in your life- such as where you live, how you spend your time, who you spend your time with, and how you earn money- and you control the support you need to get that life.

- What are some examples of Self-Determination?
  - Control over an individual budget
  - Assistance with using arrangements that support Self-Determination
  - Using arrangements that support Self-Determination
  - Hiring workers
  - Ways to make changes and solve problems

Cultural Competency

- Culture shapes an individual's expectations of health care and mental health care providers and influences how symptoms are presented to health care professionals. Also, a person's family or caretaker's behavior can be defined by culture. Culture even impacts how a person may respond to pain, suffering, and death.
- Having an awareness of an individual's culture can be profoundly important in providing health care and mental health care. If a health care provider is not aware of cultural differences, he or she might not understand why a patient presents certain symptoms in a particular manner. The health care provider might also be puzzled at patient resistance, lack of adherence to, or seeming disinterest in health and mental health services and supports. A lack of cultural understanding by the provider can have a negative impact on the efficiency and effectiveness of service provided to an individual from a different culture. This can result in a serious disconnect between an individual's needs and the services received.

Social Model of Disability

- It is the way a disability is perceived by society rather than by a person's impairment or difference. It looks at ways of removing barriers that restrict life choices for disabled individuals.

- **Social Determinants of Health:** The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social Determinants of Health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.

- **Care Delivery Model** including coordinating care along the continuum of health and wellbeing. Utilize principles to maintain or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum. Emphasis on health promotion and disease prevention and shall incorporate Community Based Health and wellness strategies with a strong focus on the Social Determinants of Health into its model of care, creating Health Equity and supporting efforts to build more resilient communities.

Advance Directives

- An advance directive is a written document that specifies what type of medical care a person wants in the future. Additionally, an advance directive can specify who will make medical decisions if a person loses the ability to make his or her own decisions.
- As a provider of services to the Member in the MI Health Link program it is important that you are familiar with the member's advance directives , and power of attorney, or guardianship delegations and have a process in place to train your staff regarding adherence.

Awareness of Personal Prejudices

- What is a personal prejudice?
  - An unjustified or incorrect attitude (usually negative) towards an individual based solely on the individual's membership of a social group.
  - This attitude could be based on socioeconomic status, race, ethnicity or disability.

Access Matters

- The Doorway Experience
  - **A person** who is blind may not be able to locate the door when braille is not present on the sign or elevator buttons.
  - **A person** with limited function in their hands may not be able turn the knob of the door to enter.
  - **A person** who uses a wheelchair or power chair may not be move through a narrow entry way.
  - **A person** with P.T.S.D. who uses a service animal might not make it past the gatekeeper because they to do not “appear to have a disability”.
  - **A person** with a developmental disability may be perceived as intoxicated or dangerous and not be allowed to enter.

- “The Doorway Experience” affects people with different disabilities and can take place at restaurants, local businesses, and even healthcare care settings.

Fraud, Waste & Abuse

- Fraud: Intentional deception or misrepresentation to obtain the money or property of a health care benefit program (by means of false or fraudulent pretenses, representations, or promises).
  - Some examples of provider health care fraud:
    - billing for services not actually performed
    - falsifying a patient's diagnosis to justify tests, surgeries or other procedures that aren't medically necessary
    - upcoding – billing for a more costly service than the one performed

- Waste: The over-utilization of services or other practices that result in unnecessary costs.
  - Some examples of waste are:
    - making excessive office visits or ordering excessive laboratory testing

- Abuse: Obtaining payment for items or services when there is no legal entitlement to that payment, but without knowing and/or intentional misrepresentation of facts to obtain payments.
  - Some examples of Abuse are:
    - billing for services that were not medically necessary
    - charging excessively for services or supplies
    - misusing codes on a claim, such as up-coding or unbundling services

To report fraud, waste and abuse please refer to the Molina Healthcare Dual Options Provider Manual

Legal Obligations to comply with the ADA

- The American Disabilities Act (ADA) prohibits discrimination against persons with disabilities in the area of employment, public accommodations and telecommunications. ADA requires providers to make reasonable access and accommodations for all persons with disabilities.
- ADA standards for review: http://courts.mi.gov/Administration/SCAO/Resources/Documents/Publication s/Manuals/ADA-Handbook.pdf

ADA Standards

- Waiting room (including furniture) can accommodate
- patients with physical and non-physical disabilities.
- The reception and waiting areas have enough room
- for a wheelchair and/or scooter to maneuver and turn around.
- Doors to access building, office and patient rooms
- are at least 32 inches wide.
- Signage and way finding is clear (i.e., color and symbol signage).
- Larger print for written materials
- Audio accommodations
- Devices for the Deaf and hard of hearing, qualified American Sign Language (ASL) interpreters and alternative cognitively accessible communication for persons with cognitive limitations.
- Building has handicap designated parking.
- Parking spaces are accessible with ramps and curb cutouts between the parking lot, office and at drop off locations.
- Building has automatic entry option or alternative access method.
- Building has elevator for public use (if building is multi-leveled).
- Elevator has enough room for the wheelchair and/or scooter to maneuver.
- Restroom is equipped with large stall and safety bars or other reasonable accommodations.

Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs

- What does it mean to have communication access?
  - Having access to large print materials, interpreters, Braille, etc.
- What does it mean to have medical equipment access?
  - Having access to equipment to aid in one's disability.
- What does it mean to have physical access?
  - Having access to structural accommodations such as ramps, elevators and handicap parking.
- What does it mean to have access to programs?
  - Having access to programs that will provide resources for any disability.

Type of barriers encountered by the target population

- What barriers could be encountered by the target population?
  - Handicap accessibility
  - Communication accessibility
  - Program accessibility

Working with Enrollees with mental health diagnoses, including crisis prevention and treatment

- The PIHP's (Pre-paid Inpatient Health Plans) offer services to individuals with mental health disorders.
- What type of services?
  - Walk- in services
  - Crisis center services
  - Developmental disability services
  - Mental illness services
  - Adolescent emotional disturbance services

Use of evidence-based practices and specific levels of quality outcomes

- What is evidence-based practices mean?
- It means to include not only the best research evidence but also clinical expertise and patient values & preferences.
- What is the process of evidence-based practice?
  - Assess the patient
  - Ask the question
  - Acquire the evidence
  - Appraise the evidence
  - Apply, talk with the patient
  - Self-evaluation
- What are quality outcomes?
  - Healthcare that is truly considerate of patients' cultural traditions, personal preferences and ideals, family conditions and lifestyles.

Continuity of Care (CoC)

- Members have the right to have continuity of care with same service provider when enrolling in MI Health Link program.
- Agency will receive authorization for CoC for the member for 90 days from the time of enrollment.
- Authorization may change within the 90 days based on completion of assessments by care coordinator .
- Agency is required to work with member/care provider to credential the provider to provide services .

Details regarding the continuity of care process and requirements can be found in the Provider Manual

Staff training, including contracted providers, subject to audit

- Caregivers are required to complete the LMS trainings:
  - Main -MI Health link LSM Trainings
- Provider staff must undergo statewide background checks for criminal history, abuse and neglect for paid LTSS providers, prior to or within 90 calendar days of hire.
- Provider must also check staff against the Office of the Inspector General List of Excluded Members/Entities on a monthly basis

Service Authorization

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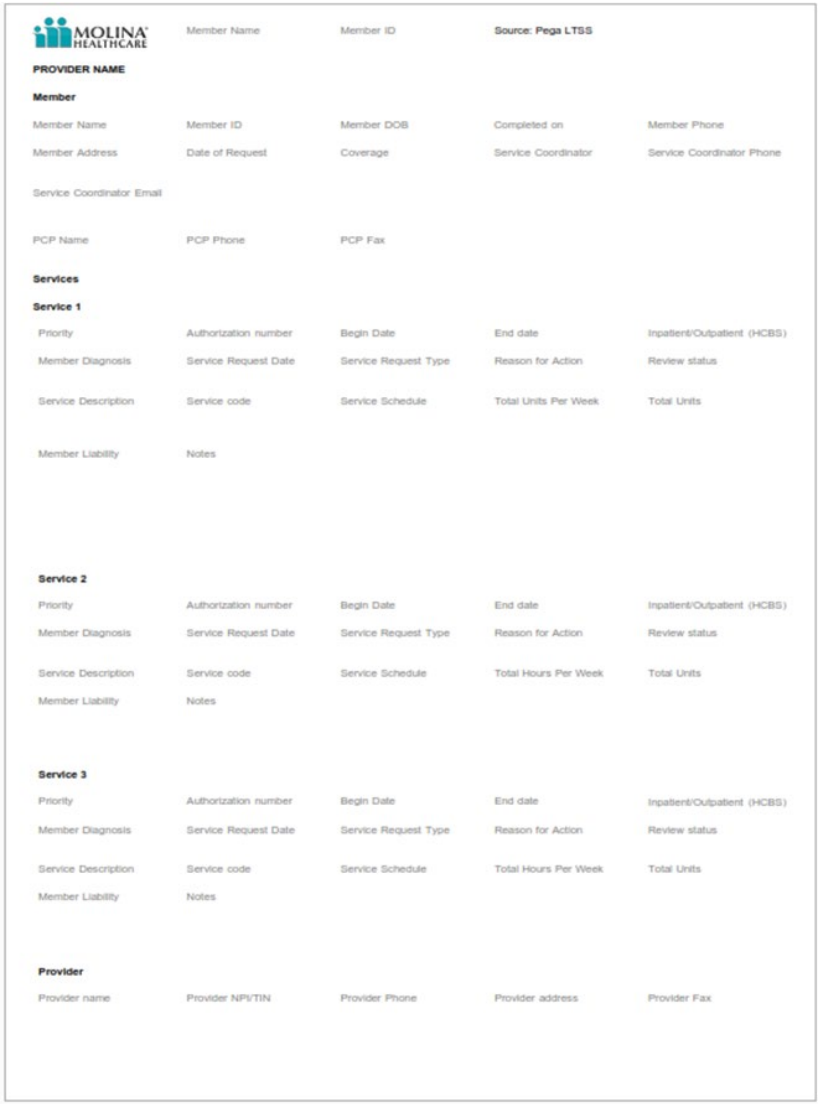
Authorizations

1. Provider will receive a service authorization form via fax with authorization number, approved date range, service code and details, and other pertinent information
2. Molina will reach out to the provider via telephone to coordinate authorized services and confirm member specific information such as service location, preferred dates and times of service with the provider .
3. Provider will be asked to confirm a start date for services and identify any potential barriers to service provision.
4. Provider will contact assigned Long Term Support Services Specialist when they have questions about service authorizations.

Provider must ensure that members are eligible prior to providing services by checking eligibility on the Provider Portal or calling (855) 322-4077.

Authorization Form



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Member Name | Member ID | **Source: Pega LTSS**

PROVIDER NAME

Member

Member Name | Member ID | Member DOB | Completed on | Member Phone

Member Address | Date of Request | Coverage | Service Coordinator | Service Coordinator Phone

Service Coordinator Email

PCP Name | PCP Phone | PCP Fax

Services

Service 1

Priority | Authorization number | Begin Date | End date | Inpatient/Outpatient (HCBS)

Member Diagnosis | Service Request Date | Service Request Type | Reason for Action | Review status

Service Description | Service code | Service Schedule | Total Units Per Week | Total Units

Member Liability | Notes

Service 2

Priority | Authorization number | Begin Date | End date | Inpatient/Outpatient (HCBS)

Member Diagnosis | Service Request Date | Service Request Type | Reason for Action | Review status

Service Description | Service code | Service Schedule | Total Hours Per Week | Total Units

Member Liability | Notes

Service 3

Priority | Authorization number | Begin Date | End date | Inpatient/Outpatient (HCBS)

Member Diagnosis | Service Request Date | Service Request Type | Reason for Action | Review status

Service Description | Service code | Service Schedule | Total Hours Per Week | Total Units

Member Liability | Notes

Provider

Provider name | Provider NPI/TIN | Provider Phone | Provider address | Provider Fax

Billing & Claims

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Claims Submission

- Claims are required to be submitted electronically through a clearinghouse or Molina's Provider Portal or Availity Essentials Portal.
  - Claims submission through a clearinghouse will need to be submitted in the 837P format with electronic Payor ID 38334.
  - Claims submission through Molina's Provider Portal requires registration.
    - Web Portal Overview training guide includes registration and claims submission instructions including how to submit an appeal electronically.
  - All claims are required to be received within 365 days of the service being rendered to be considered for reimbursement.

Claims Disputes

- Providers disputing a claim previously processed must request within 120 days of Molina's original remittance advice date.
  - All claim disputes must be submitted on the Molina Claims Dispute Request Form (CDRF) found under frequently used forms as well as the Provider Portal.
- Refer to the Molina Healthcare Provider Manual for more detailed information and instructions on the claim's submission and disputes processes.
- Providers can combine multiple disputes on a single dispute form

Appeals & Grievances

MOLINA HEALTHCARE

What is an Appeal

- **Appeal:** The request for review of the Plan's decision that results in any of the following actions:
  - The denial or limited authorization of a requested service, including the type or level of service;
  - The reduction, suspension or termination of a previously authorized service;
  - The denial, in whole or in part, of payment for a properly authorized and covered service;
  - The failure to provide services in a timely manner, as defined by the State;
  - The failure of Molina Healthcare to act within the established timeframes for grievance and appeal disposition
- Post-Service Appeal- an appeal of any adverse determination after rendering a service or procedure. Post-Service Appeals must be submitted within 90 calendar days from the denial date of the claim.

What is a Grievance?

- **Grievance (Complaint):** A verbal or written expression of dissatisfaction about any matter other than an action subject to appeal. Possible subjects for grievances include, but are not limited to:
  - The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review
  - Benefits or claims payment, handling or reimbursement for health care services
  - Matters pertaining to the contractual relationship between an or enrollee and Molina Healthcare

How to File a Grievance

- A member may file a grievance at any time. If a grievance is filed with a provider, the provider is required to forward the grievance to Molina Healthcare of Michigan. 42 CRF 438.402 (c)(3)(i)
- Grievance can be filed orally or in writing:
  - Via Fax: (248) 925-1799
  - Via Call Center: (855) 735-5604
  - Via Mail or in person: Molina Healthcare of Michigan
    Attn: Appeals and Grievances
    880 W. Long Lake
    Troy, MI 48098

Compliance

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HIPAA- The Health Insurance Portability and Accountability Act

- A broad federal law passed in 1996 due to the rapid growth of health information systems and the need to safe guard individuals' health information. That also addresses many health care privacy, security and electronic billing issues. It improves portability and continuity of health insurance coverage in the group and individual markets, and simplifies the administration of health insurance.
- In some cases states may have different rules and restrictions. If the state laws are more stringent then those found in HIPPA we must follow the state's regulation.

Workplace Security Guidelines

- Documents that contain PHI
  - should never be left around your work space at any given time.
- Paper documents containing PHI
  - should be shredded when no longer needed.
- PHI and sensitive documents
  - stored within locked drawers, cabinets, containers, or rooms.

Workplace Security Guidelines Continued..

- **Never**
  - Allow anyone to use your computer
  - Share your username/ password with anyone
  - Write down your password and leave it unsecured or in a public space
  - email or forward PHI to anyone unless it is needed to preform a specific task
  - email proprietary/ confidential information to personal email accounts
- **Always**
  - lock your computer before you step away from your work space.
  - Ensure your laptop is in the docking station when you leave for the day
  - Use a “strong password” that contains and alphanumeric and special charters
  - use secure email, if communicating with Molina about any participant
  - Double – check your recipients before you send out or reply to any email regarding PHI

Incident Reporting

- Report to Molina
  - Contact Member Services
  - LTSS Specialist
  - Contracting Manager
- Report to APS/CPS
  - call 911 if there is immediate danger to you or anyone else.
  - Reports can be anonymous
  - Police should be called if there is illegal activity
- APS & CPS contact information: Centralized Intake for Abuse and Neglect (CPS/APS)
  - Phone: (855) 444-3911
  - Email: DHS-CPS-CIGroup@michigan.gov
  - Fax: (616) 977-1154 or (616) 977-1158
  - Address: 5321 28th St. Ct. SE, Grand Rapids, MI 49546

Key Links and Documents

Contact Reason	Link
MI Health Link Toolkit	https://www.michigan.gov/mdhhs/doing-business/providers/integrated/resources-toolkit
Minimum Operating Standards	https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder2/Folder3/Folder1/Folder103/Minimum_Operating_Standards_for_MI_Health_Link.pdf?rev=3f859e91696d412c8660cd4d4128abed
MI Health Link Training	Sign In- MI Healthlink Course Mill
Molina MMP Provider Manual	https://www.molinahealthcare.com/providers/mi/duals/manual/provd.aspx
Availity	https://www.availity.com/essentials-portal-registration
MOLINA LTSS WEBSITE	Long Term Support Services
ECHO	https://www.providerpayments.com/Register.aspx

Key Contacts

Contact Reason	Primary Contact
Provider Services Vanessa Mesler	1-947-622-3138 mhmltsscontracting@molinahealthcare.com
Contracting/ Credentialing Sheri Dankert	248-925-1711 mhmltsscontracting@molinahealthcare.com
Authorizations / Service Coordination	Care Coordination Line 248-925-1792
Compliance	Compliance Hotline 888-898-7969
Appeals & Grievances	Member & Provider Contact Center - 855-735-5604
Billing & Claims	Member & Provider Contact Center - 855-735-5604 Preferred Method: Provider Portal mhmltsscontracting@molinahealthcare.com

LTSS Training Attestation

- In order to document completion of this training, please complete and sign the attestation form.
- (Link)
- Once complete please email to MHMLTSSContracting@MolinaHealthCare.Com