Managed Long-Term Services and Supports (MLTSS) Orientation

2022 | Molina Healthcare

MOLINA HEALTHCARE

MHO-1796
0222

Agenda


Provider Resources
Provider Portal
LTSS Waiver
Electronic Visit Verification
Billing and Claims
Grievances
Credentialing and Contracting
Contact Molina

Provider Resources

MOLINA HEALTHCARE

Provider Services

Satisfaction

- Provider Services Representatives and Engagement Teams
- Annual Assessment of Provider Satisfaction
- The It Matters to Molina Program that Includes Monthly Forums, surveys, and an Information Page on the Provider Website

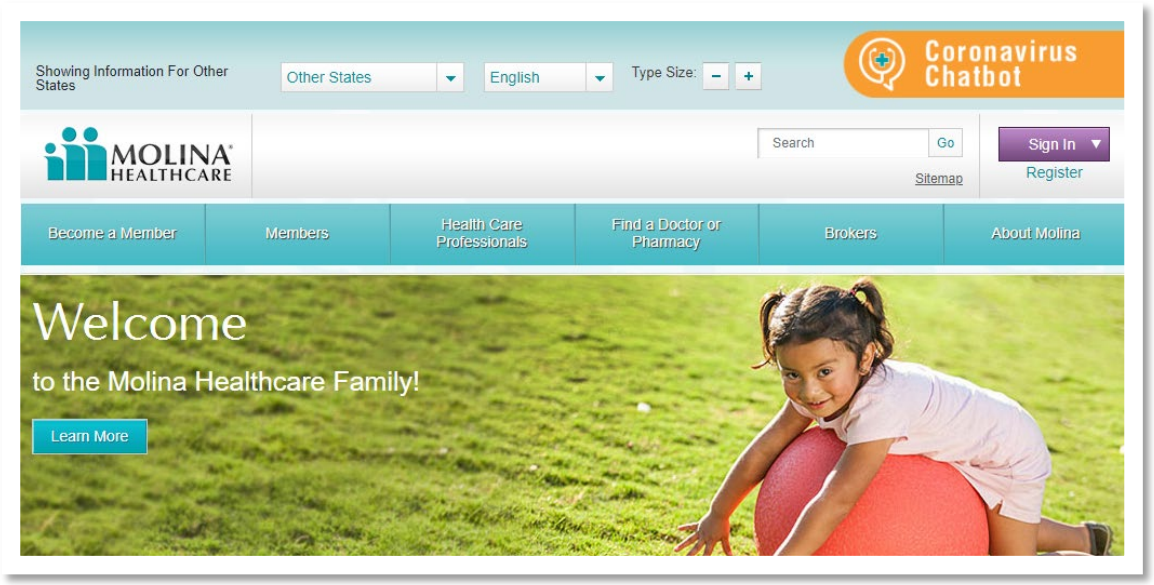
Communication

- Provider Bulletin and Provider Newsletters
- Online Provider Manuals
- Online Trainings, Health Resources, and Provider Resource Guides
- Interactive Voice Response (IVR) Phone System

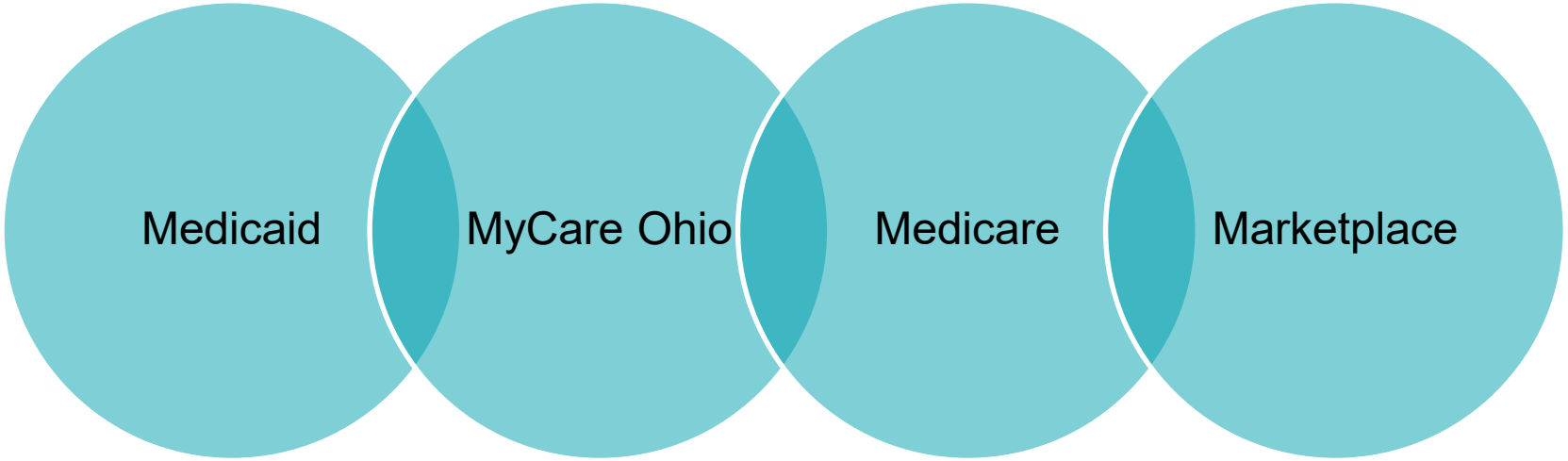
Technology

- 24-hour Provider Portal
- Electronic Funds Transfer and Electronic Remittance Advice
- Online Prior Authorization and Claim Dispute Submission
- Supplemental Prior Authorization Lookup Tool on Provider Portal and Provider Website

Provider Website



Molina has a Provider Website for each line of business.



Find the Provider Website at MolinaHealthcare.com.

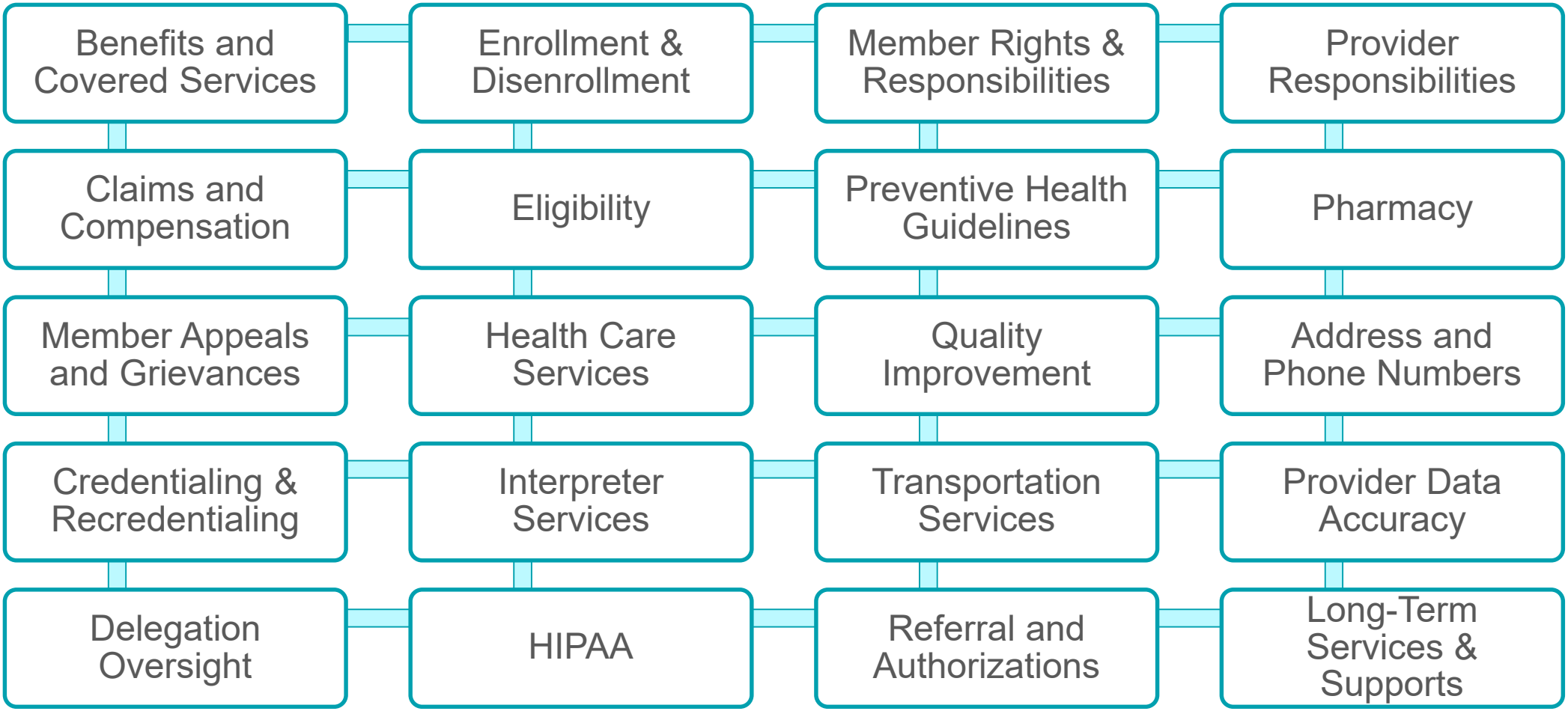
Provider Online Resources

Molina's Provider Website has a variety of online resources:

- Provider Manual
- Dental Manual
- Provider Portal
- It Matters to Molina Page and a Claims Payment Systemic Errors (CPSE) Page
- Provider Online Directory
- Contact Information
- Preventive and Clinical Care Guidelines
- Claims Information
- Health Insurance Portability and Accountability Act (HIPAA)
- Advanced Directives
- Frequently Used Forms
- Pharmacy Information
- Prior Authorization Information
- Claim Reconsiderations
- Provider Communications: Provider Bulletins and Provider Newsletters
- Fraud, Waste and Abuse Information
- Member Rights and Responsibilities
- Molina Policies

Provider Manual Highlights

The Provider Manual is customarily updated annually, but may be updated more frequently. Information in the Provider Manual includes:



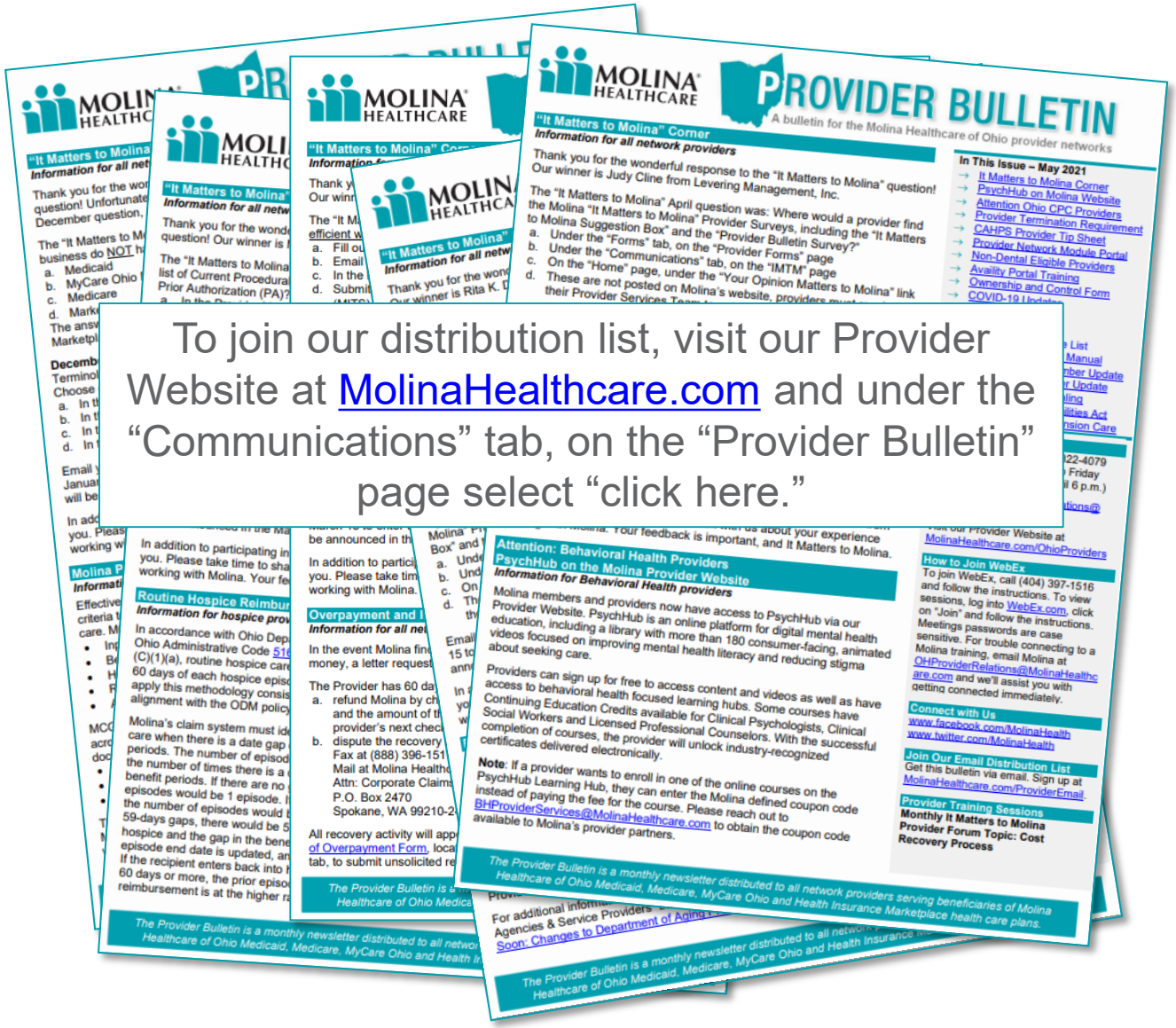
Provider Manuals are specific to each line of business.

Provider Bulletin

A monthly Provider Bulletin is sent to Molina's provider network to report updates.

The Provider Bulletin includes:

- Prior authorization changes
- Training opportunities
- Updates to the Provider Portal
- It Matters to Molina Corner
- Changes in policies that could affect:
  - Claim submissions
  - Billing procedures
  - Payment
  - Appeals



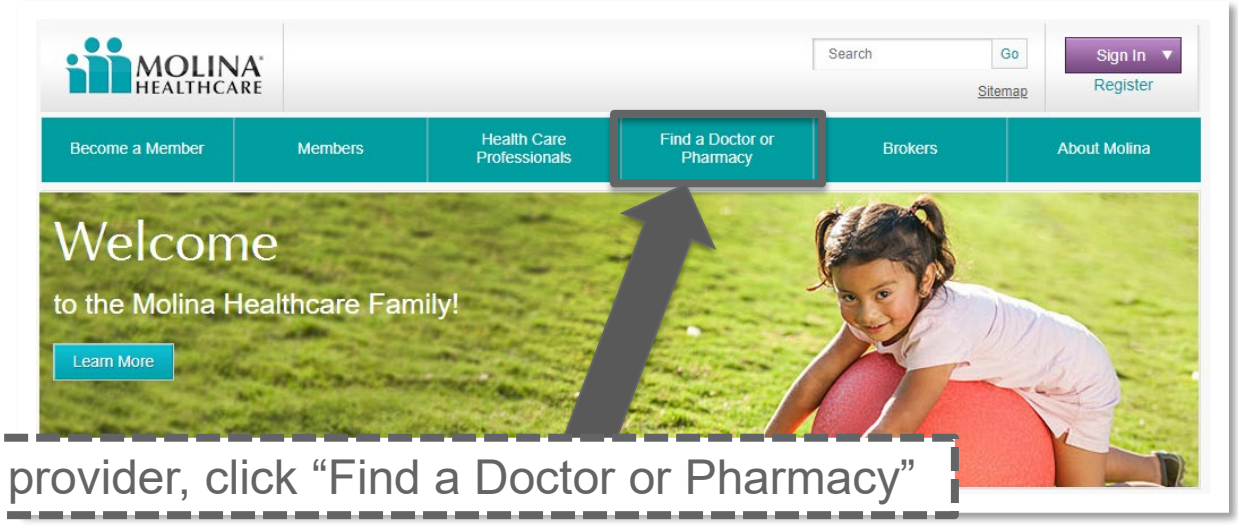
To join our distribution list, visit our Provider Website at MolinaHealthcare.com and under the "Communications" tab, on the "Provider Bulletin" page select "click here."

Provider Online Directory

The Provider Online Directory now offers enhanced search functionality so information is available quickly and easily. Molina providers are encouraged to use the Provider Online Directory linked on our Provider Website to find a network provider or specialist.

Key Benefits Include:				
User-friendly and intuitive navigation	Provider profile cards for quick access to information	Browsing by category, search bar, and common searches	Expanded search options and filtering for narrowing results	Provider information that can be saved to use later

Members should be referred to participating providers.



To find a Molina provider, click “Find a Doctor or Pharmacy”

Provider Data Accuracy

Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement, as well as a National Committee for Quality Assurance (NCQA)-required element.

Important Reminder: Providers must validate the Provider Online Directory information at least quarterly for correctness and completeness.

Please notify Molina at least 30 days in advance for any of the following:

- Change in office location, office hours, phone, fax, or email
- Addition or closure of an office location
- Addition or termination of a provider
- Change in Tax ID and/or National Provider Identifier (NPI)
- Open or close your practice to new patients (PCP only)

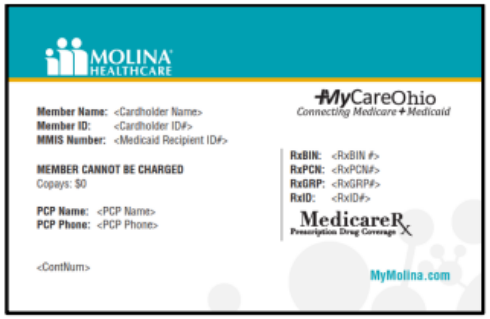
Please use the Provider Information Update Form to make these changes.

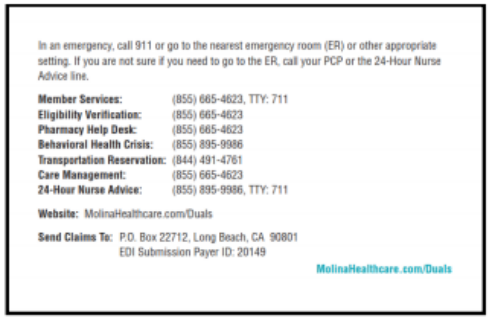
Reminder: The Ohio Department of Medicaid (ODM) is migrating to the new Provider Network Management (PNM) system in 2022 for provider information and updates.

Molina ID Cards

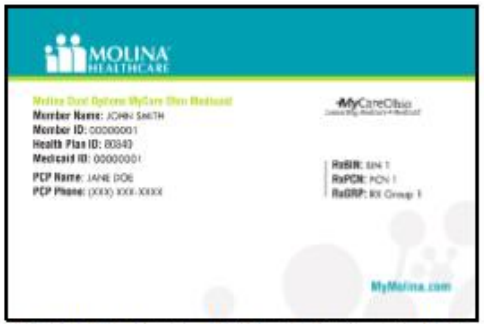
Providers are encouraged to review the most up-to-date version of the Molina Member Cards available in our Provider Manuals at MolinaHealthcare.com on the “Manual” page.

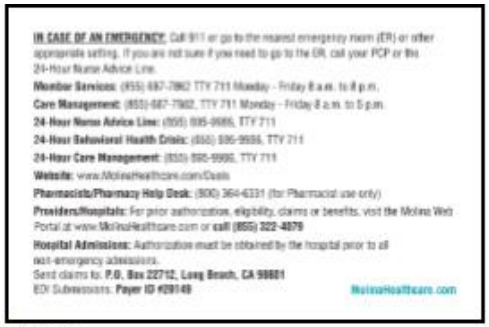
Sample Cards:



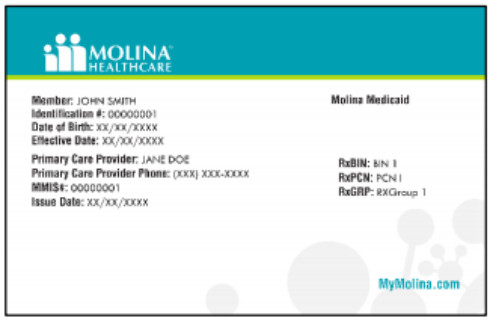


MyCare Ohio (Full Benefits)





MyCare Ohio (Opt-Out/Medicaid Only)



Medicaid

Molina ID Cards

Providers are encouraged to review the most up-to-date version of the Molina Member Cards available in our Provider Manuals at MolinaHealthcare.com on the “Manual” page.

Sample Cards:

Medicare

Marketplace

Prior Authorization (PA)

Prior Authorization (PA) is a request for prospective review. Requests for services on the Molina PA Code List are evaluated by licensed nurses and trained staff.

PA is designed to:				
Assist in benefit determination	Prevent unanticipated denials of coverage	Create a collaborative approach to determining the appropriate level of care	Identify care management and disease management opportunities	Improve coordination of care

The PA Code List is a list of the services that require a provider to submit a PA request and if there are limitations to the code.

View the PA Code List on our Provider Website, under the “Forms” tab

Utilize the PA Lookup Tool on our Provider Website and Provider Portal to determine if a PA is required

Provider Responsibilities

Molina expects our contracted providers will respect the privacy of Molina members (including Molina members who are not patients of the provider) and comply with all applicable laws and regulations regarding the privacy of patient and member Protected Health Information (PHI).

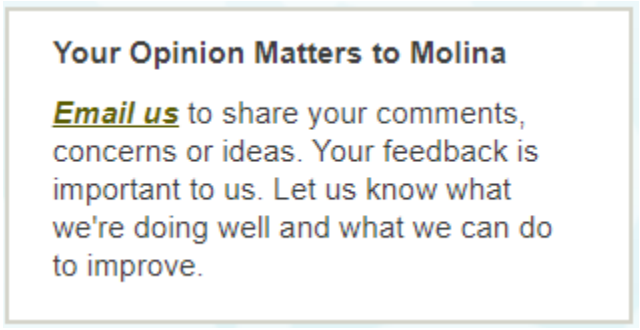
For additional information view the “Provider Responsibilities” section of the Provider Manual, located at MolinaHealthcare.com under the “Manual” tab. Topics include:

- Non-Discrimination of Health Care Service Delivery
- Provider Data Accuracy and Validation
- National Plan and Provider Enumeration System (NPPES) Data Verification
- Electronic Solutions/Tools Available to Providers
- Primary Care Provider (PCP) Responsibilities

It Matters to Molina

Molina wants your feedback! Please take time to share feedback with us about your experience working with Molina. Please let us know what we are doing well, and what we can do to improve your experience. Please share training ideas that would benefit your practice, references/resources we can develop.

Your feedback is important, and It Matters to Molina.



Ways to provide feedback includes:

- Click on the “Email us” link under “Your Opinion Matters to Molina” at the top of our Provider Website
- Email your Provider Services Team
- Take one of our post-training or general feedback surveys located on the It Matters to Molina page
- Join our Provider Advisory Committees

Monthly It Matters to Molina Provider Forum:

Molina offers monthly It Matters to Molina Provider Forums with either a set presentation topic, or as an open question and answer session between our provider partners and Molina subject matter experts. Find a list of upcoming trainings on the It Matters to Molina page.

Molina Provider Portal and Availity

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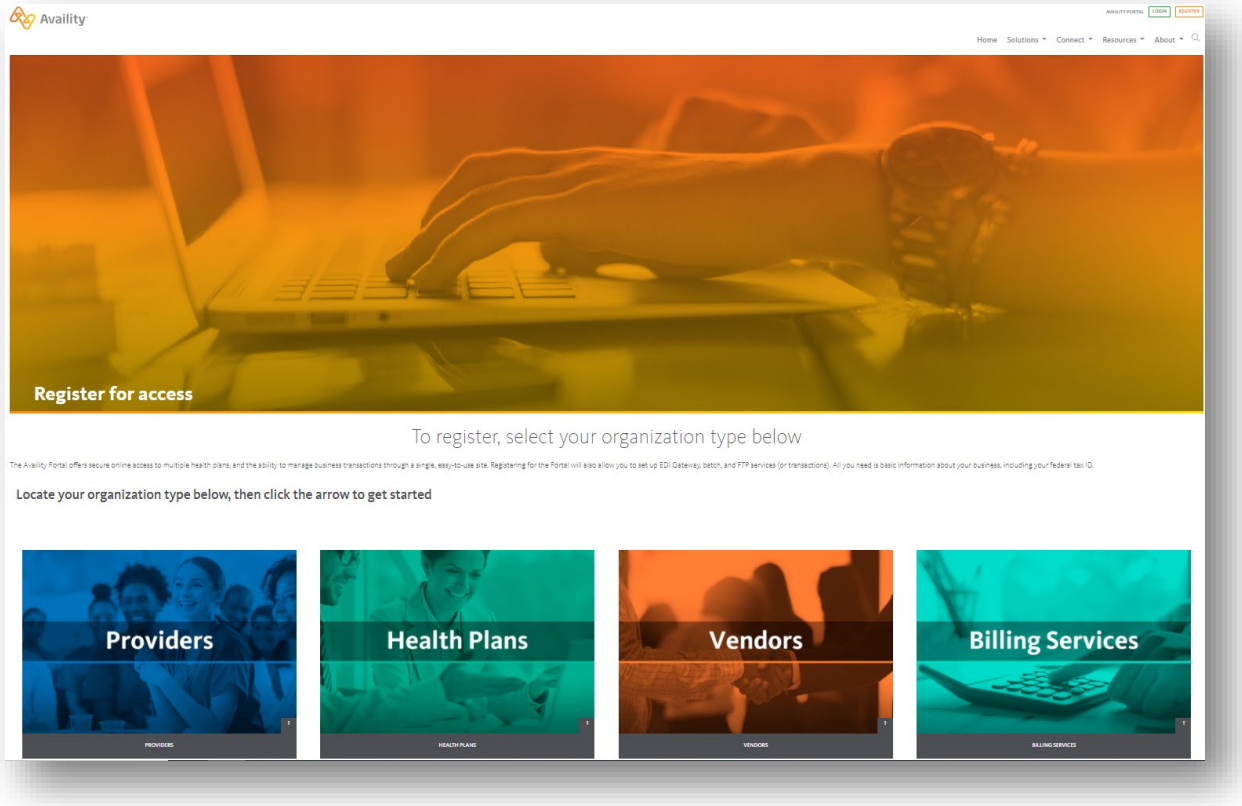
Provider Portal: Transition from Molina Provider Portal to Availity

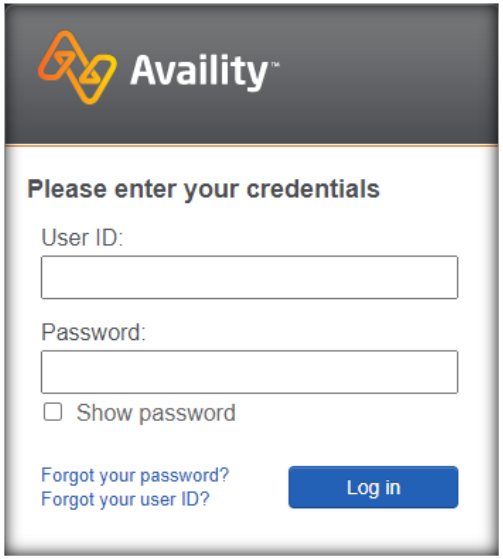
Molina has chosen Availity as its exclusive Provider Portal provider.

- The Molina Provider Portal, including all features, functionality, and resources will continue transitioning to Availity in 2022.
- This is a phased transition, with access to both the Molina Provider Portal and the Availity Portal being available as features and functionality are deployed on the Availity Portal.
- Features currently available on the Availity Portal include submitting new claims, correcting claims, accessing claims reports and claim status, adding attachments, eligibility verification, and Electronic Remittance Advice (ERA).
- Molina providers have access to Molina on Availity at this time.

Availity Provider Portal

Register for Availity at availity.com/provider-portal-registration and select your organization type.

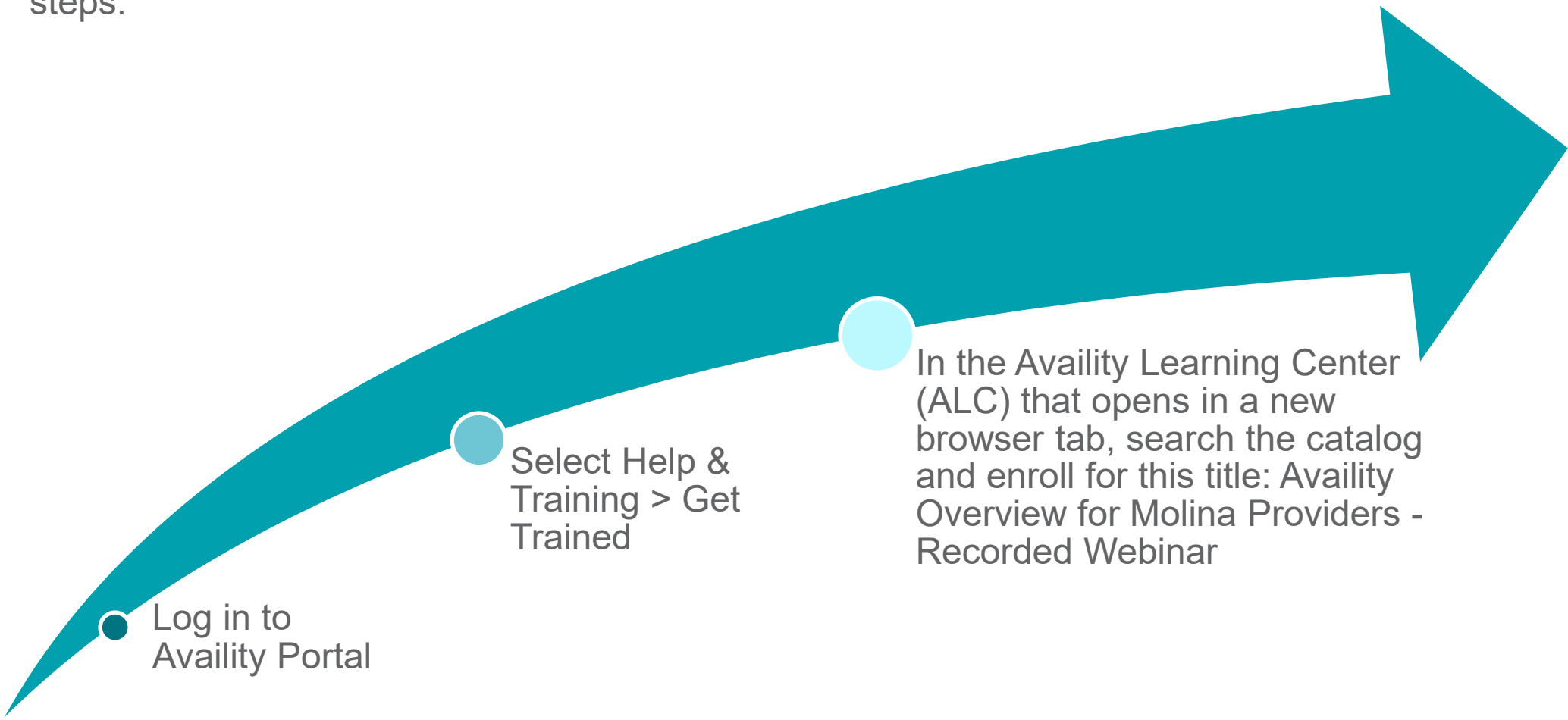




Log into Availity at: apps.availity.com/availity/web/public.elegant.login.

Availity Provider Portal

Once registered providers will have access to the Availity Portal training by following these steps:



Atypical Providers:
Under “News and Announcements” select “Atypical Providers: Here’s your Ticket to Working with the Availity Portal” to view training sessions.

Molina Provider Portal

The Molina Provider Portal is secure and available 24 hours a day, seven days a week. Self-service Provider Portal options include:

- Online Claim Submission
- Claims Status Inquiry
- Corrected Claims
- Healthcare Effectiveness Data and Information Set (HEDIS®) Missed Service Alerts for Members
- Member Eligibility Verification and History
- Update Provider Profile
- Online Claim Reconsideration Requests
- Member Nurse Advice Line Call Reports
- Check Status of Authorization Request
- Coordination of Benefits (COB)
- View PCP Member Roster
- Submit PA Requests

Reminder: The Molina Provider Portal including all features, Functionality, and resources will transition to Availity throughout 2022.

MLTSS Waiver

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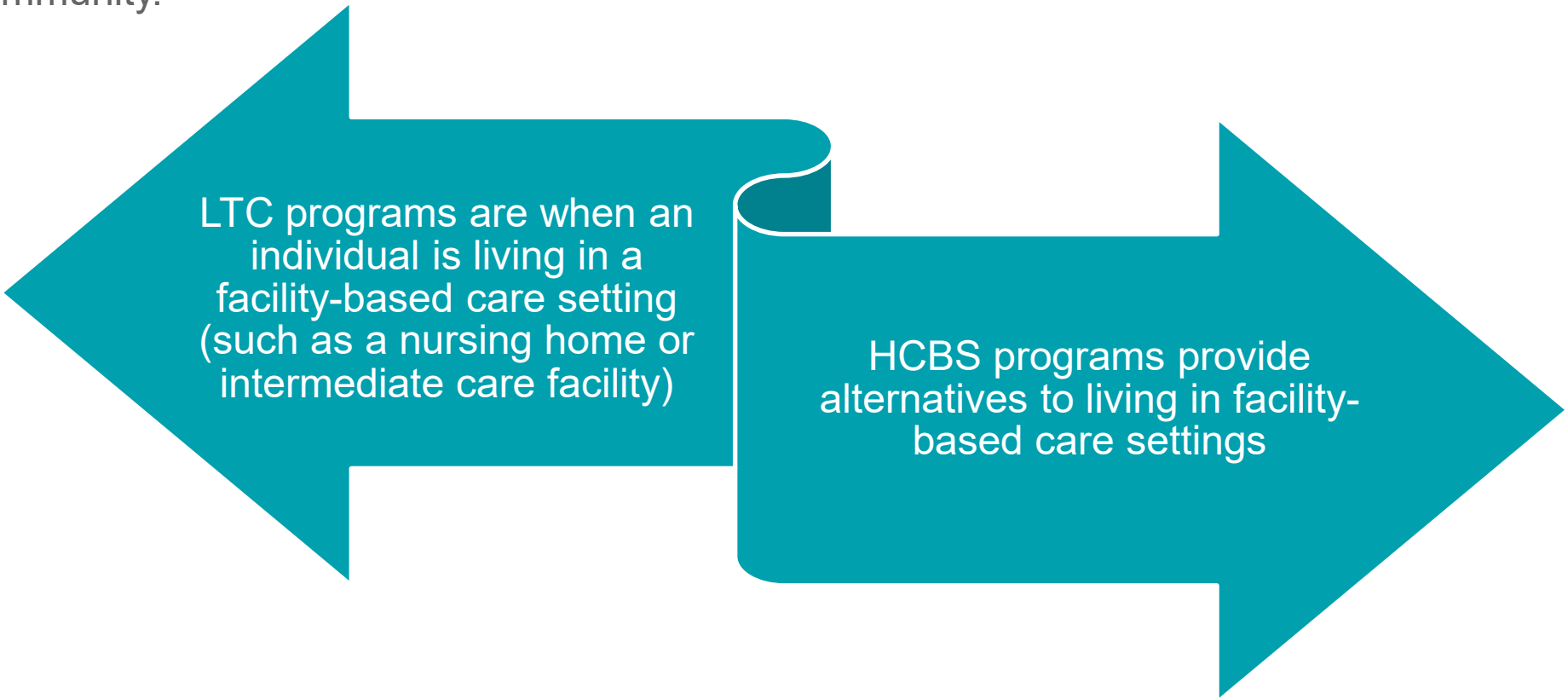
Managed Long-Term Services and Supports

Molina Managed Long-Term Services and Supports (MLTSS) includes both Long-Term Care (LTC) and Home and Community-Based Services (HCBS). These programs empower consumers to take an active role in their health care and to remain in the community.



Both programs serve older adults, people with intellectual and/or developmental disabilities, or people with physical disabilities.

MLTSS Waivers

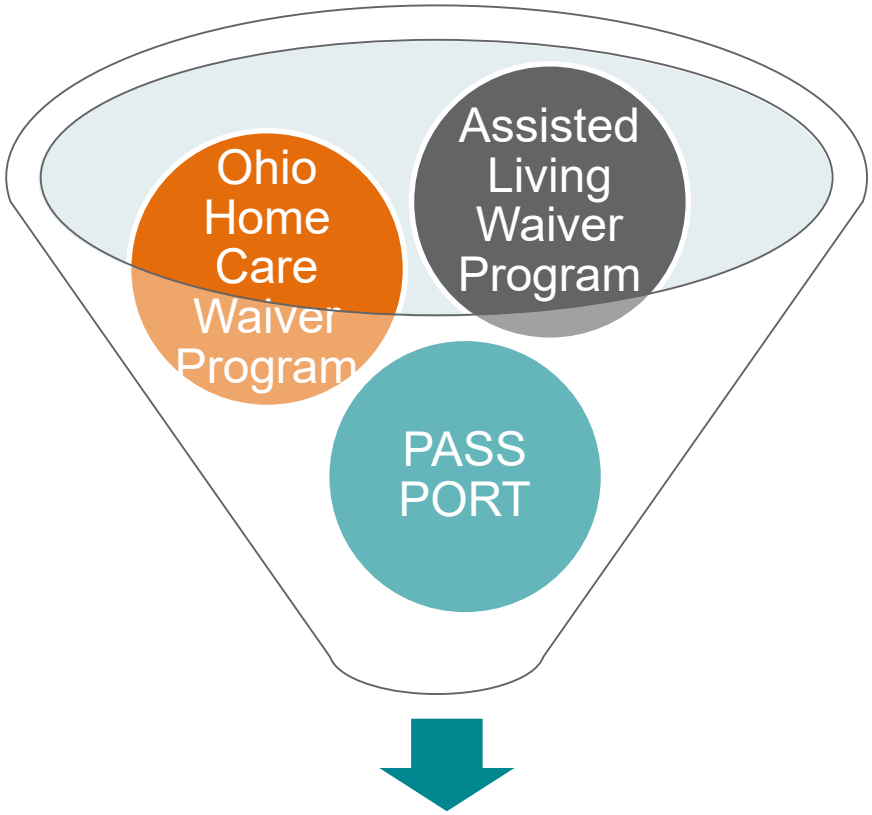
Medicaid waivers are programs offered through ODM. Waiver programs provide services to people who would otherwise be in a nursing facility (NF) or hospital to receive long-term care. Each waiver provides different types of services.

- MyCare Waiver:
  Services provided are listed in Ohio Administrative Code (OAC) 5160-58-04
- Ohio Home Care Waiver:
  Services provided are listed in OAC 5160-46-04
- Assisted Living Waiver:
  Services provided are listed in OAC 5160-33-02
- Pre-Admission Screening System Providing Options and Resources Today (PASSPORT) Waiver:
  Services provided are listed in OAC 5160-31-05

There are many factors that determine a person's eligibility for a waiver, such as the type and extent of their disability, the prognosis, and their financial assets.

Waiver of Origin

After the initial Transition of Care (TOC) has concluded, all benefits associated with the waivers below will be included in one benefit, the MyCare Waiver program.



MyCare Waiver (MyCare Ohio Waiver)

The MyCare Waiver, also known as the MyCare Ohio Waiver, or the Integrated Care Delivery System (ICDS) Waiver program encompasses the services offered under the Ohio Home Care, PASSPORT, and Assisted Living Waivers, and is designed to help meet the needs of people who are:

- Financially eligible for Medicaid
- Enrolled in the MyCare Ohio program
- Have been assessed to require an Intermediate or Skilled Level of Care (LOC)
- Are age 18 or older

Note: A person may not be eligible for the Ohio Department of Aging (ODA) and ODM administered HCBS Waivers if they are receiving, or qualify for, Developmental Disabilities (DD) waiver services.

MyCare Waiver Benefits and Covered Services

MyCare Waiver covered services include:

- Adult Day Health Services
- Alternative Meal Services
- Assisted Living Services
- Home Medical Equipment and Supplemental Adaptive and Assistive Devices Services
- Out-of-Home Respite Services
- Community Integration Services
- Enhanced Community Living Services
- Homemaker Services
- Choices Home Care Attendant Services
- Nutrition Consultation Services
- Home Modification Services
- Home Care Attendant
- Personal Care Aide Services
- Community Transition Services
- Waiver Nursing Services
- Home Maintenance and Chore Services
- Personal Emergency Response Services
- Social Work Counseling Services
- Home-Delivered Meal Services
- Waiver Transportation Services

Area Agency on Aging (AAA)

The Area Agency on Aging (AAA) determines a member's eligibility for the MyCare Waiver. Ohio AAAs are designated by the ODA.

The AAA office that is designated for each of the counties represented in the Molina Dual Options MyCare Ohio, a Medicare-Medicaid Plan program are:		
Central Ohio Area Agency on Aging, AAA6 Serving: Delaware, Franklin, Madison, Pickaway and Union counties	Council on Aging of Southwestern Ohio, AAA1 Serving: Butler, Clermont, Clinton, Hamilton and Warren counties	Area Agency on Aging for West Central Ohio, AAA2 Serving: Clark, Greene and Montgomery counties

When a client contacts the AAA or a referral is completed by a Molina Care Manager for the MyCare Waiver, an intake coordinator will assess the need, schedule a LOC assessment to be completed with the member, and provide the requested resources the member is eligible to receive.

Area Agency on Aging (AAA)

Molina contracts with the AAA to provide waiver service coordination for members age of 60 and older.

Members aged 60 and over may select their Waiver Service Coordinator entity as either the AAA or Molina.

If the member is aged 59 and younger, Molina will automatically be the Waiver Service Coordinator.

The Care Manager and Waiver Service Coordinator may be the same individual.

Molina will ensure the provision of the following service coordination services for the members:

• Crisis Intervention	• Care and Service Plan Review
• Event-Based Visits	• Institution-Based Visits
• Service Management	• Assessment of MLTSS Need
• Member Education	• MLTSS Waiver Service Coordination/Care Management

After the member's needs have been determined, Molina will work closely with the various Community-Based Organizations (CBOs) for HCBS to ensure that the member is getting the care they need.

Care Management

All members enrolled in the MyCare Waiver will receive Care Management Services and be assigned a Molina Care Manager.

The Care Management team for MLTSS will include, at a minimum, the member and/or their authorized representative, Care Manager, Waiver Service Coordinator, and Primary Care Provider (PCP).

The person-centered Interdisciplinary Care Team (ICT) will include, at minimum, the member and/or their authorized representative, the PCP, the Care Manager, the Waiver Service Coordinator, and anyone the member requests to participate.

ICT members may also include MLTSS providers, specialist(s), behavioral health clinician, pharmacist, family/caregivers, peer supports, or other informal supports.

Individualized Care Plan Coordination

The Individualized Care Plan (ICP) includes the consideration of medical, behavioral, and long-term care needs of the member identified through a person-centered assessment process.

- A Person-Centered Service (PCS) Plan refers to the plan that documents the amount, duration, and scope of the home and community-based services.
- The ICP will be developed under the member's direction and implemented by the assigned members of the ICT.
- The ICT under member's direction is responsible for developing the ICP and is driven by and customizable according to the needs and preferences of the member.
- Molina will ensure the PCS Plan complies with the Department of Health and Human Services (DHHS) HCBS final rule section 441.301.

Additional services can be requested at any time; including during the assessment process and through the ICT process.

Continuity of Care

Molina has processes and systems in place to ensure smooth transitions between each member's setting of care and LOC.

This includes transitions to and from inpatient settings (i.e. nursing facility to home).

The care coordinators facilitate on-site, in-person, and home-based assessments that are housed in an electronic health management platform.

For a table on the Continuity of Care (COC) policy and requirements, view the Managed Long-Term Services and Supports (MLTSS) section in the Combined Provider Manual at MolinaHealthcare.com/OhioProviders, under the "Manual" tab.

Transition Period

A member's existing provider may be changed during the transition period only in the these circumstances:

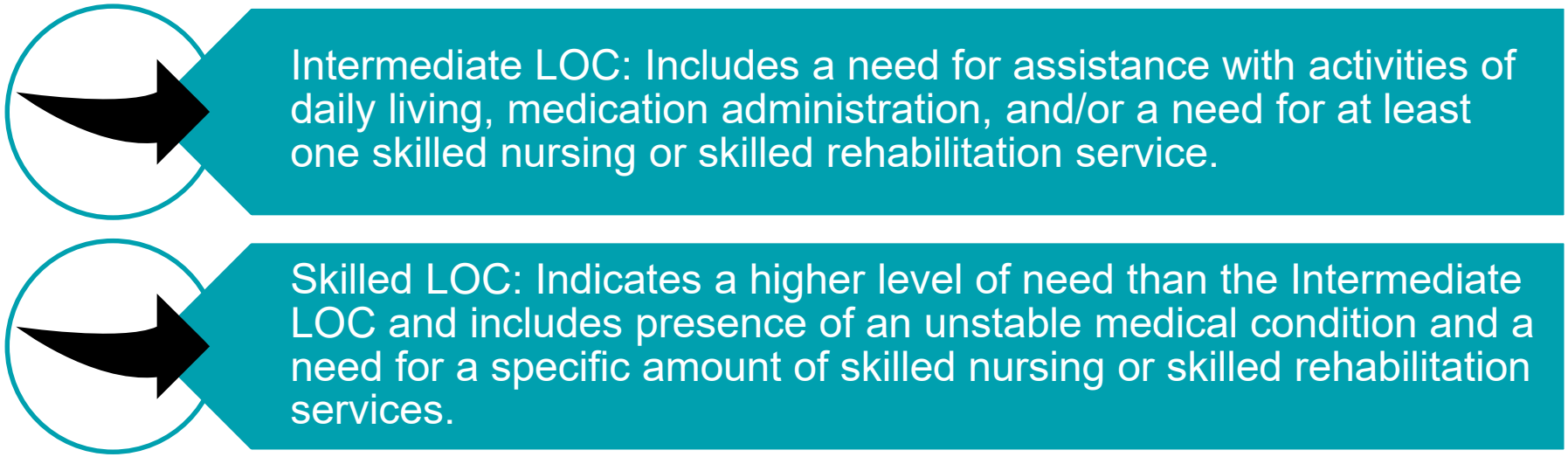
- Member requests a change
- Provider is excluded under state or federal exclusion requirements
- Molina or ODM identify provider performance issues that affect a member's health or welfare
- Provider chooses to discontinue providing services to a member as currently allowed by Medicaid

Transition Period, Continued

- Plan-initiated change in a service provider can only occur after the completion of an in-home assessment and development of a plan for the transition to a new provider
- Members in a nursing facility at the time of Molina MLTSS enrollment may remain in that NF as long as the member continues to meet nursing facility LOC
- Existing providers can continue to serve current members who transition to MyCare Ohio
- Out-of-network providers who are providing services to members during the initial TOC period shall be contacted to offer information on how to become credentialed, in-network providers with Molina

Nursing Facility-Based Level of Care

MLTSS Services require a Nursing Facility (NF)-Based LOC. This LOC includes the Intermediate and Skilled LOC:



A member must meet NF-Based LOC to receive long-term care services in a nursing facility or to enroll on the MyCare Waiver.

The Nursing Facility and Assisted Living Reference Guide for Ohio is available on the MyCare Ohio Molina Provider Website, under the “Manual” tab.

Self-Directed Care Services

Self-Directed Services is when participating members or their representatives have decision-making authority over certain services and manage their services with support.

Under self-directed care, a member is the "boss" and can hire and/or fire a provider for violations of their contract

All member-directed personal care providers are required to meet established training requirements

A Waiver Care Manager will provide oversight to assist the member with self-directed personal care

Federal law prohibits spouses, parents, or legal guardians from being paid caregivers

Public Partnerships, LLC (PPL) will work with the member to handle the taxes, payroll, and worker's compensation responsibilities of being an employer

Note: The member also may choose an authorized representative to help with the day-to-day supervision of their service provider and to assist with employer-related tasks.

Self-Directed Care Services, Continued

Members must demonstrate the ability to direct providers in accordance with paragraph (D) of OAC 5160-58-03.2:

Employer Authority: ability of the member to hire, fire, and train employees for the following services:

- Choices Home Care Attendant Services provided by a participant-directed individual provider
- Personal Care Services provided by a participant-directed personal care provider

Budget Authority: ability of the member to negotiate rates of reimbursement in the following services:

- Alternative Meals
- Choices Home Care Attendant Services
- Home Maintenance and Chore Services
- Home Modification Services
- Home Medical Equipment and Supplemental Adaptive and Assistive Devices

Self-Directed Care Services, Continued

When a member is already participating in self-directed care through a Medicaid waiver prior to enrolling in the MyCare Waiver, the current provider will remain for up to one year with the same services, frequency, and rates; unless any of the following happens:

- There is no longer an assessed need for one of the services
- The authorized representative is no longer able to fulfill the responsibilities of member
- There is no longer an authorized representative, if required
- The health and well-being of the member is affected, as determined by the Waiver Service Coordinator

Waiver Provider Signature Requirement

Waiver service providers for the Assisted Living, MyCare Ohio, Ohio Home Care, and PASSPORT waivers are required to sign the member's person-centered service plan to show the provider acknowledges and agrees to provide the waiver service.

Providers who are affected by this requirement include those who are delivering direct care services including:			
Personal Care	Adult Day Services	Home Care Attendant	Enhanced Community Living
Waiver Nursing	Out-of-Home Respite	Social Work Counseling	Independent Living Assistance

Transition of Care

- The Utilization Management and Care Management teams facilitate the TOC for members whose benefits have come to end.
- Alternatives to coverage are explored with the member, the PCP, community resources, and any new coverage to ensure continuity of care.
- For additional information on TOC for Durable Medical Equipment (DME) view Appendix B in the Molina Provider Manual, under the “Manual” tab at MolinaHealthcare.com/OhioProviders.

Transition of Care, Continued

As noted in the Molina Provider Manual:

Transition of Care – Molina Dual Options, MyCare Ohio Medicare-Medicaid Plan (MMP):

- **HCBS Waiver Beneficiaries:** Must honor Prior Authorization (PA) when item has not been delivered and must review ongoing PAs for medical necessity.
- **Non-Waiver Beneficiaries with LTC Needs (Home Health [HH] and Private Duty Nurse [PDN] Use):** Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity.
- **Nursing Facility Beneficiaries/Assisted Living (AL) Beneficiaries:** Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity.
- **Beneficiaries not Identified for LTC Services:** Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity.

Transition of Care, Continued

As noted in the Molina Provider Manual:

Transition of Care – Medicaid

Members Aged 21 and Older: Honor Medicaid Fee-for-Service (FFS) PAs for no less than 90 days from the enrollment effective date. After the 90 days has expired, the Managed Care Plan (MCP) can conduct a medical necessity review pursuant to OAC Rule 5160-26-03.1.

Members Under Age 21: Unless noted in the Provider Manual, the MCP must honor Medicaid FFS PA for no less than 90 days from the enrollment effective date. After the 90 days has expired, the MCP can conduct a medical necessity review pursuant to OAC Rule 5160-26-03.1. The MCP must honor the Medicaid FFS PA for 90 days or the duration of the PA, whichever is longer, for the following items: Enteral Feeding Supply Kit, Hearing Aids, Synthesized Speech Generating Devices, Parenteral Nutritional Supply Kits.

Electronic Visit Verification

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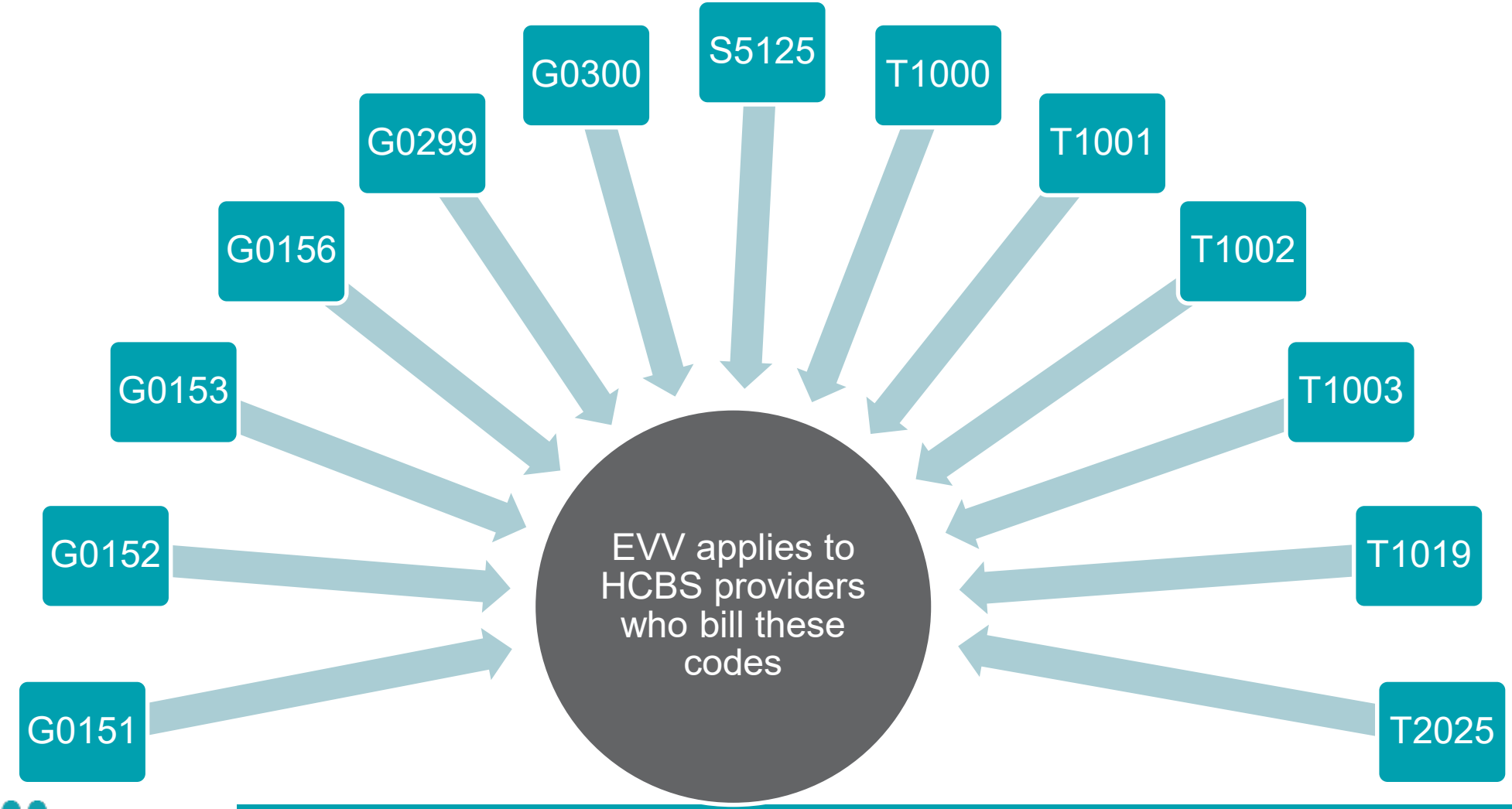
Electronic Visit Verification

ODM implemented Electronic Visit Verification (EVV) for some HCBS providers in response to federal requirements set forth in section 12006 of the H.R. 34 (114th Congress) (2015-2016) of the 21st Century Cures Act.



Electronic Visit Verification, Continued

EVV is an electronic system that verifies key information about the services rendered by the provider including the following:

- Date of the service
- Service start and end time
- Individual receiving the service
- Person providing the service
- Location of the service

EVV applies to the following services:

• State Plan Home Health Aide	• HCBS 1915c Waiver Nursing
• State Plan Home Health Nursing	• HCBS 1915c Waiver Personal Care Aide
• Private Duty Nursing	• HCBS 1915c Waiver Home Care Attendant
• State Plan Registered Nurse Assessment	

ODM has contracted with Sandata Technologies LLC to provide the EVV system at no cost to providers or individuals receiving services. For additional details visit the EVV page on the ODM website.

Note: Upon future notice by ODM, Molina will begin denying claims for providers who do not utilize the EVV system.

Billing and Claims

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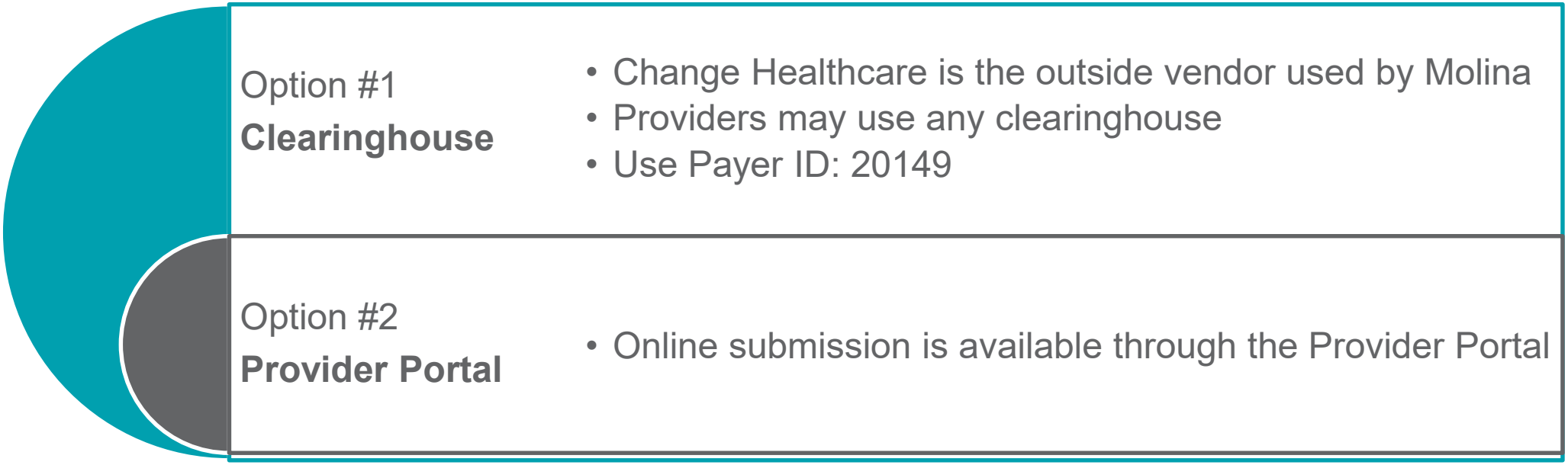
Claims Submission Options

Provider must utilize electronic billing through a Clearinghouse or the Provider Portal:



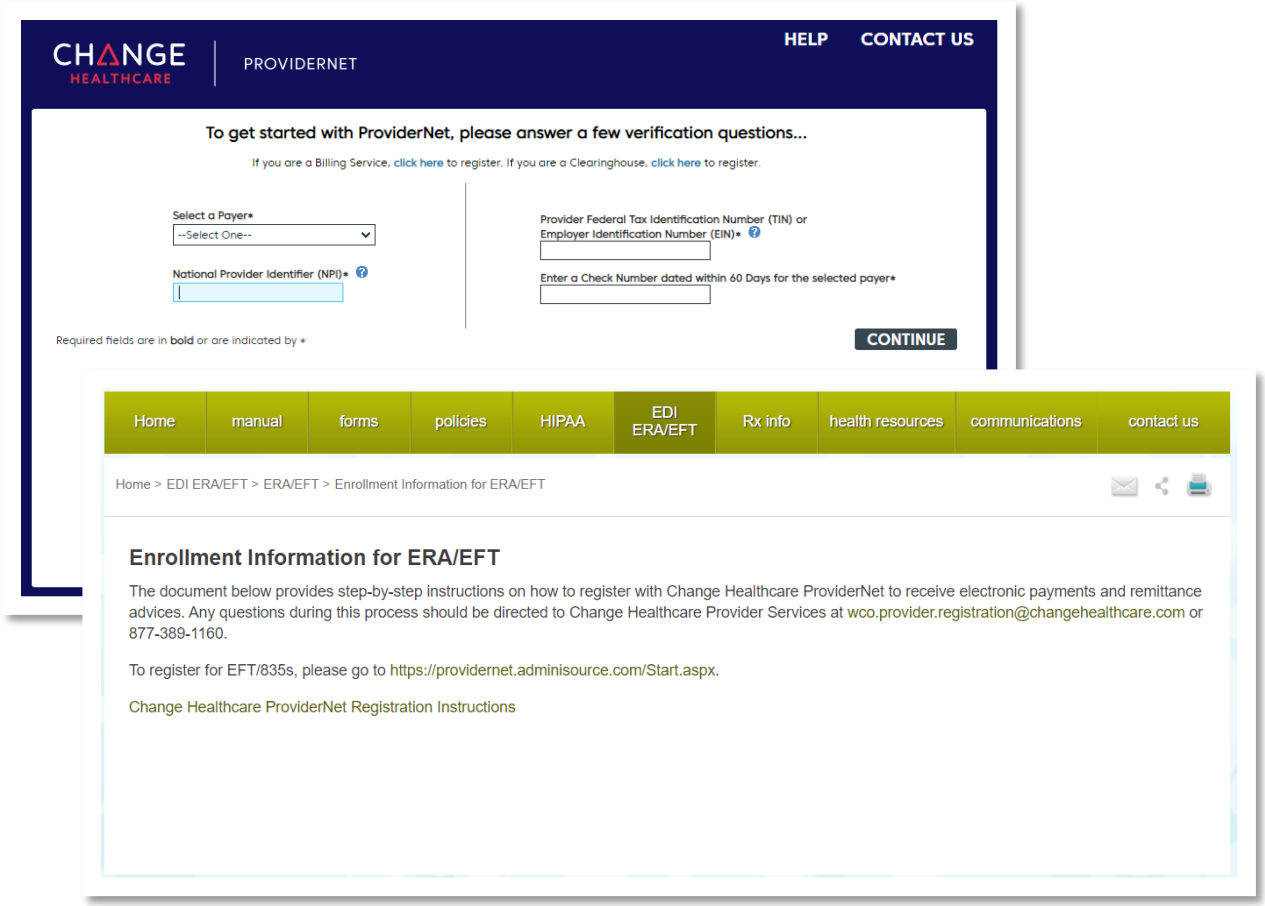
Reminder: The Molina Provider Portal including all features, functionality, and resources will transition to Availity in 2021.

Electronic Payments and Remittance Advice

Molina partners with our payment vendor, **Change Healthcare**, for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA).

Access to Change Healthcare is **FREE** to our providers. We encourage you to register at providernet.adminisource.com/Start.aspx after receiving your first check from Molina.

If you have any questions about the registration process, contact Change Healthcare at (877) 389-1160 or via email at WCO.Provider.Registration@ChangeHealthcare.com.



Visit the EDI ERA/EFT pages at MolinaHealthcare.com for additional information.

Claim Reconsideration Process

Submit a claim reconsideration only when disputing a payment denial, payment amount, or code edit. Claim reconsiderations are applicable for disputes unrelated to clinical appeals or reconsiderations associated with pre-service and post-service authorization.

- Primary insurance Explanation of Benefits (EOB), corrected claims, and itemized statements are not accepted via claim reconsideration. Please refer to the Corrected Claims submission process guidelines.
- The Claim Reconsideration Request Form (CRRF) must be filled out entirely and include the claim number, or it will not be processed, and the provider will be notified. Paper submissions received by mail will not be processed and the provider will be notified.
- The form and supporting documents can be submitted through our Provider Portal or the form can be faxed to (800) 499-3406.

For additional information on the Claim Reconsideration process, view the It Matters to Molina Provider Claim and Authorization Reconsideration presentation on the Molina Provider Website.

Published Guidance for Durable Medical Equipment, Prosthesis, Orthotics, and Supplies (DMEPOS) Benefit

Access to claims processing and coverage criteria guidance:

- Molina follows the DME guidelines as referenced in the ODM Supply List and the Orthotic and Prosthetic List.
- It is imperative that appropriate billing is used to identify the services provided and to process claims accurately.
- For additional guidance on the DMEPOS benefit, view the "Durable Medical Equipment" section in Appendix A of the Provider Manual.

Timelines for Claims Adjudication Processes Specific to DMEPOS:

Claim processing will be completed for contracted providers in accordance with the Ohio Medicaid Program Prompt Pay Requirements.

DMEPOS Modifiers and Status Indicators

Medicaid Requirements

- Reimbursement varies based on the Status Indicator.
- Utilize the table to the right to determine which indicator to bill.
- Please note: an indicator is different than a modifier.

Type	Status Indicator
Purchase Only	PP
Rental Only	RO
Rental To Purchase	RP

Modifier	Definition
NU	New equipment purchase, including complete replacement of an owned item
RR	Equipment rental
RP	Repair and replacement parts for patient owned equipment
UE	Used

Medicare Modifier Requirements

- A modifier is required based on whether the authorization shows it to be a new purchase or a rental.
- Correct pricing is driven by these modifiers. Utilize the table to the left to view valid modifiers.

Reminder: Information regarding the appropriate modifiers can be found in the Molina Provider Manual.

DMEPOS Modifiers and Status Indicators, Continued

Capped DME Rental Modifiers

To identify the rental months billed use these modifiers:

Modifier	Definition
KH	First rental month
KI	Second and third rental months
KJ	Fourth through fifteenth rental months

Note: Information regarding the appropriate modifiers can be found in the Provider Manual, located under the "Manual" tab at MolinaHealthcare.com.

Respite Services for Children

With the implementation of revised OAC 5160-26-03 Managed Health Care Programs: Covered Services, the eligibility criteria for children with MLTSS needs has been updated.

Behavioral Health (BH) eligibility criteria has been added to allow children with a severe emotional disturbance (SED) diagnosis to access respite services.

The billing codes below will be used for both MLTSS and BH respite services	
S5150: Per 15-minute unit	S5151: Per diem for any respite services lasting beyond 12 hours of care

Note: The provider type will be used to differentiate between the two respite services.

Respite Services for Children, Continued

Each child may receive up to 100 hours of respite services per calendar year.

MLTSS and BH Criteria

- Under 21 years of age
- Reside with unpaid primary caregiver in a home
- Not a foster child
- Enrolled in the MCP Care Management Program

Additional BH Criteria

- Have BH needs – as determined through a functional assessment
- Diagnosed with an SED as documented in the appendix to OAC 5160-26-03
- Not exhibiting symptoms or behaviors that indicate risk of harm to self or others
- MCP determination that child's caregiver has a need for temporary relief to prevent out-of-home stay or due to history of out-of-home stays

Additional MLTSS Criteria

- Have MLTSS needs as determined through an institutional LOC
- Require skilled nursing or skilled rehab at least once a week
- Determined eligible for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)
- MCP determination that child's caregiver has a need for temporary relief to prevent out-of-home stay
- Had a need for at least 14 hours per week of Home Health Aide services for two months prior

Atypical Providers

Atypical providers are service providers that do not meet the definition of health care provider.

- Examples include taxi services, home and vehicle modifications, insect control, habilitation, and respite services, etc.
- Although they are not required to register for a National Provider Identifier (NPI), these providers perform services that are reimbursed by Molina.
- Atypical providers are required to use the Ohio Medicaid ID given to them by the State of Ohio to take place of the NPI.
- As long as the provider submits the claim with the Medicaid ID number, the claim will not be rejected back to the provider for missing information.

Grievances

MOLINA HEALTHCARE

Grievances and Complaints

Grievances: The Ohio Administrative Code defines a grievance as an expression of dissatisfaction with any aspect of Molina or participating providers' operations, provision of health care services, activities, or behaviors.

Molina will investigate, resolve, and notify the member or representative of the findings no later than the following time frames:

Line of Business	Access Grievance	Billing Grievance	Standard Grievances
MyCare Ohio	2 Business days	30 Calendar days	30 Calendar days
Medicaid	2 Business days	60 Calendar days	30 Calendar days

Quality of Care and Potential Quality of Care Grievances

A Quality of Care (QOC) grievance is a type of grievance that is related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care.

Potential Quality of Care issues (PQOC) can be identified/reported by any employee, member, caregiver, and/or provider.

PQOCs include Serious Reportable Adverse Events (SRAE)/Hospital Acquired Conditions (HAC) and Never Events.

The direction a PQOC/QOC investigation takes is dependent on the issue being reviewed.

The PQOC/QOC investigation could involve inappropriateness of care, poor continuity of care, refusal of care, or the provider's plan of treatment which may have a negative impact on the member's health.

Provider expectations for PQOC/QOC are based on their contractual obligation to participate in the quality process and can include responding to requests for medical records or additional information.

QOC and PQOC Grievances, Continued

Examples of a QOC/PQOC grievance include care that adversely impacted or had the potential to adversely impact the member's health, and can include any of the following:

Medication Safety: Any medication error or inadequate medication management

Treatment: Treatment that is delayed, inappropriately given or missed

Medicaid and MyCare Ohio Quality of Service Grievances

- Quality of Service (QOS) is defined as any expression of dissatisfaction with the behavior of an aide or customer service received.
- QOS examples include reported rudeness of a care aide, long wait time for an aide to arrive or the aide does not show up, theft of member's property.
- Provider Services Representatives will reach out to the office to get the provider details on the QOS, that will then be shared with ODM.
- QOS requests have a due date which will be shared with your office.
- Failure to respond or provide information on the QOS will be reported back to ODM as provider non-responsive.

Grievances and Complaints

Member may file a grievance or complaint by calling Molina's Member Services Department:

- **Medicaid**: (800) 642-4168 (TTY/Ohio Relay (800) 750-0750 or 711), Monday - Friday from 7 a.m. to 7 p.m.
- **Molina Dual Options MyCare Ohio (full benefits)**: (855) 665-4623 (TTY 711), Monday - Friday from 8 a.m. to 8 p.m.
- **Molina Dual Options MyCare Ohio Medicaid (opt-out)**: (855) 687-7862 (TTY 711), Monday - Friday from 8 a.m. to 8 p.m.

Medicaid and MyCare Ohio Opt-Out lines of business may also submit a grievance or complaint in writing to:	MyCare Ohio Opt-In line of business may also submit a grievance in writing to:
Molina Healthcare of Ohio, Inc. Attn: Appeals and Grievances Department P.O. Box 349020 Columbus, Ohio 43234-9020	Molina Healthcare Medicare Attn: Grievances and Appeals P.O. Box 22816 Long Beach, CA 90801-9977

Credentialing and Contracting

MOLINA HEALTHCARE

Credentialing and Contracting

Credentialing of MLTSS providers is performed by the applicable AAA and contracting is performed by Molina.

Molina is required to contract only with providers who have been approved by the ODA to perform a particular waiver service or set of services.

Medicaid ID Number

In order to comply with federal rule 42 CFR 438.602, providers are required to have enrolled or applied for enrollment with ODM at both the group practice and individual levels to receive payment for clean claims submitted to Molina for covered services.

Providers without a Medicaid ID number will need to submit an application to ODM. Enrollment is available through the MITS portal or providers can start the process at medicaid.ohio.gov.

For dates of service on Aug. 15, 2021 and after, Molina denies claims for providers who are not registered and active in the state's system.

Reminder: ODM is migrating to a new Provider Network Management (PNM) system in 2022 for provider information and updates.

Ombudsman

LTC Ombudsmen safeguard members who receive care services, advocating for quality care, investigating complaints, and giving members a voice.

Region 1: Cincinnati Area	• Counties: Butler, Clermont, Clinton, Hamilton and Warren • Website: proseniors.org
Region 2: Dayton Area	• Counties: Champaign, Clark, Darke, Greene, Logan, Miami, Montgomery, Preble and Shelby • Website: dayton-ombudsman.org
Region 6: Columbus Area	• Counties: Delaware, Fairfield, Franklin, Fayette, Licking, Madison, Pickaway and Union • Website: centralohio.easterseals.com

Contact Molina

MOLINA HEALTHCARE

Frequently Used Email Addresses

Molina of Ohio Provider Services Contact Information:

Molina has designated email addresses based on provider types to help get your questions answered more efficiently or to connect you to training opportunities.

- **MyCare Ohio MLTSS and Ancillary questions**: OHMyCareLTSS@MolinaHealthcare.com
  Note: DME providers should utilize the OHMyCareLTSS@MolinaHealthcare.com email address for questions and to connect to training opportunities
- Nursing Facilities questions: OHProviderServicesNF@MolinaHealthcare.com
- Behavioral Health questions: BHProviderServices@MolinaHealthcare.com
- Hospital or hospital-affiliated physician group questions: OHProviderServicesHospital@MolinaHealthcare.com
- Physician practice questions: OHProviderServicesPhysician@MolinaHealthcare.com
- General questions: OHProviderRelations@MolinaHealthcare.com

For additional contact information view the “Contact Information” section of the Provider Manual, located at MolinaHealthcare.com.

Molina Provider Training Survey

The Molina Provider Services Team hopes you have found this training session beneficial.

Please take a few minutes to complete the Molina Provider Training survey to provide feedback on this session.

The survey is located on the It Matters to Molina Page of our Provider Website, under the "Communications" tab.

Molina wants to hear about what other topics you'd like training on in the future.

Please share your feedback with us so we can continue to provide you with excellent customer service!