Molina Healthcare

Provider Orientation & Training

MOLINA®
HEALTHCARE

Agenda

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2. Molina Healthcare
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Molina Healthcare of Michigan

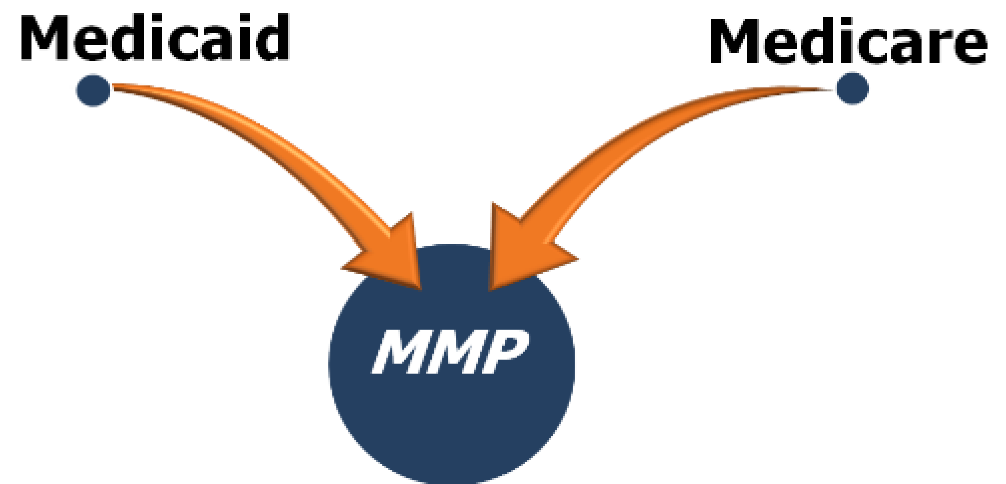
Molina Healthcare, headquartered in Long Beach, California, is a national managed care company focused on providing health care services to people who receive benefits through government-sponsored programs. Molina is a health plan driven by the belief that each person should be treated like family and 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 (MHM) has been serving Michigan Medicaid beneficiaries since 1997 and has been serving MMP members since the MI Health link pilot program first launched in 2015. MHM is the largest plan serving MMP members in the State, with over 11,000 members currently enrolled. Molina also serves 318,000 Medicaid members and 12,600 DSNP members.

What is MMP?

- MMP (Medicare-Medicaid Product) Definition:
  - The MMP product is a program created to fully integrate Medicare and Medicaid. This product will serve to ‘merge’ benefits of the Medicare and Medicaid, providing members one program and eliminating barriers to care and increasing services to this population.
  - Guided by an agreement between Molina, MDHHS, and CMS---aka the 3-way agreement.
  - Known by other names:
    - Duals demonstration
    - MI Health Link
    - Integrated duals
    - Molina Dual Options



What is MMP?

- 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
  - Eligible for Medicare Parts A and B
  - Eligible for Full Medicaid Benefits
  - Reside in Wayne or Macomb counties
- Enrollment process
  - Member 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.

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)

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 beneficiary, client or participant validation of the day, time, location and type of personal care or home health care services provided.

Who?

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

When?

The Cures Act requires States to implement EVV by January 1, 2020 for Personal Care services and January 1, 2023 for Home Health Care services.

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).
- Required EVV date TBD

Program Requirements

MOLINA HEALTHCARE

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 actually 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

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.

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 individuals 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 PCP, the individual will be able to identify their goals, hopes, interests and preferences in their life. PCP 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

Social Model of Disability

- What is the 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.

Independent Living Philosophy

- The right of people with disabilities to control and direct their own lives and to participate actively in society. To control and direct one’s life means making cultural and life style choices among options that minimize reliance on others in decision-making and in performance of every day activities, limited only in the same ways that people without disabilities are limited.

Recovery Model

- The recovery model is a person centered approach that believes 2 basic philosophies about recovery to be true:

  1. It is possible to recover from a mental health condition or diagnosis.
  2. The most effective recovery is patient directed.

- What is the goal of the recovery model?
  - To help people with substance use and mental health disorders, enter into a state of long-term recovery. Through the community programs, family members, providers and county administrators.

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.

Chronic Conditions in the Population

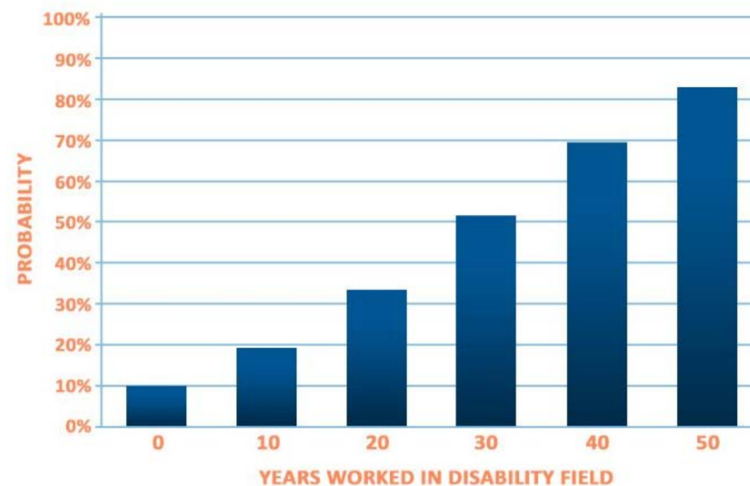
- The MMP population experiences an array of physical and mental health conditions:
  - Physical Conditions such a COPD, Congestive Heart Failure, Diabetes, and paralysis are common.
  - Mental health conditions such as depression, anxiety, substance abuse, bi-polar disorder and schizophrenia are very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

Awareness of Personal Prejudices

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

Awareness of Personal Prejudices

- Based on the findings of a study completed by The Council on Quality and Leadership (CQL), there was a relationship between unconscious attitudes and defining disability as lacking independence, in relation to the norm or as impairment. Findings suggest people who define disability in relation to the norm have slightly more prejudice attitudes than people who define disability as a lacking of independence, or impairment. The longer someone works in the disability field, the more likely they are to understand disability as simply a general difference- a form of human variation.



Awareness of Personal Prejudices

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.

Legal Obligations to comply with the ADA

- What is ADA?
  - American Disabilities Act (ADA) prohibits discrimination against persons with disabilities in the are of employment, public accommodations, and telecommunications.
  - Examples of reasonable accommodations are as follows;
    - Braille
    - Permitting of service dogs
    - Disability accessibility opportunities (i.e. wheelchair ramps, handicap parking, automatic doors, elevators etc.)
    - Larger print for written materials
    - Audio accommodations

Legal Obligations to comply with the ADA

- Disability Etiquette
  - Treat others with respect and ask yourself how you want to be treated if you were a person with a disability.
  - Conversation: Speak in your normal tone of voice. Use plain language and confirm understanding.
  - Ask before you assist: Respect the individual's response. Don't assume a wheelchair user wants to be pushed or an older adult needs help with their bags.
  - Words: Use appropriate language when discussing a person's disability.
  - Ask when unsure: If you're not sure how to assist an individual with a disability, ask them what to do. The individual is the most knowledgeable person when it comes to their disability.
  - Service dogs: Never pet or distract service animals. Speak to the handler, not the dog.
  - Interpreters: Speak to the individual directly when using an interpreter. Be aware of your body language. Get an interpreter when needed.
  - Written Instructions/Materials: Offer materials in alternate formats.

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

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:
  - https://courses.mihealth.org/MIHealthLink/
- 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.

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

Molina HealthCare

MMP LTSS Service Request / Coordination Form

Date Sent To Provider: 6/27/2019	
Member Information	
Member Name:	Mickey Mouse
Date of Birth:	12/18/1938
Medicaid ID:	0123456789
Preferred Phone Number:	313-555-5555
Service Address:	123 Detroit St. Detroit, MI 48120
Assigned Care Coordinator:	Daffy Duck
Service Information	
Service Requested:	Personal Care Services
HCPCS Code:	T1019
Standardized Remark:	Click or tap here to enter text.
Units Authorized:	1000
Frequency of Service:	Click or tap here to enter text.
Authorization Start Date:	7/1/2019
Authorization End Date:	12/31/2019
Additional Service Details	Caregiver is Daffy Duck
	313-666-6666
	55 Units/wk
	Click or tap here to enter text.
Vendor Information	
Vendor:	ABC Personal Care Experts
Vendor Fax Number:	Click or tap here to enter text.
Vendor Contact Person:	Click or tap here to enter text.
Vendor Phone Number:	Click or tap here to enter text.
Estimated Start Date:	Click or tap to enter a date.
Identified Barriers:	
Referral Accepted:	Yes: ☐ No: ☐
Service Confirmation	
Confirmed Date of Service Start with Vendor:	Click or tap to enter a date.
Confirmed Service in-place and member satisfaction:	Click or tap here to enter text.

Authorization Number:	321231321

Billing & Claims

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Claims Submission

- Claims are required to be submitted electronically through a clearinghouse or Molina's Provider 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 90 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 claims submission and disputes processes.
- Providers can combine multiple disputes on a single dispute form

Appeals & Grievances

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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

Marketing Guidelines

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Marketing Guidance for Member Communications

- Molina and its providers are not allowed to direct market to potential or current members
- Providers may not use Molina logo without direct Molina approval
- All marketing communications must be submitted for plan approval prior to submission for CMS/DHHS approval.

Key Contacts

Contact Reason	Primary Contact
Contracting/Credentialing	Glena Krapohl 888-562-5442 ext. 151186
Provider Services	Provider Services Line 855-322-4077
Authorizations / Service Coordination	Care Coordination Line 888-562-5442 ext. 751583
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

Provider Survey

- https://www.surveymonkey.com/r/BWLGVRF