Reference Guide – Invoice Submission

Personal Care Supplement Payment for Adult Foster Care (AFC) and Home for the Aged (HFA)

Molina's process to submit invoices

1. Once the AFC home has received confirmation that the AFC or HFA is set up in our system and an authorization number has been provided an invoice can be submitted to Molina for processing payment.
2. Send in your request for payment using the Invoice for Supplement Payment created by MDHHS – make sure each field on the form is completed before submitting.
3. The supplemental payment is always billed after services are rendered; billing is sometimes only as frequent as one time per year.
4. The rate for the Personal Care Supplement payment is $218.92 per month. This amount can be prorated for partial month stays in an AFC or HFA. Please note: This rate could change based on the MDHHS budget.
5. Submission Address for Invoice Submission:
   Molina Healthcare of MI, Inc.
   Healthcare Services Care Coordination – Administrative Assistant
   880 West Long Lake Road Suite 600
   Troy, MI 48098
   MHL_HCS_AFCMailbox@molinahealthcare.com

Any questions regarding this process should be directed to our Provider Contact Center at (888) 560-4087.

Personal Care Supplement Guide

1. What is the Medicaid Personal Care Supplement?

The Personal Care Supplement is paid to licensed Adult Foster Care (AFC) homes and Homes for the Aged (HFA). It is a legislatively mandated payment made for personal care services provided to eligible individuals residing in AFC homes or HFAs. The personal care supplement amount is set by the Michigan legislature.

2. Who is eligible for the Personal Care Supplement?

MI Health Link enrollees are eligible for this payment if they meet all three of the following criteria

- Receive or are eligible for Medicaid
- Live in a Michigan licensed Adult Foster Care Home or Home for the Aged
- Score at a **2** or above on the Personal Care Assessment for activities of daily living

Enrollees participating in the MI Health Link Home and Community Based Services **WAIVER** are not eligible to receive the Personal Care Supplement if they live in an AFC or HFA.

3. How will ICOs know to pay Personal Care Supplement?

For enrollees residing in an AFC or HFA at the time of enrollment in MI Health Link, the CareConnect360 (CC360) flag for AFC/HFA will be “Yes”. The MI Health Link health plan will be able to drill down in CC360 to the provider information.
For all other enrollees moving into an AFC home and HFA, the Care Coordinator will complete the in-person Personal Care Assessment to determine if the enrollee meets the scoring requirement (**2** or higher for one Activity of Daily Living). The health plan will confirm that the AFC or HFA in which the enrollee is interested in residing is licensed by checking the licensing status at http://www.dleg.state.mi.us/brs_afc/sr_afc.asp. The health plan will contact the enrollee’s DHS Eligibility Worker to determine if the enrollee receives or is eligible for the SSI benefit. If all three criteria are met, the health plan will work to enroll the AFC or HFA into the health plan’s network, if applicable.

4. How will DHS know to stop payment when a person enrolls in MI Health Link?

Following enrollment, MDHHS will identify all enrollees for whom the Personal Care Supplement was paid in the 6 months prior to enrollment. This list will be sent to the county offices so local Adult Service Workers can close these cases to stop payments.

Revised 2.14.17

5. What is required of the provider?

The AFC or HFA must be licensed and contracted with the MI Health Link health plan to receive the Personal Care Supplement. The provider must submit an invoice to the health plan to be paid the Personal Care Supplement. Billing is sometimes only as frequent as one time per year.

6. How much is the Personal Care Supplement payment?

As of 2017 the rate for the Personal Care Supplement is $218.92 per month. This amount can be prorated for partial month stays in an AFC or HFA. The rate may potentially change when the legislature establishes the annual MDHHS budget.

7. How do I obtain a contract?

Please see the contact info below:

Phone: (248) 729-0900
Fax: (248) 925-1784
Email: MHMProviderContractingMailbox@MolinaHealthCare.Com

Invoice for Adult Foster Care/Homes for the Aged Personal Care Supplement

Billing Provider Information

1. Adult Foster Care (AFC) home or Home for the Aged (HFA) Organization Name or Caretaker First and Last Name (to whom the payment will be remitted):

2. Is the AFC/HFA home owned by a person or an organization?

3. What is the National Provider Identification (NPI) number? If not applicable, what is the Tax Identification Number (TIN)?

4. To what address should the payment be remitted? (Address Line, City, State, Zip):

Beneficiary Information

1. Beneficiary First and Last Name:

2. Beneficiary's Medicaid ID:

3. Beneficiary's Address (Address Line, City, State, Zip):

4. Beneficiary's Birthdate:

5. Beneficiary's Gender:

Rendered Services Information

1. This personal care supplement will cover dates from __/__/____ to __/__/____.

2. Amount charged: $___________ (Note: The current rate for one full month's service is $218.92.)

3. Molina Prior Authorization Number: _______________________

Provider: By signing this claim, you are attesting that you and/or your organization rendered personal care services to the above beneficiary in the specified time frame, and you believe the beneficiary to be eligible for the personal care supplement.

Submission Address for Invoice Submission:
Molina Healthcare of MI, Inc.
Healthcare Services Care Coordination – Administrative Assistant
880 West Long Lake Road Suite 600
Troy, MI 48098
MHL_HCS_AFCMailbox@molinahealthcare.com

Provider Signature: ____

SAMPLE

Invoice for Adult Foster Care/Homes for the Aged Personal Care Supplement

Billing Provider Information

1. Adult Foster Care (AFC) home or Home for the Aged (HFA) Organization Name or Caretaker First and Last Name (to whom the payment will be remitted): **Sue Sample AFC Home**

2. Is the AFC/HFA home owned by a person or an organization? **Person**

3. What is the National Provider Identification (NPI) number? If not applicable, what is the Tax Identification Number (TIN)? **XXXXXXXXXX**

4. To what address should the payment be remitted? (Address Line, City, State, Zip):
   1234 First Street, Detroit, MI 48207

Beneficiary Information

1. Beneficiary First and Last Name: **John Smith**

2. Beneficiary's Medicaid ID: **0123456789 (10 digit id number)**

3. Beneficiary's Address (Address Line, City, State, Zip): **3456 Second Street, Detroit, MI 48207**

4. Beneficiary's Birthdate: **05/13/1965**

5. Beneficiary's Gender: **MALE**

Rendered Services Information

1. This personal care supplement will cover dates from 01/01/2016 to 03/31/2016.
   Services can only be billed for those months that the member was in your AFC home and all months being billed must be in the past, we will not pay for any future months of service.

2. Amount charged: $__656.76__ (Note: The current rate for one full month's service is $218.92.)
   This would be the number of months being billed multiplied by the monthly rate of $218.32.
   So for this example: 3 months x $218.92 = $656.76

3. Molina Prior Authorization Number: _XXXXXXXXXX__ **(10 DIGIT NUMBER)**
   Provided to the AFC Home by Molina – letter is sent for each member that provides the authorization number

Provider: By signing this claim, you are attesting that you and/or your organization rendered personal care services to the above beneficiary in the specified time frame, and you believe the beneficiary to be eligible for the personal care supplement.

Provider Signature: ***AFC PROVIDER SIGNATURE HERE***