Nursing Facility Provider Newsletter – Spring 2019

In This Issue:

Molina Quality Living Program – Exciting New Enhancements!

Molina is excited to announce enhancements to our **Molina Quality Living (MQL)** program allowing more facilities to participate in our **Pay-For-Quality** program! Molina has paid out over **$3.6 MILLION to Nursing Facilities in quality incentive payments and conducted over 5,700 activities in Nursing Facilities touching the lives of more than 73,000 residents!**

Effective September 1, 2018, Molina removed the membership threshold as a qualifying criterion to participating in the **Molina Quality Living** program. This increased the opportunity for facilities with an overall CMS 4- and 5-STAR rating to earn **up to $70 per member per month** in quality incentive payments!

We held a series of focus group meetings with Administrators regarding ways we could enhance the MQL program further to support Nursing

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Facilities in providing quality care and enhancing the lives of their residents. The various focus groups recommendations resulted in the following enhancements that were effective January 1, 2019:

- Molina Sponsored Employee Appreciation Activities
- Exclusive off-site special events for residents of **MQL** qualifying facilities
- Pre-payment quarterly of a portion of the Pay-For-Quality funds (**MQL** Advance Payment – Shared Risk Arrangement)

These enhancements have resulted in the number of qualifying nursing facilities to double!

To qualify for the program, facilities must be an overall CMS 4 or 5 STAR rated facility for the entire quarter and have at least one Molina member. The **MQL** program data is reviewed on a quarterly basis and payments are automatically generated to qualifying facilities.

We hope that these enhancements continue to encourage quality care in nursing facilities and enhancing the lives of our elderly Texans.

Molina Healthcare of Texas "Operation Celebrate Veterans"

On October 25, 2018, we honored our nursing facility veterans at the VFW #76 in San Antonio with our Operation Celebrate Veterans event. VFW #76 was the first VFW to be established in Texas. We had approximately 30 veterans from 8 different nursing facilities attend, including a 99-year-old veteran who led the ceremony with the Pledge of Allegiance. Councilman Robert Trevino handed out the recognition certificates while Molina VTO staff assisted the veterans with refreshments and fellowship.

Molina would like to thank Luis Canela, a Molina Nursing Facility Community Engagement Coordinator (CEC) who worked closely with the Nursing Facilities, VFW and Molina staff to organize this wonderful event. Another special thank you and **job well done** to Juan Rivera, CEC, who sang the national anthem and shared his personal story of growing up with a veteran.


Operation Celebrate Veterans
With respect, honor and gratitude,
thank you for your service.
MolinaHealthcare.com


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Christmas in the Nursing Facilities!

Throughout the whole month of December 2018, Molina Nursing Facility Community Engagement Team hand delivered **744** holiday cards, signed by **244** MHT employees, to nursing facility residents. The month of December can be a lonely and isolating time for residents. To help bring some joy during this time, the NF Community Engagement team visited **85** nursing facilities throughout Texas, to not only hand out the holiday cards, but also facilitate a holiday activity of ornament making accompanied by caroling and learning about the history of the holidays.

Credentialing DEADLINE JUNE 30, 2019

On April 1, 2018, HHSC (Health and Human Services) implemented the STAR+PLUS nursing facility (NF) state-identified credentialing standards to credential NF providers seeking to participate in MCO's STAR+PLUS provider networks. All Nursing Facility providers that were part of Molina's network as of April 1, 2018 must be credentialed by June 30, 2019.

Letters were sent in June and September of 2018 and most recently in March of 2019 to Nursing Facilities that are not credentialed with Molina. If you are not credentialed with Molina, it is critical that you submit a credentialing packet no later than April 15th to assure complete processing and approval by June 30th. Failure to become credentialed with Molina by June 30, 2019 will result in the **termination of your STAR+PLUS Nursing Facility Provider Agreement** and any other Molina contracts.

If you have any questions or need a credentialing application, please contact your Provider Services Representative (PSR) or email: NFProviderServices@Molinahealthcare.com

Molina Receives NCQA Accreditation News

Molina Healthcare of Texas has been awarded four separate distinctions from the National Committee for Quality Assurance (NCQA).

- The Molina Medicaid HMO received a ***Commendable*** status – NCQA awards this status to health plans with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement.
- The Molina Marketplace HMO received the status of both ***Accredited*** and ***Distinction*** for NCQA's Long-Term Services and Supports (LTSS) certification.
- Additionally, Molina was awarded with NCQA's Multicultural Health Care – ***Distinction*** status.

Molina is proud to have achieved these levels and strives daily to improve the quality of services and healthcare provided to our members.

Rendering Therapist NPI on Claim Forms

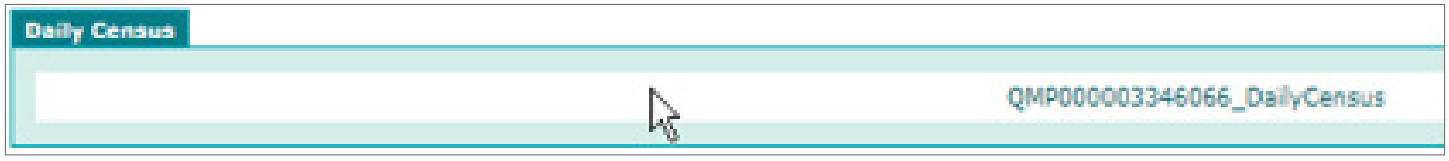
HHSC is postponing the implementation of requiring the NPI of Rendering Therapists on Claims Forms. HHSC has provided the following information on the issues surrounding the rollout:

- Proposed implementation date: TBD
- Uses the CMS-1450/UB-04 claim form
- Currently, direction is for the billing provider and rendering provider to only be different when therapy services are rendered.
    - On the CMS-1450/UB-04 claim form, the rendering provider would go in boxes 78 and 79.
- Barriers to implementation
    - This form has limitations for scenarios when more than 1-2 rendering therapy providers must be identified.
    - In instances where more than 1-2 rendering providers must be identified for therapy services, the provider will have to send separate claims to capture all of the rendering providers for therapy services.
        - This is an administrative burden for providers due to the frequency this occurs.
    - This claim form does not allow for direct correlation from the rendering provider to their rendered service.
    - TexMedConnect will require a system update to allow for multiple rendering providers to be added.
    - HHSC is re-reviewing national billing standards and ability to require the rendering provider on this claim form.
- Many providers expressed an administrative burden to implement this piece. Please quantify how long is needed to fully implement and provide an explanation for that time frame.
- MCOs may have to make system changes to fully implement this piece. Please quantify how long is needed to fully implement and provide an explanation for that time frame.

Medicaid Recertification Date is now available on the Molina MESAV for Molina Nursing Facility Members

To access the Medicaid Recertification Date on the MESAV tool for Nursing Facility Members, complete the following steps:

1. Log into the Molina Provider Portal: https://provider.molinahealthcare.com/provider/login
2. Select “Reports” from the left hand menu on the Home screen
3. Select the Daily Census Tab



Member Information		Medicaid ID:	12345678
Name:	Member's Name	County:	Harris
Date of Birth:	1/1/1900	Address:	1234 Happy Street
Gender:	Female	City:	Anywhere, Texas
Client SSN:	*******1234	Zip Code:	77777
Recertification:	04/19/2019		

Medicaid Eligibility			
Effective Date	End Date	Program/Description	Coverage Category
12/01/2017	10/31/2018	Medicaid HMO/STAR+PLUS	14

For further information on the Molina MESAV tool, please access the following link: https://www.molinahealthcare.com/providers/tx/medicaid/comm/PDF/Molina-NF-MESAV-Provider-Training.pdf.

Claims Appeals for All Skilled Claims, including MMP, Medicare Advantage, and Outpatient Therapy Claims

Prior to filing an appeal, verify that the claim was originally submitted with accurate information. If an error is found, correct the claim. Though the PSR cannot correct or appeal a claim for you, they can review the claim to make sure it is accurate prior to filing an appeal.

If an appeal is done and then a claim is corrected, the appeal is voided.

If the appeal is upheld by Molina and the provider wants to escalate the appeal, CMS appeal rights information and link is below.
http://www.medicareappeal.com/medicare-appeals-your-rights

Medicare Appeals and Your Rights

There are **five levels of Medicare appeals**:

- The **first level appeal** is called a request for reconsideration and is done by the **health plan**.
- If your health plan does not change its decision, then the health plan must send your case file to **MAXIMUS Federal Services** for a **second level appeal**, called an **External Review**.
- If MAXIMUS Federal Services agrees with the health plan, you may try the **third level appeal**, called an **Administrative Law Judge Hearing (ALJ Hearing)**.
- If you are unhappy with the ALJ Hearing decision, you may ask the Medicare Appeals Council (Council) to review your case. This is called a Council Review; it is the **fourth level appeal**.
- If you are unhappy with the Council Review, you may ask a Federal Court Judge to review your case, This is the **fifth level appeal**.

Each of these levels has steps that you and your health plan must follow. In each of these five levels of appeal:

- **You have the right** to have someone help you with your appeal. You can pick anyone you want, such as a friend, family member, doctor, or lawyer.

The First Level Appeal: Health Plan Reconsideration

If you requested services or payment from the plan and the plan decided to deny all or part of what you requested, you can ask the plan to reconsider their decision. This is called an appeal or request for reconsideration.

The Second Level Appeal: External Review

If your health plan does not change its decision after your request for reconsideration, the plan automatically sends your case file to MAXIMUS Federal Services for an External Review.

The external review by MAXIMUS Federal Services includes:

- MAXIMUS Federal Services sends you and your representative (if you have one) a letter telling you that they have your case file.
- MAXIMUS Federal Services carefully reviews
    - Medicare rules
    - Your agreement with the health plan,
    - All the information in your case file, and
    - Any additional information that you provide
- MAXIMUS Federal Services makes a decision in
    - 72 hours, or up to 17 days in certain cases, for an expedited (fast) review
    - 30 to 44 days for health care you are waiting for
    - 30 to 60 days for payment of a denied bill.
- MAXIMUS Federal Services sends you a letter with the decision.
    - If MAXIMUS Federal Services disagrees with the plan (overturns the plan's denial), then MAXIMUS Federal Services will send a letter to you and a letter to your health plan telling your health plan to pay for or provide for your health care.
    - If MAXIMUS Federal Services agrees with your health plan (upholds the plan's denial), your letter will tell you what you can do. If you want to appeal this decision, you can ask for the third level appeal, an ALJ Hearing.

Your Rights in an External Review with MAXIMUS Federal:

MAXIMUS Federal Services
Medicare Managed Care & PACE Reconsideration Project
3750 Monroe Avenue
Suite 702
Pittsford, NY 14534-1302

- You have the right to send us information about your case. We must get this information 10 days after the date you receive MAXIMUS Federal Services' letter telling you we have your case file. You can have someone such as a family member, friend, or doctor help you write this information. Please include your name and appeal number on your information. Send your information to:
- You have the right to ask for MAXIMUS Federal Services letters in a language you understand.
- You have the right to a copy of everything in your file.
- You have the right to receive a written appeal decision from MAXIMUS Federal Services.

The Third Level Appeal: ALJ Hearing

If MAXIMUS Federal Services agrees with your health plan but not with you, you can ask for a hearing with an Administrative Law Judge (ALJ). If you ask for a hearing, an ALJ from the Office of Medicare Hearings and Appeals will decide your case. You can learn more about the ALJ hearing process by visiting www.hhs.gov/omha.

You can ask for an ALJ hearing only if what you were asking the health plan for (services or equipment) is worth more than $160

Write to MAXIMUS Federal Services and ask for an ALJ Hearing. You have to write and ask for an ALJ Hearing within 60 days of the date of the decision.

- The Office of Medicare Hearings and Appeals will schedule your hearing, and will tell you the time and place of the hearing.
- You participate in the hearing and give information about your case. Your health plan may also have someone at the hearing to give information. You can include anyone to speak for you or help you. This person does not have to be a lawyer. You can pick anyone, such as a family member, friend, or doctor.
- The ALJ makes a decision based on your case file and the information given at the hearing.
- The ALJ sends the written decision to you, your health plan, and to MAXIMUS Federal Services.
- If the ALJ agrees with you, then MAXIMUS Federal Services will send a letter to your health plan telling them to pay or provide for your health care.

The Fourth Level Appeal: Medicare Appeals Council Review

If you are unhappy with the decision made by the ALJ, you may be able to ask for Medicare Appeals Council review of your case. This board is part of the federal department that runs the Medicare program.

The Fifth Level Appeal: Federal Court

If you are unhappy with the decision made by the Medicare Appeals Council, you may be able to take your case to a federal court. For appeals filed during calendar year 2018, the dollar value of your medical care must be at

least $1,600 to go to a federal court. For appeals filed during calendar year 2019, the dollar value of your medical care must be at least $1,630 to go to a federal court.

More about your rights and who can help you

To get more information about your appeal rights:

- Visit the Medicare Appeal web site (www.medicare.gov)
- Talk to your health plan about how to file appeals and your rights.

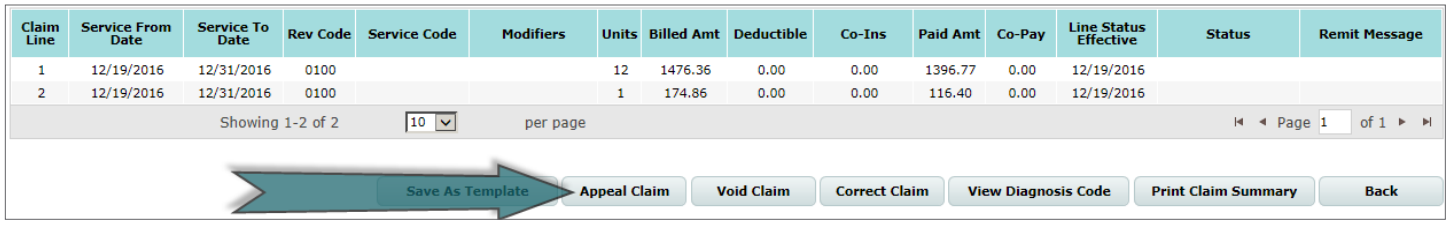
To get help with your appeal:

- Call your local Bar Association or legal aid program. If you do not have much money, these offices may be able to help you with your appeal.
- Talk to a private lawyer who may charge you a fee.
- Call 1-800-MEDICARE to request the telephone number of your State Health Insurance Assistance Program.

Filing an Appeal on the Molina E-Portal

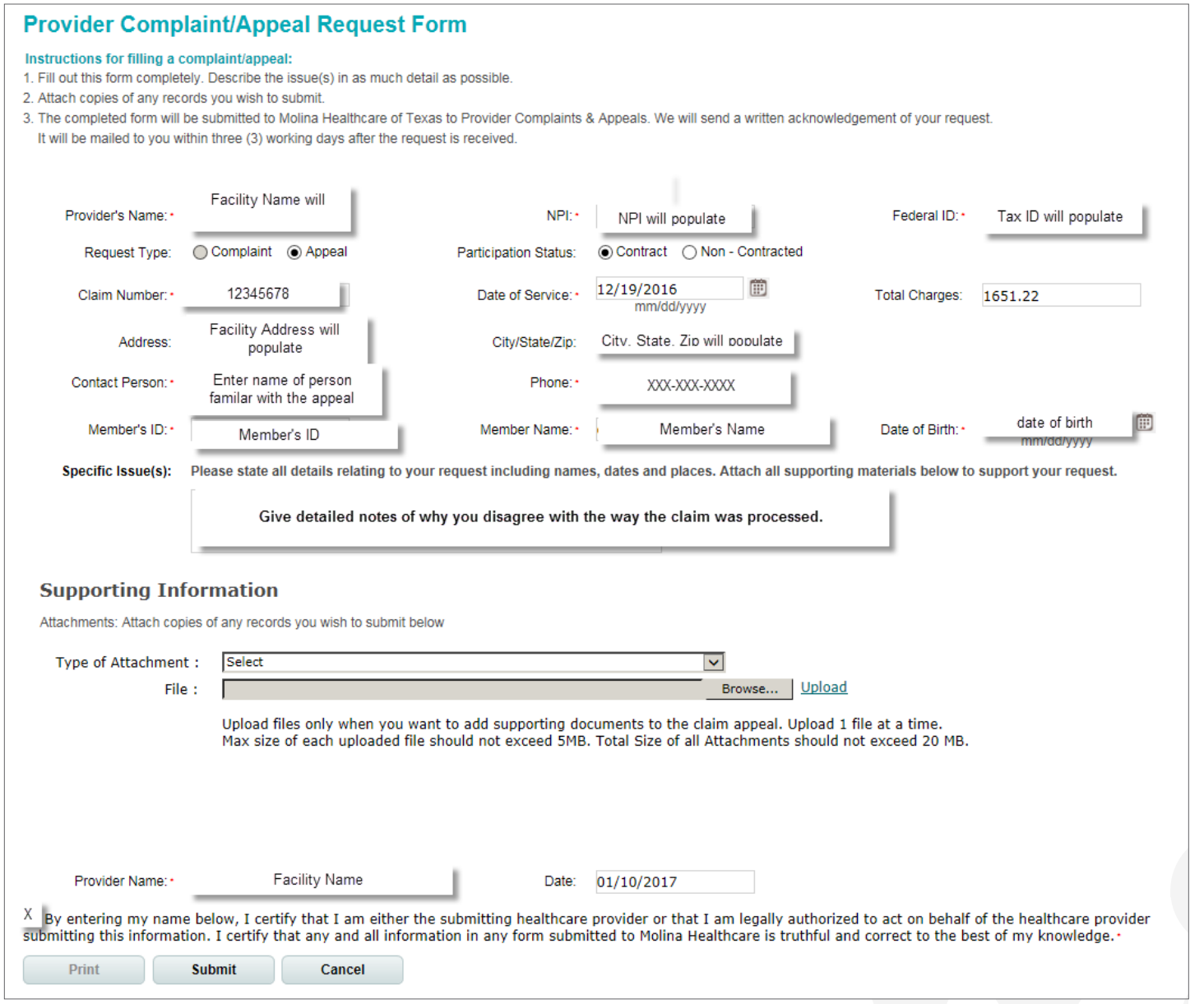
Claims Inquiry on Molina E-Portal, search for the claim in question

Click on the claim ID to open the claim.



Claim Line	Service From Date	Service To Date	Rev Code	Service Code	Modifiers	Units	Billed Amt	Deductible	Co-Ins	Paid Amt	Co-Pay	Line Status Effective	Status	Remit Message
1	12/19/2016	12/31/2016	0100			12	1476.36	0.00	0.00	1396.77	0.00	12/19/2016		
2	12/19/2016	12/31/2016	0100			1	174.86	0.00	0.00	116.40	0.00	12/19/2016		

Select “Appeal Claim”



Provider Complaint/Appeal Request Form

Instructions for filling a complaint/appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit.
3. The completed form will be submitted to Molina Healthcare of Texas to Provider Complaints & Appeals. We will send a written acknowledgement of your request. It will be mailed to you within three (3) working days after the request is received.

Provider's Name: * Facility Name will

NPI: * NPI will populate

Federal ID: * Tax ID will populate

Request Type: ○ Complaint ◉ Appeal

Participation Status: ◉ Contract ○ Non - Contracted

Claim Number: * 12345678

Date of Service: * 12/19/2016 mm/dd/yyyy

Total Charges: 1651.22

Address: Facility Address will populate

City/State/Zip: City, State, Zip will populate

Contact Person: * Enter name of person familar with the appeal

Phone: * XXX-XXX-XXXX

Member's ID: * Member's ID

Member Name: * Member's Name

Date of Birth: * date of birth mm/dd/yyyy

Specific Issue(s): **Please state all details relating to your request including names, dates and places. Attach all supporting materials below to support your request.**

Give detailed notes of why you disagree with the way the claim was processed.

Supporting Information

Attachments: Attach copies of any records you wish to submit below

Type of Attachment : Select

File : Browse... Upload

Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time.
Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

Provider Name: * Facility Name

Date: 01/10/2017

X By entering my name below, I certify that I am either the submitting healthcare provider or that I am legally authorized to act on behalf of the healthcare provider submitting this information. I certify that any and all information in any form submitted to Molina Healthcare is truthful and correct to the best of my knowledge. *

Print Submit Cancel

For additional training or assistance please contact your assigned Provider Services Representative or email: NFProviderServices@Molinahealthcare.com

Nursing Facility Responsibilities Reminder

Per the Nursing Facility Provider agreement, Nursing Facilities fulfill the following requirements:

- **2.22 – Notice to the MCO of Adverse Change in Medical Condition and other events**
  To facilitate care coordination, the Nursing Facility must provide notice to the MCO's designated Service Coordinator via phone, facsimile, email or other electronic means no later than one business day after the following events:
  1. A significant, adverse change in the Member's physical or mental condition or environment that could potentially lead to hospitalization;
  2. An admission to or discharge from the Nursing Facility, including admission or discharge to a hospital or other acute facility, skilled bed, long term services and supports provider, non-contracted bed, another nursing or long term care facility; and
  3. An emergency room visit.

  Notice is not required when a Member is absent from the Facility for a therapeutic home visit.
- **2.23 – Nursing Facility Admissions and Discharges**
  2.23.2 – The Provider must submit Form 3618 or Form 3619, as applicable, to HHSC's administrative services contractor electronically no later than 72 hours after a Member's admission or discharge from the Medicaid nursing facility vendor payment system, as required by 40 TAC § 19.2615.

MOLINA HEALTHCARE

5605 N. MacArthur Blvd., Suite 400
Irving, TX 75038

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