

Provider Bulletin – 2017 First Quarter

A bulletin for the **Molina Healthcare of Texas** Network



Notice from HHSC: Cost Reporting Training

To: Community Living Assistance and Support Services Case Management Agency and Direct Services Agency Providers, Day Activity and Health Services Providers, Deaf Blind Multiple Disabilities Providers, Home and Community-based Services Providers, Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions Providers, Nursing Facility Providers, Primary Home Care Providers, Residential Care, Texas Home Living Providers, STAR+PLUS Services (affiliated with the above service types)

Subject: Information Letter No. 17-01
2016 Cost Report Training Information

Dear Providers,

The purpose of this letter is to notify providers of the training schedule for the 2016 cost report. Cost report training is required every other year for the odd-year cost report in order for the preparer to be qualified

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Questions?

Call Provider Services
(855) 322-4080
8 a.m. – 5 p.m.
Monday through Friday

MolinaHealthcare.com



Your Extended Family.

to complete both that odd-year cost report and the following even-year cost report. Preparers who completed cost report training for the 2015 cost report will not be required to complete additional cost report training in order to prepare a 2016 cost report.

All cost report training is offered via webinar. There are separate webinars for new preparers and for those who have taken cost report training in previous years for each program. Each webinar will include both the general and program-specific content for a program.

A preparer must complete the appropriate webinar in order to be able to submit a cost report. Upon completion of the appropriate webinar, preparers will be given the appropriate credit in order to submit cost report in the State of Texas Automated Information Reporting System (STAIRS), which is the web-based data collection tool used to submit cost reports. There are no certificates issued at the completion of a webinar training since training credit is electronically stored in STAIRS. Additionally, there will be NO credits issued for Continuing Education Units (CEUs) or Continuing Professional Education (CPEs) for completing either of the cost report training webinars.

INITIAL COST REPORT TRAINING

There will be a separate Initial Cost Report Training webinar session for each program. All first-time cost report preparers **MUST** complete an Initial Cost Report Training webinar session for each program for which they will submit a cost report. While a first-time preparer may attend a Refresher Cost Report Training webinar session, they will be unable to submit a 2016 cost report if they do not also complete an Initial Cost Report Training webinar.

The Initial Cost Report Training webinar sessions will provide in-depth discussions of the Cost Determination Process Rules, including the cost determination process, the cost-reporting process, accrual accounting, direct costing, employee benefits/insurance, depreciation, related-party transactions and documentation requirements. They will also include information specific to each program, providing an opportunity to focus on program expertise and cost-reporting issues specifically related to the program

Upon successful completion of an Initial Cost Report Training webinar session for a specific program, a first-time preparer will be awarded credit and will be able to submit a 2016 cost report for the specific program.

REFRESHER COST REPORT TRAINING

Preparers who previously attended cost report training except for the 2015 cost report for a specific program **MUST** attend a Refresher Cost Report Training in order to submit a 2016 cost report. Additionally, these preparers may attend an Initial Cost Report Training webinar session in lieu of a Refresher Cost Report Training webinar session, however it should be noted that duration times for “Initial” webinar sessions are longer since they are intended to provide an in-depth discussion of rules, processes and other topics which the preparer may have already been exposed to.

The Refresher Cost Report Training webinar sessions will provide a review of the 2016 cost report, with an emphasis on cost-reporting issues specifically related to the program, cost allocation, allowable and unallowable costs and deficiencies noted during the review and audit of cost reports from previous years.

Upon successful completion of either an Initial or Refresher Cost Report Training webinar, preparers who have previously completed cost report training for that same program will be awarded credit for completing the webinar and will be able to submit a 2016 cost report for the specific program.

RATE ANALYSIS WEBSITE

The HHSC Rate Analysis Department (RAD) website contains program specific cost report instructions, cost report training information and materials, payment rates, RAD staff contact information and web links for training information and registration. Additional information and features are added periodically. We encourage you to visit our website at:

<http://legacy-hhsc.hhsc.state.tx.us/rad/long-term-svcs/index.shtml>

RESOURCES

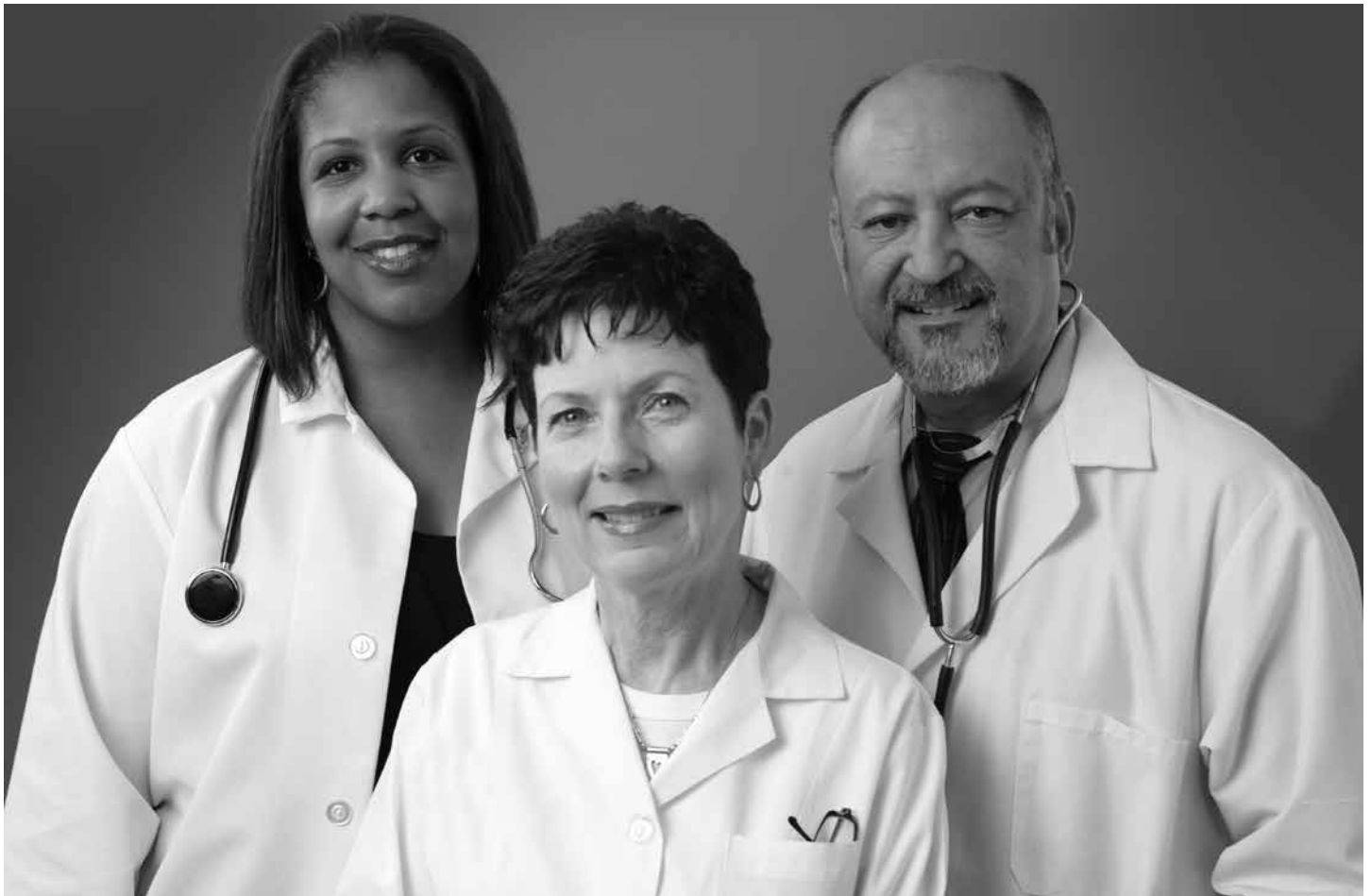
Please contact the Rate Analyst for your program if you have any questions about the information in this letter. Contact information for RAD staff is available on our website at:

<http://legacy-hhsc.hhsc.state.tx.us/rad/long-term-svcs/contacts.shtml>

Sincerely,

Victor Perez

Director of Rate Analysis for Long Term Services & Supports



Memorial Hermann Transfer Update

Molina and Memorial Hermann Health Plan have decided not to move forward with the transfer of STAR and CHIP members in the Harris service area from Molina to Memorial. Molina remains committed to serving STAR, CHIP, STAR+PLUS, and MMP members in the greater Houston area. If you have questions, please contact your provider services representative.

Medicare-Medicaid Plan (MMP) Billing Policy: Balance Billing

Medicare-Medicaid Plan (MMP) providers contracted with Molina cannot bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers may not charge Members fees for covered services beyond copayments or coinsurance.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider. Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State or another payer such as a Medicaid Managed Care Plan is responsible for paying such amounts. Balance billing a Medicare and/or Medicaid Member for Medicare and/or Medicaid covered services is prohibited by Law. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.

For additional information please refer to the Claims and Compensation and the Compliance sections of the Provider Manual.

Corrected Claims Requirements

For HCFA 1500 claims, the corrected claim must have a resubmission code of 7 and/or the words "Corrected Claim" stamped on the image of the claim.

For UB claims, the corrected claim must have a bill type ending with digit 7 and/or the words "Corrected Claim" stamped on the image of the claim.

If the previous paid claim was processed and the corrected claim is not properly labeled, it will be denied as a duplicate claim.

Provider Demographic Updates

In an effort to maintain data integrity and up-to-date records, Molina asks that providers complete the Provider Data & Demographic Form once a quarter. The Provider Data & Demographic form can be found at www.MolinaHealthcare.com. Completed forms can be faxed to (877) 900-8452 or emailed to MHTXProviderServices@MolinaHealthcare.com.

Please Note: Providers should notify Molina 30 days in advance of any demographic changes. This includes changes to office location and office hours, contact information, tax ID numbers, NPIs, additions or terminations of an office location or provider, and the opening or closing of PCP practices to new patients.



Get Paid Faster with Electronic Data Interchange & Electronic Funds Transfer

Submitting claims electronically via Electronic Data Interchange (EDI) and receiving payment via an Electronic Funds Transfer (EFT) increases the rate in which Molina processes payments and eliminates unnecessary costs associated with paper claims and payments. EDI and EFT are free services to providers that also allow for claims to be processed faster, eliminate data entry errors and ensure HIPAA compliance.

Using EDI and EFT also allows providers to:

- Deliver information to Molina efficiently
- Have files routed to their FTP and/or associated clearinghouse
- Search for historical Explanation of Payment (EOP), also known as Remittance Advice, by claim number, member name, etc.
- View, print, download and save a PDF version of the EOP for easy reference.

For more information on EDI or EFT, contact your Provider Services Representative. If you would like to register for EDI or EFT services, visit MolinaHealthcare.com.

CAHPS Results and State Survey

Molina Healthcare of Texas is committed to continuously improving the quality of care and services delivered to our members. Each year Molina contracts with an accredited vendor to survey its membership on their perception and satisfaction with care and services they have received.

Results from the respondents to this survey are reviewed to identify all opportunities for improvement. The results for calendar year 2016 have recently been completed and areas for targeted improvement have been identified and are being shared with you. While the survey results provided some positive feedback, they also determined areas in which the dissatisfaction of our members must be addressed. Specifically, the survey results show member expressed the highest levels of dissatisfaction in the areas of appointment access and how well doctors communicate. The table below outlines survey results that were below Molina's goal to achieve the 75th percentile ranking.

Measure	MHT 2016 Scores	MHT 2015 Scores	Difference	Percentile	Goal (Met/Not Met)
Getting Needed Care	80.5%	77.8%	2.7% ↑	16th	Not Met
Getting Care Quickly	81.2%	83.0%	1.8% ↓	<10th	Not Met
How Well Doctors Communicate	88.2%	89.3%	1.1% ↓	<10th	Not Met

Molina would also like to make you aware that it annually measures compliance of contracted providers for the availability of routine, preventive, urgent and emergency care through internal audits. In addition to these audits, HHSC has recently began measuring Medicaid providers itself. Molina would like to share the results from these studies with you.

Primary Care Results			
Appointment Type	Standard	MHT Study % Compliant	HHSC Study % Compliant
Routine Care	Within 14 days	97%	67%
Urgent Care	Within 24 hours	43%	96%

Vision Provider Results		
Appointment Type	Standard	HHSC Study % Compliant
Appointment Available without Referral	Referral Not Needed	85%

OB/GYN Results		
Appointment Type	Standard	MHT Study % Compliant
Routine Care	Within 30 days	92%
Urgent Care	Within 24 hours	64%

Molina acknowledges that in today’s healthcare environment, providing care includes other aspects, such as coding of claims, documenting care in patients’ medical record, etc. While these tasks are necessary, it is important to find balance between completing these along with meeting patient expectations relating to appointment availability and wait times upon arrival at your office. Molina’s goal as you partner in providing care is to inform you of CAHPs survey member satisfaction reports, provide information regarding appointment standards set by the State and to offer support as you strive to serve our members with the highest quality of health care.

Medical Appointment Types	Standard
Routine, asymptomatic	Within 60 calendar days
Routine, symptomatic	Within 14 calendar days
Urgent Care	Within 24 hours
After Hours Care	24 hours/7day a week availability
Specialty Care (High Volume)	Within 30 calendar days
Specialty Care (High Impact)	Within 30 calendar days
Urgent Specialty Care	Within 24 hours

If you have questions regarding CAHPs survey results or appointment standards, contact Provider Services at MHTXProviderServices@MolinaHealthcare.com or call (855) 322-4080, Monday to Friday, 8 a.m. – 5 p.m. You can also submit your suggestions that may help Molina improve the satisfaction of our membership to your Provider Services representative.



Molina's Provider Portal: Information at your Fingertips

Providers throughout the Molina Healthcare of Texas network now have access to use Clear Coverage through the Provider Web Portal. Clear Coverage is a web-based application that allows providers to enter prior authorization requests electronically and receive **immediate** authorization for specific services. With Clear Coverage, you can also upload medical records; verify member eligibility, print proof of authorization and more.

The Provider Portal also allows you to identify members who are in need of various services, submit and check claims statuses and view your HEDIS scores.

Sign in to your Provider Portal profile today to access all that it has to offer! If you are not registered to use the Provider Web Portal, you can sign up by visiting Provider.molinahealthcare.com. If you have questions about the Provider Portal or Clear Coverage, please contact Provider Services.

Monthly Risk Adjustment Training Opportunities

The Risk Adjustment team, along with Molina's Quality Improvement team, offers a monthly online training session to review important Risk and Quality related topics, policies and procedures and upcoming initiatives. These sessions also give providers the opportunity to ask questions and discuss any issues they are facing.

The trainings are held every second Tuesday of the month via WebEx. The specific topics that will be covered in each month's training will be faxed to providers a week before the training. Providers can RSVP for a training session by emailing TXRiskAdjustment@MolinaHealthcare.com.

You can also use the Risk Adjustment email to contact a RA team member for questions or concerns. They can help you with reporting diagnosis codes, proper documentation and coding, answer your ACE questions and more.

Medicare ACE Forms

ACE stands for Annual Comprehensive Exam and each Molina Medicare member needs a completed exam. This is the provider's opportunity to document *all* of the member's conditions. This information is submitted to CMS and determines the member's risk score for the year.



This year, Molina targeted specific Medicare providers in regards to completing and returning the ACE forms. If you received information regarding the ACE forms, please reach out to the Risk Adjustment department with any questions at TXRiskAdjustment@MolinaHealthcare.com

Top Reasons ACE Forms are Returned to Providers:

- They do not address historical data.
- The faxed ACE form is missing pages.
- DOS is not on the form.
- Advance Directive information has not been provided.
- BMI is missing.
- When writing in the code for the diagnosis, the descriptor is not included.
- The EMR Progress note is not attached with the ACE form.

Home Health Provider Service Team Transitioned to Irving Office

Effective January 1, 2017, Molina Healthcare transitioned our Home Health Provider Services representatives to a centralized office in Irving. Provider Services Representatives will no longer be located in each service delivery area; however, they will continue to provide quality service in each area.

What this means for you:

- Home Health providers will have a dedicated and centralized team with specific home health knowledge and expertise that can identify trends and resolve issues timely.
- Provider Services representatives will be available to providers via phone and WebEx conferencing.
- Communications from this team will be focused on home health and the issues and concerns presented.
- The Home Health Provider Services team will also work with you on EVV-related concerns.

A unique mail box and fax number has been created from all home health related communications. If you have any questions or concerns, please reach out to Provider Services via email MHTXHomeHealth@MolinaHealthcare.com or via fax at (844) 310-6686.

Thank you for your continued participation in providing health care services to our Molina Healthcare members.

Texas Health Steps: Documenting Health Education and Anticipatory Guidance

Health education is designed to provide information for all ages about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. Health education for parents allows parents and caregivers to understand what to expect in terms of their child's development and how to identify potential health issues.

Health education and counseling, including Anticipatory Guidance, must be provided at each checkup and documented in the child's THSteps medical record. General categories for useful health education topics are listed in the Health Education/Anticipatory Guidance section of the Child Health Clinical Record Form. Specific age-appropriate topics are listed on the back of the Clinical Record Form. Some age-appropriate topics include, but are not limited to: nutrition and crib safety (infants), reading and toilet training (toddlers), puberty (older children), and mental health and communication (adolescents).

Providers must complete this component of the Texas Health Step checkup in order to be reimbursed for the checkup. To document the completion of the Health Education and Anticipatory Guidance component of a THSteps checkup, providers must check the box that indicates the appropriate education and guidance was provided.

For more information about Health Education and Anticipatory Guidance, documentation requirements or the Texas Health Steps program, you can reference the TMHP Provider Manual, visit the Department of State Health Services website or contact Provider Services at (855) 322-4080, Monday – Friday, 8:00 a.m. – 5:00 p.m.

Provider Complaints and Appeals

To ensure timely resolution of complaints and appeals, completed Provider Complaint/Appeal Request Forms should only be sent to:

Molina Healthcare of Texas
Attn: Provider Complaints & Appeals
P.O. Box 165089
Irving, TX 75016

Complete forms can also be faxed to (877) 319-6852.



Marketplace Growth

Open enrollment for Marketplace took place from November 1, 2016 – December 15, 2016.

As a valued partner participating in serving Molina members, we want to provide you with information to help you adjust to the growth of membership Molina experienced during the open enrollment season. Below, we have compiled a few points of interest to help guide you through the next few months as we prepare to onboard these new members.

- Molina Marketplace is growing. For the 2017 coverage year, we are expecting many Texas residents to choose Molina Healthcare of Texas as their Marketplace health plan.
- If you currently participate in Molina's Marketplace network, your information is being included in the Molina Marketplace Provider Directory. Please anticipate phone calls from prospective and new members regarding your availability to accept new patients. Please make every effort to work with these members, advise them of your availability, and schedule them for an appointment when needed.
- If you are not currently participating in Molina's Marketplace network and would like to join, complete the Contract Request Form and submit it along with a current W-9 via fax at (877) 900-5655 or via email at MHTContractRequest@MolinaHealthcare.com.
- If you have a billing or claims question, please reach out to Provider Services at (855) 322-4080 or MHTXProviderServices@MolinaHealthcare.com

We are excited about the growth of our Marketplace program and thank you for your continued support in providing access to quality healthcare to our members. Please feel free to reach out to Molina Provider Services at any time with comments, questions or concerns.



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- Group Name
- TIN
- NPI
- Service Locations
- Contact Name
- Contact Phone and Fax
- Email



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