MOLINA HEALTHCARE

Your Extended Family.

Community Supports: Provider Guide

Version 3.0

December 2023

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Introduction:

1.1. What is CalAIM

California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reform across the Medi-Cal program.

1.2. CalAIM Goals:

Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health.

Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.

Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

1.3. Purpose and Administration of Community Supports:

Community Supports are services or settings that may be offered in place of services or settings covered under the California Medicaid State Plan and that are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Community Supports are optional to offer and for Members to utilize. Members are not required to use a Community Supports instead of a service or setting listed in the Medicaid State Plan.

Medi-Cal managed care plans will have the option to integrate Community Supports into their population health management plans – often in combination with the new enhanced care management (ECM) benefit.

Community Supports must be cost effective and may not be duplicative from other State, local tax, or federally funded programs, which should always be considered first, before using Medi-Cal funding. For example, Community Supports might be provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays and emergency department use.

Please refer to the CA Medi-Cal Provider Manual for other information regarding Medi-Cal benefits.

To learn more about CS, please refer to the DHCS Community Supports Policy Guide, housed on the DHCS CalAIM Resources website: Resources (ca.gov)

MOLINA HEALTHCARE

Service Footprint:

Community Supports	Los Angeles	Riverside	Sacramento	San Bernardino	San Diego
Housing Transition Navigation Services	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Housing Deposits	7/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Housing Tenancy and Sustaining Services	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Short-Term Post-Hospitalization	1/1/2023	7/1/2022	7/1/2022	7/1/2022	1/1/2023
Recuperative Care (Medical Respite)	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Respite Services	1/1/2023	7/1/2022	7/1/2022	7/1/2022	7/1/2022
Day Habilitation Programs	1/1/2023	7/1/2022	7/1/2022	7/1/2022	7/1/2022
Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities	1/1/2023	1/1/2023	1/1/2024	1/1/2023	1/1/2024
Community Transition Services/Nursing Facility Transition to a Home	1/1/2023	1/1/2022	1/1/2023	1/1/2022	1/1/2022
Personal Care and Homemaker Services	1/1/2023	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Environmental Accessibility Adaptations (Home Modifications)	7/1/2022	1/1/2023	7/1/2023	1/1/2023	7/1/2023
Medically Tailored Meals/Medically-Supportive Food	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Sobering Centers	1/1/2022	1/1/2022	1/1/2022	1/1/2024	1/1/2022
Asthma Remediation	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022

Eligibility Criteria

Medi-Cal only, Non-aliged Duals (Medicare with a separate insurance carrier and Medi-Cal with Molina), and Molina D-SNP members with exclusively aligned enrollment (D-SNP and Medi-Cal with

Molina) are eligible for Community Supports. Los Angeles County will follow Health Net's Community Supports criteria.

Criteria for each Community Supports is as follows:

3.1. Housing Transition Navigation Services:

Assists members experiencing homelessness with obtaining housing by providing support with items such as housing applications, benefits advocacy, securing available resources, and providing help with landlords upon move-in.

- Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or
- Members who meet the Housing and Urban Development (HUD) definition of homeless and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder; or
- Members who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations; or
- Members at risk of experiencing homelessness and have one or more serious chronic conditions; have a serious mental illness; are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents); are receiving Enhanced Care Management (ECM); or are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

3.2. Housing Deposits:

Assists members experiencing homelessness with identifying, coordinating, securing or funding one-time services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as providing security deposits. These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the member is unable to meet such expense.

- Members who received Housing Transition/Navigation Services Community Supports; or
- Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or
- Members who meet the Housing and Urban Development (HUD) definition of homeless and who are receiving Enhanced Care Management (ECM), or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder.

Restriction/Limitation:

- Housing Deposits are available once in an individual's lifetime. Housing Deposits can only be approved one additional time. Referrer must provide documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more

successful on the second attempt.
- Housing Deposits over $5000 require additional approval.

3.3. Housing Tenancy and Sustaining Services:

Provides tenancy and sustaining services to maintain safe and stable residency once housing is secured for members who had been experiencing homelessness and are now newly housed.

- Members who received Housing Transition/Navigation Services Community Supports; or
- Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or
- Members who meet the Housing and Urban Development (HUD) definition of homeless and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder; or
- Members who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations; or
- Members at risk of experiencing homelessness and have one or more serious chronic conditions; have a serious mental illness; are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents); are receiving Enhanced Care Management (ECM); or are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

Restriction/Limitation:

- Housing Tenancy and Sustaining Services are only available for a **single duration in the individual's lifetime** and can be approved one additional time. Referrer must provide documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt.

3.4. Short-Term Post-Hospitalization

Provides members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care and avoid further utilization of State plan services.

- Members who have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, rehospitalization, or institutional readmission; and
- Members who are exiting recuperative care; or
- Members who are exiting an inpatient hospital stay (acute, psychiatric, or Chemical Dependency and Recovery hospital), residential substance use disorder

treatment/recovery facility, residential mental health treatment facility, correctional facility, or nursing facility AND who meet one of the following criteria:

- Members who meet the HUD definition of homeless and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder; or
- Members who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations; or
- Child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
- A child or youth who does not qualify as "homeless" under this section but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him or

- Members at risk of experiencing homelessness and have one or more serious chronic conditions; have a serious mental illness; are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents); are receiving ECM; or are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

Restriction/Limitation

- Members must be offered Housing Transition Navigation Services during Short-Term Post-Hospitalization Housing. Short-Term Post-Hospitalization Housing is available once in a member's lifetime and cannot exceed six (6) months (but may be authorized for a shorter period based on member's needs).

3.5. Recuperative Care (Medical Respite):

Provides short-term residential care for members who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. Clinical information must be provided.

- Members who are at risk of hospitalization or are post-hospitalization; or live alone with no formal supports; or face housing insecurity or have housing that would jeopardize their health and safety without modification; or
- Members who meet the Housing and Urban Development (HUD) definition of homeless and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder; or

- Members who meet the HUD definition of at risk of homelessness; or
- Members at risk of experiencing homelessness and have one or more serious chronic conditions; have a serious mental illness; are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents); are receiving ECM; or are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

Restriction/Limitation:

- Recuperative Care is not more than 90 days in continuous duration.

3.6. Respite Services

Provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief for the caregiver and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only. Home Respite Services are provided to the Member in his or her own home or another location being used as the home. Facility Respite Services are provided in an approved out-of-home location.

- Members who live in the community and are compromised in their Activities of Daily Living (ADLs) requiring dependency on a qualified caregiver, and the qualified caregiver, who provides most of the member's support, requires caregiver relief to avoid institutional placement for the member; or
- Member is a child who previously received Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, Members enrolled in either California Children's Services or the Genetically Handicapped Persons Program (GHPP), and Members with Complex Care Needs.

Restriction/Limitation:

- These services, in combination with any direct care services being received, may not exceed 24 hours per day of care. Respite Services are maxed at 336 hours per calendar year.

3.7. Day Habilitation Programs

Provided in an out-of-home, non-facility setting to assist members in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the member's natural environment.

- Members who are experiencing homelessness; or
- Members who exited homelessness and entered housing in the last 24 months; and are at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

3.8. Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities:

Assist individuals to live in the community and/or avoid institutionalization when possible. The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for members with an imminent need for nursing facility level of care (LOC).

- **Transition:**
  - Has resided 60+ days in a nursing home; and
  - Willing to live in an assisted living setting as an alternative to a Nursing Facility; and
  - Able to reside safely in the community with appropriate and cost-effective supports and services
- **Diversion:**
  - Is interested in remaining in the community; and
  - Is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and
  - Is receiving medically necessary nursing facility LOC or meets the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility

Restriction/Limitation:

- Individuals are directly responsible for paying their own living expenses.

3.9. Community Transition Services/Nursing Facility Transition to a Home:

Assists members who have been living in a skilled nursing facility to live in the community and avoid further institutionalization by supporting members with becoming newly housed and covering non-recurring setup expenses.

- Members currently receiving medically necessary nursing facility level of care (LOC) services and in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; and
- Has lived 60+ days in a nursing home and/or Medical Respite setting; and
- Is interested in moving back to the community; and
- Is able to reside safely in the community with appropriate and cost-effective supports and services.

Restriction/Limitation:

- California Community Transitions Project must be explored and utilized prior to the CS.
- Community Transition Services/Nursing Facility Transition to a Home are available once in an individual's lifetime with a **lifetime maximum of $7,500**. Community Transition Services/Nursing Facility Transition to a Home can only be approved one additional time. Referrer must provide documentation that the member was compelled to move from a provider-operated living arrangement to a living arrangement in a private residence

through circumstances beyond their control.

3.10. Personal Care and Homemaker Services:

Provides care for members who need assistance with Activities of Daily Living (ADLs)and Instrumental Activities of Daily Living (IADLs).

- Members at risk for hospitalization or institutionalization in a nursing facility or with functional deficits and no other adequate support system with:
  - Needs above and beyond any approved county In-Home Supportive Services hours when additional hours are required (pending reassessment); or
  - Initially referred to IHSS and during the IHSS waiting period to be approved and hire a caregiver (Member must be already referred to In-Home Supportive Services); or
  - Members not eligible to receive In-Home Supportive Services and need help to avoid a short-term stay in a skilled nursing facility which **cannot exceed 60 days**.

3.11. Environmental Accessibility Adaptations (Home Modifications):

Physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the member would require institutionalization.

- At risk for institutionalization in a nursing facility; and
- Has been conducted in accordance with applicable state and local building codes; and
- Physical or occupational therapy evaluation and report provided to show medical necessity; and
- Home visit conducted to determine the suitability of requested equipment or service

Restriction/Limitation:

- EAAs are payable up to a total lifetime maximum of $7,500. The only exceptions are if the Member's place of residence changes or if the member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the member, or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization.

3.12. Medically Supportive Food/Meals/Medically Tailored Meals:

Provides meals for members recently discharged from a hospital or skilled nursing facility. Meals are delivered weekly by UPS or FedEx and are tailored to the member's dietary needs.

- Members discharged from the hospital or a skilled nursing facility who are referred and meet criteria will receive up to two meals per day, and/or medically supportive food for up to four weeks per hospitalization at a maximum of 12 weeks in a calendar year; or
- Members with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders or
- Members who have extensive care coordination needs.
- **Los Angeles County**: Members must have a chronic condition; discharged from the

hospital or skilled nursing facility or at high risk of hospitalization or nursing facility placement; or have extensive care coordination needs.

3.13. Sobering Centers:

Provides alternative destinations for members who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail.

- Members aged 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, and free from any medical distress (including life-threatening withdrawal symptoms or apparent underlying symptoms) and who would otherwise be transported to the emergency department or jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.
- The service covered is for a duration of less than 24 hours.
- **Los Angeles County:** Health Net will be providing the authorization for Molina members.

3.14. Asthma Remediation:

Assists members by identifying, coordinating, securing, or funding services and modifications necessary to a home environment to ensure the health, welfare, and safety of the individual or to enable the individual to function in the home without acute asthma episodes, which could result in the need for emergency services and hospitalization. The referral must be signed by a licensed health care professional.

- Members with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two Primary Care Physician (PCP) or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the services will likely help avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

Restriction/Limitation

- Asthma Mitigation Project funding must be explored and utilized prior to the CS. Asthma Remediation are available once in an individual's lifetime with a **lifetime maximum of $7,500.** Asthma Remediation can only be approved one additional time. Referrer must provide documentation describing the significant changes to condition that additional modifications are necessary to ensure the health, welfare, and safety of the member, or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization.

Referral

Community Supports require referral forms to be completed and submitted for review as all referred members must meet the Community Supports eligibility criteria.

All Community Supports require a prior authorization with the exception of Sobering Centers. Members must consent to the submitted referral and acknowledge the once-in-a-liftetime maximum or timeframe restrictions for Housing Deposits, Housing Tenancy and Sustaining Services, Short-Term Post-Hospitalization, Recuperative Care, Home Modifications, Respite

Services – Home, Community Transition Services/Nursing Facility Transition to a Home, and Asthma Remediation.

The following Community Supports are inherently time sensitive and therefore must be subject to expedited authorization within 72 hours if submitted as an urgent request depending on the member condition/circumstance:

- Recuperative Care
- Short-Term Post-Hospitalization Housing
- Sobering Centers
- Medically Tailored Meals being offered post-acute care

Submission of the referral is an attestation that Community Supports are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Referral forms are available on the Provider website, under **Referral Forms** in the **Frequently Used Forms** section: Frequently Used Forms (molinahealthcare.com). There is a specific form for each CS service that includes the CS eligibility criteria, and instructions for submitting CS Referrals.

Once reviewed and approved for CS services, an authorization will be provided to the accepting Community Supports Provider. Referrers will be notified of the review and authorization number. Upon receiving authorization, Community Supports Providers are approved to provide services and are then eligible for reimbursement through claims submission. As Medi-Cal eligibility is subject to change on a monthly basis, please verify member's Molina Medi-Cal prior to rendering services.

For any follow up or additional questions, please reach out to the MHC Community Supports team at MHC_CS@MolinaHealthCare.Com.

Case Management

Not all members receiving Community Supports may be engaged with Molina's Case Management program or Enhanced Care Management (ECM). ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries. If a referral to ECM or Case Management is needed, please submit a referral as follows:

- **ECM:** MHC_ECM@MolinaHealthCare.Com
- **Case Management:** MHCCaseManagement@MolinaHealthCare.Com

Referral forms are available on the Provider website:
https://www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx

Step-by-Step Guide to apply for a National Provider Identifier (NPI)

Steps	Action / Additional Guidance
1. Create an account on the CMS NPI Application/Update Form page.	**Action for new applicants:** 1. Click on the 'Apply Now' link under the Related Links section at the bottom of the main page. 2. Click on "*CREATE or MANAGE AN ACCOUNT*" to be re-directed to the CMS Identify and Access Management System (I&A). Create a login through the I&A page. PRINT THE PAGE WITH YOUR USERNAME AND PASSWORD FOR YOUR RECORDS. Your organization will need the user ID and password to update its information as it changes over time. (This information is also included in the email that you will receive from NPPES when your NPI is issued.) 3. When completed you will be returned to the original NPPES page. Login to NPPES under "*Manage or Apply for your personal NPI Record*" with your I&A Username and password.
2. Start NPI Application Online Help is available from each page of the application by clicking "Help" at the top right of each of the pages.	1. Click on "*NEW NPI Application"* 2. Read Terms 3. Click on "*Submit New NPI Application*" 4. Select appropriate Entity Type: □ Type 1 - Individual (this also includes sole proprietorships) or □ Type 2 - Organizations **Note: if your organization already has an NPI, you do not need to submit a new application, though please confirm the organization's information, including taxonomy (step 8) remain accurate.**
3. Complete Provider Profile (Identifying Information)	1. Complete all applicable fields in the Provider Profile section *Note: An asterisk (*) indicates a required field*
4. Insert Business Mailing Address	1. Enter your business address*.

Steps	Action / Additional Guidance
	It is recommended that personal addresses are not used unless it is also the primary place of business.
5. Insert Business Practice Location	1. Click on "*Same As Business Mailing Address*", if applicable. 2. Enter your business phone number. It is recommended that personal phone numbers are not used, unless it is also the primary business phone number.
6. Confirm Business Mailing Address Standardization	1. Click on "*Accept Standardized Address.*"
7. Insert Other Identification Numbers	1. If your organization has obtained a Medicaid or other non-Medicare Provider Number, enter the information on this page 2. If your organization does not have those numbers, click "*Next"* to go on to the next page
8. Complete Taxonomy/License Information **For more information about Taxonomy Codes and to access the full list, please visit the CMS Find Your Taxonomy Code page.**	If your organization is applying for an NPI for the first time, please ensure that the most appropriate Taxonomy code(s) for the ECM or Community Supports services that it will be providing is entered. □ Multiple taxonomy codes may be entered; however, one code must be selected as an organization's "primary" Taxonomy code. □ Below is a general guide for selecting a taxonomy code or codes associated with the ECM and Community Supports program. If your organization already has an NPI, please ensure the Taxonomy codes in the organization's NPI profile are current and reflect the licenses and services that it will provide as part of its participation in the ECM or Community Supports programs. **For ECM Services, including:** Comprehensive Assessment and Care Management Plan, Enhanced Coordination of Care, Health Promotion, Comprehensive Transitional Care, Member and Family Supports, Coordination of and Referral to Community and Social Support Services Consider Taxonomy Code: 171M00000X-Case Manager/Care Coordinator

Steps	Action / Additional Guidance
	For Community Supports services, including: □ Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services – Consider Taxonomy code: 251X00000X - Supports Brokerage □ Short-Term Post-Hospitalization Housing, Recuperative Care (Medical Respite), Respite Services – Consider Taxonomy code: 385H00000X Respite Care □ Day Habilitation Programs – Consider Taxonomy code: 251C00000X – Day Training, Developmentally Disabled Services □ Nursing Facility Transition/ Diversion to ALF, Community Transition Services/Nursing Facility Transition to a Home – Consider Taxonomy code: 71M00000X-Case Manager/Care Coordinator □ Medically-Supportive Food/Meals/Medically Tailored Meals – Consider Taxonomy code: 332U00000X – Home Delivered Meals □ Sobering Centers: Consider Taxonomy code: 261QR0405X – Rehabilitation, Substance Use Disorder □ Personal Care and Homemaker Services – Consider taxonomy codes: 376J00000X –Homemaker 3747A0650X –Attendant Care Provider 3747P1801X – Personal Care Attendant 3747P1801X – Technician/Personal Care Attendant □ Environmental Accessibility Adaptations, Asthma Remediation (Home Modifications) – Consider Taxonomy code: 171W00000X – Contractor
9. Contact Person Information	The individual completing the NPI application will likely be in the best position to answer questions that may come up in reference to your organization's application and serve as the Contact Person. **Action:** 1. Click on *Same as Provider* 2. Under *Additional Information for the Contact Person*, use your phone number and email address
10. Certification Statement	Read the Statement, check the box and click *Submit*. The organization's application will be processed, and the

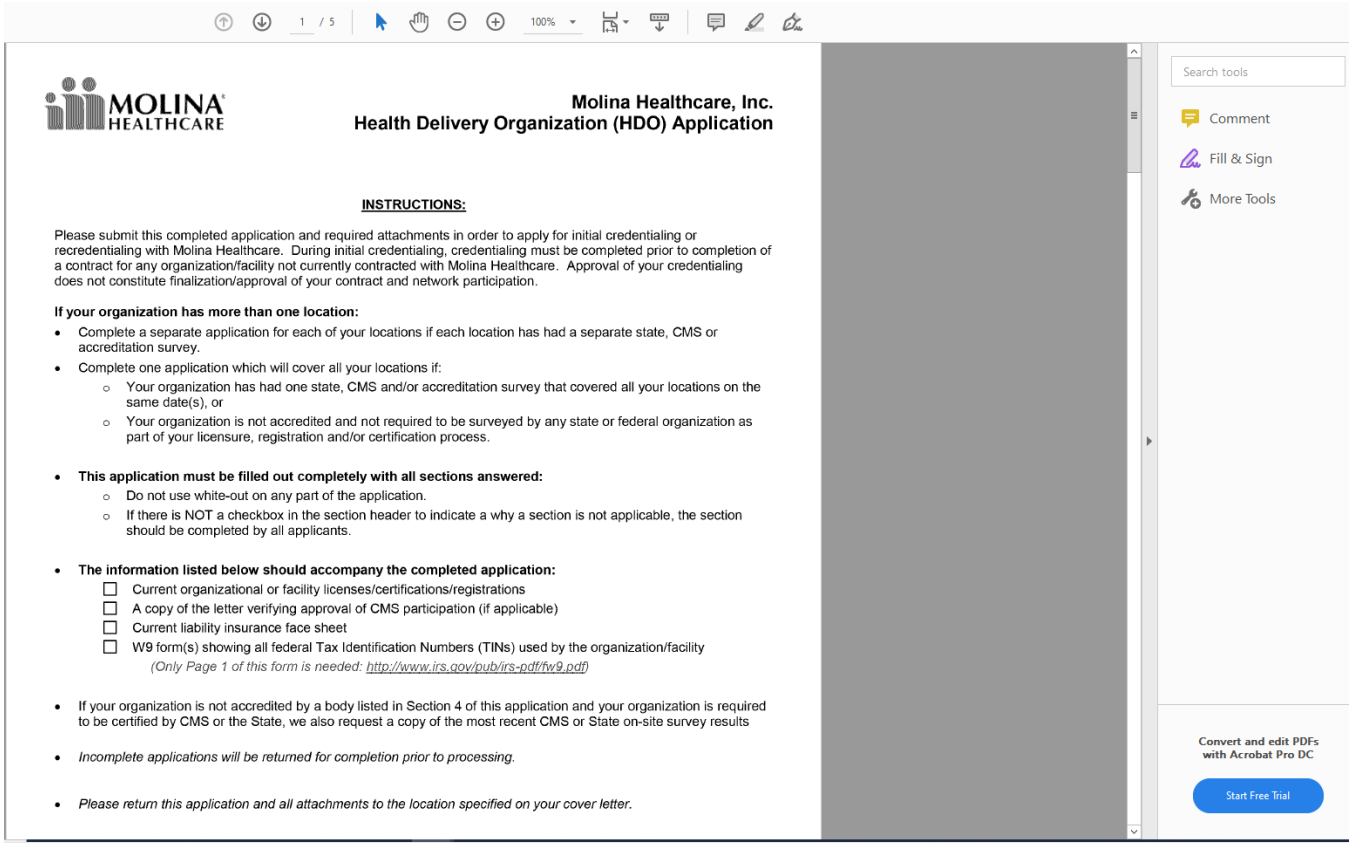
Steps	Action / Additional Guidance
	submitter will receive email notification when an NPI is issued. Print a copy of this email and retain for the organization's files as it will likely be regularly needed through the organization's billing and care coordination interactions with other ECM and Community Supports program stakeholders (e.g., managed care plans).

Credentialing

Medi-Cal managed care plan network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS All Plan Letters (APLs) including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. When there is no state-level enrollment pathway, managed care plans must have a process for vetting the CS Provider.

Please complete the following embedded application, include all required attachments, at a minimum and submit to MolinaHealthcare. Please refer to section 10.1.

Below is an extract of the application form. Please activate the form's fill feature by clicking on the "Fill & Sign" option.



MOLINA HEALTHCARE

Molina Healthcare, Inc.
Health Delivery Organization (HDO) Application

INSTRUCTIONS:

Please submit this completed application and required attachments in order to apply for initial credentialing or recredentialing with Molina Healthcare. During initial credentialing, credentialing must be completed prior to completion of a contract for any organization/facility not currently contracted with Molina Healthcare. Approval of your credentialing does not constitute finalization/approval of your contract and network participation.

If your organization has more than one location:

- Complete a separate application for each of your locations if each location has had a separate state, CMS or accreditation survey.
- Complete one application which will cover all your locations if:
  - Your organization has had one state, CMS and/or accreditation survey that covered all your locations on the same date(s), or
  - Your organization is not accredited and not required to be surveyed by any state or federal organization as part of your licensure, registration and/or certification process.

- **This application must be filled out completely with all sections answered:**
  - Do not use white-out on any part of the application.
  - If there is NOT a checkbox in the section header to indicate a why a section is not applicable, the section should be completed by all applicants.

- **The information listed below should accompany the completed application:**
  - ☐ Current organizational or facility licenses/certifications/registrations
  - ☐ A copy of the letter verifying approval of CMS participation (if applicable)
  - ☐ Current liability insurance face sheet
  - ☐ W9 form(s) showing all federal Tax Identification Numbers (TINs) used by the organization/facility
    (Only Page 1 of this form is needed: http://www.irs.gov/pub/irs-pdf/fw9.pdf)

- If your organization is not accredited by a body listed in Section 4 of this application and your organization is required to be certified by CMS or the State, we also request a copy of the most recent CMS or State on-site survey results

- *Incomplete applications will be returned for completion prior to processing.*

- *Please return this application and all attachments to the location specified on your cover letter.*

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Convert and edit PDFs with Acrobat Pro DC
Start Free Trial

Claims Management

8.1. Claims Submission

8.1.1. Billing Form

Providers are requested to submit claims on CMS-1500. Please refer to the following website for more information: https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500. Molina Healthcare of California will accept invoices from Community Supports Providers who do not have the technical capabilities to generate a claim. However, at a minimum, CA DHCS requires that Providers submit information related to the *minimum data elements* in their invoices, which are in **colored font** on the CMS-1500 image, below.

PLEASE ENSURE THAT THE "BILLING PROVIDER NAME" IN BOX 33 IS YOUR "PAYTO NAME{a space}{a dash}{a space}CS". This will aid claims being linked to the correct provider contract, which has been configured.

*All claims must be submitted within 180 days of the date of service. In addition, any corrected claims must also be submitted within 180 days of the date of service. Refer to your contract for specific timely filing requirements.

MOLINA HEALTHCARE

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PAYER PRIMARY IDENTIFIER
PAYER NAME

CARRIER

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
MEMBER CLIENT IDENTIFICATION NUMER (CIN)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
MEMBER LAST NAME, MEMBER FIRST NAME

3. PATIENT'S BIRTH DATE MM DD YY SEX M F
MM DD YYYY

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
MEMBER RESEDENTIAL ADDRESS

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY
MEMBER CITY

STATE

8. RESERVED FOR NUCC USE

CITY

STATE

ZIP CODE
MEMBER ZIP

TELEPHONE (Include Area Code)
( )

ZIP CODE

TELEPHONE (Include Area Code)
( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind.

A MEMBER DIAGNOSES CODE(S)

B C D E F G H I J K L

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 SERVICE START DATE MM DD YYYY	SERVICE END DATE MM DD YYYY	POS		PROCEDURE CODE(S)			SERVICE UNIT COST	SERVICE UNIT COUNT(S)		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
BILLING PROVIDER TAX IDENTIFICATION NUMBER (TIN)

26. PATIENT'S ACCOUNT NO.
INVOICE NUMBER

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ INVOICE AMOUNT

29. AMOUNT PAID $

30. Reserved for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a NPI b

33. BILLING PROVIDER INFO & PH # ( ) BILLING PHONE #
ENTITY TYPE QUALIFIER
BILLING PROVIDER LAST NAME, BILLING PROVIDER FIRST NAME
BILLING PROVIDER ADDRESS
a BILLING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) b

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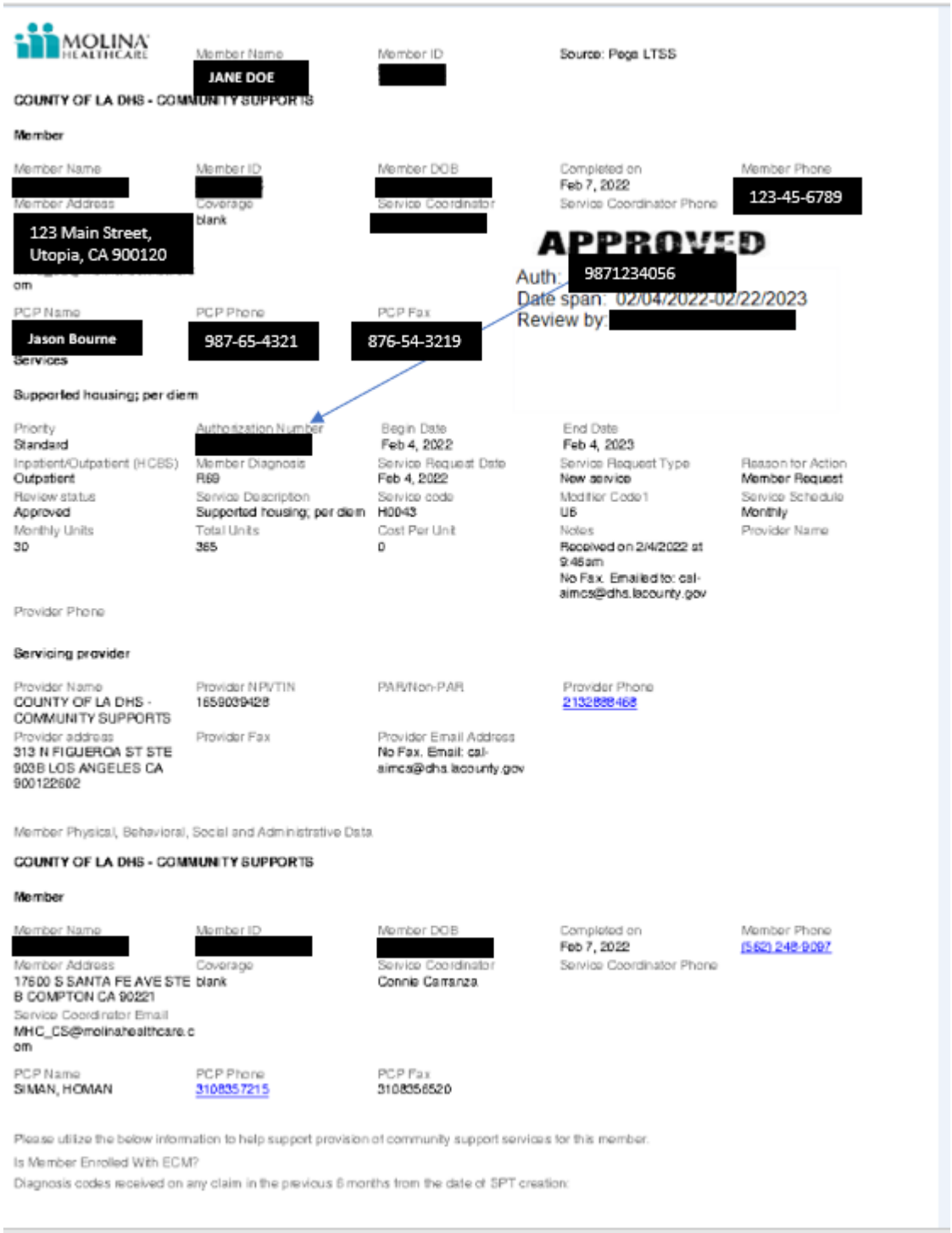
Provider Portal: https://provider.molinahealthcare.com/Provider/Login

MOLINA HEALTHCARE



MOLINA HEALTHCARE

Member Name: JANE DOE
Member ID: [redacted]
Source: Pega LTSS

COUNTY OF LA DHS - COMMUNITY SUPPORTS

Member

Member Name	Member ID	Member DOB	Completed on	Member Phone
[redacted]	[redacted]	[redacted]	Feb 7, 2022	123-45-6789

Member Address: 123 Main Street, Utopia, CA 900120
Coverage: blank
Service Coordinator: [redacted]
Service Coordinator Phone:
om

APPROVED
Auth: 9871234056
Date span: 02/04/2022-02/22/2023
Review by: [redacted]

PCP Name	PCP Phone	PCP Fax
Jason Bourne	987-65-4321	876-54-3219

Services

Supported housing; per diem

Priority	Authorization Number	Begin Date	End Date	
Standard	[redacted]	Feb 4, 2022	Feb 4, 2023	
Inpatient/Outpatient (HCBS)	Member Diagnosis	Service Request Date	Service Request Type	Reason for Action
Outpatient	R69	Feb 4, 2022	New service	Member Request
Review status	Service Description	Service code	Modifier Code1	Service Schedule
Approved	Supported housing; per diem	H0043	U6	Monthly
Monthly Units	Total Units	Cost Per Unit	Notes	Provider Name
30	365	0	Received on 2/4/2022 at 9:46am No Fax. Emailed to: cal-aimcs@dhs.lacounty.gov	

Provider Phone

Servicing provider

Provider Name	Provider NPI/TIN	PAR/Non-PAR	Provider Phone
COUNTY OF LA DHS - COMMUNITY SUPPORTS	1659039428		2132888468
Provider address	Provider Fax	Provider Email Address	
313 N FIGUEROA ST STE 903B LOS ANGELES CA 900122602		No Fax. Email: cal-aimcs@dhs.lacounty.gov	

Member Physical, Behavioral, Social and Administrative Data

COUNTY OF LA DHS - COMMUNITY SUPPORTS

Member

Member Name	Member ID	Member DOB	Completed on	Member Phone
[redacted]	[redacted]	[redacted]	Feb 7, 2022	(562) 248-9097
Member Address	Coverage	Service Coordinator	Service Coordinator Phone	
17600 S SANTA FE AVE STE B COMPTON CA 90221	blank	Connie Carranza		
Service Coordinator Email				
MHC_CS@molinahealthcare.com				

PCP Name	PCP Phone	PCP Fax
SIMAN, HOMAN	3108357215	3108356520

Please utilize the below information to help support provision of community support services for this member.
Is Member Enrolled With ECM?
Diagnosis codes received on any claim in the previous 6 months from the date of SPT creation:

Provider Portal: https://provider.molinahealthcare.com/Provider/Login

8.1.2. Claims Codes

Diagnosis Codes

Enter the appropriate diagnosis code(s) in box 21 A-L on the CMS-1500 claim form. Enter the corresponding diagnosis pointer code indicated in box 21 A-L in box 24 E for every service line entered.

Place of Service Code

Enter the appropriate place of service code in box 24 B. The place of service code list can be found in the following CMS website:

https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

Procedure Codes

Enter the procedure code that has been approved using the appropriate HCPCS code, unit and modifier, based on the description in the following table. Enter the codes in 24 D-G.

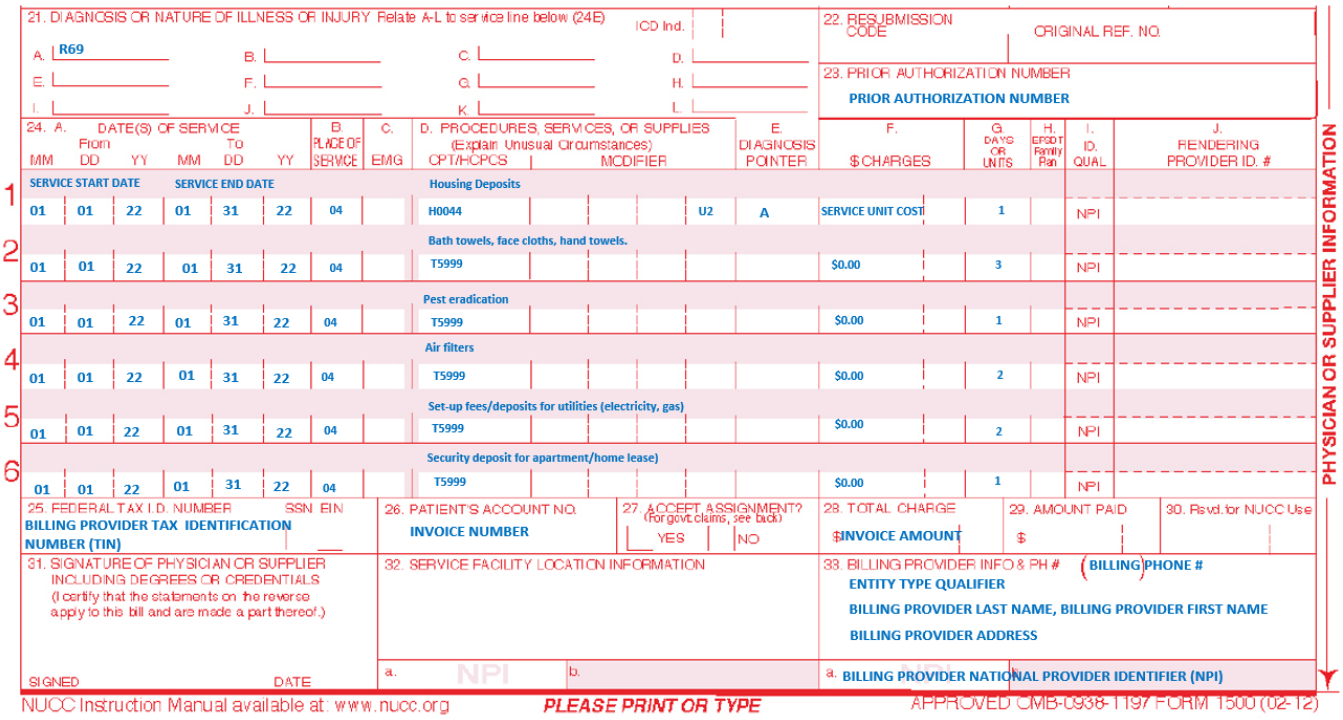
Description	HCPCS Code	Units Description	Modifier To Use	Routine Authorization Timeframe*	Initial Max Units to Authorize
Housing Transition/Navigation Services: Supported housing, per month	H0043	1 unit = 1 day (monthly case rate)	U6	Initial 12 months and 6 months thereafter	365
Housing Deposits: Supported housing, per month. Requires deposit amounts to be reported on the encounter.	H0044	1 unit = 1 month	U2	6 months	6
Housing Tenancy and Sustaining Services: Support brokerage, self-directed; per month	T2041	1 unit = 15 mins (monthly case rate)	U6	Initial 12 months and 6 months thereafter	35040

Description	HCPCS Code	Units Description	Modifier To Use	Routine Authorization Timeframe*	Initial Max Units to Authorize
Short-Term Post-Hospitalization Housing: Supported housing; per month. Modifier used to differentiate Short-Term Post Hospitalization Housing from Housing Deposits.	H0044	1 unit = 1 month	U3	3 months	3
Recuperative Care: Residential care, not otherwise specified, waiver, per diem	T2033	1 unit = 1 day	U6	Monthly	30
Respite Services – Home: Respite care, in the home; per diem	S9125	1 unit = 15 mins	U6	Daily for 4 hours and dependent on need.	16
Day Habilitation Programs: Skills training and development; per 15 minutes	H2014	1 unit = 15 mins	U6	24 hours per 6 months	96
Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities: Community transition; per service	T2028	1 unit = 1 month (monthly case rate)	U4	6 months	6

Description	HCPCS Code	Units Description	Modifier To Use	Routine Authorization Timeframe*	Initial Max Units to Authorize
Community Transition Services/Nursing Facility Transition to a Home: Community transition, per service. Requires billed amount(s) to be reported on the encounter.	T2038	1 unit = 1 month (monthly case rate)	U5	6 months	6
Personal Care/Homemaker Services: Personal care services; services, per hour	T1019	1 unit = 15 minutes	U6	Daily for 4 hours and dependent on need.	16
Environmental Accessibility Adaptations (Home Modifications): Home Modifications per service	S5165	1 unit= 1 month	U6	6 months	6
Medically-Supported Food/Medically Tailored Meals: Home delivered meal	S5170	1 unit = 1 delivered meal	U6	Up to 4 weeks	56
Sobering Centers: Alcohol and/or drug services; ambulatory detoxification	H0014	1 unit = 1 day	U6	Daily	1
Asthma Remediation: Home modifications; per service	S5165	1 unit = 1 service	U5	6 months	12 (2 units per month)

Two (2) examples of a primary/secondary claim submission:

(a) Housing Deposits:



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind.
A. R69 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
SERVICE START DATE	SERVICE END DATE			Housing Deposits							
1 01 01 22	01 31 22	04		H0044	U2	A	SERVICE UNIT COST	1		NPI	
				Bath towels, face cloths, hand towels.							
2 01 01 22	01 31 22	04		T5999			$0.00	3		NPI	
				Pest eradication							
3 01 01 22	01 31 22	04		T5999			$0.00	1		NPI	
				Air filters							
4 01 01 22	01 31 22	04		T5999			$0.00	2		NPI	
				Set-up fees/deposits for utilities (electricity, gas)							
5 01 01 22	01 31 22	04		T5999			$0.00	2		NPI	
				Security deposit for apartment/home lease)							
6 01 01 22	01 31 22	04		T5999			$0.00	1		NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
BILLING PROVIDER TAX IDENTIFICATION NUMBER (TIN)

26. PATIENT'S ACCOUNT NO.
INVOICE NUMBER

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE
$INVOICE AMOUNT

29. AMOUNT PAID
$

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.

33. BILLING PROVIDER INFO & PH # (BILLING) PHONE #
ENTITY TYPE QUALIFIER
BILLING PROVIDER LAST NAME, BILLING PROVIDER FIRST NAME
BILLING PROVIDER ADDRESS
a. BILLING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI)

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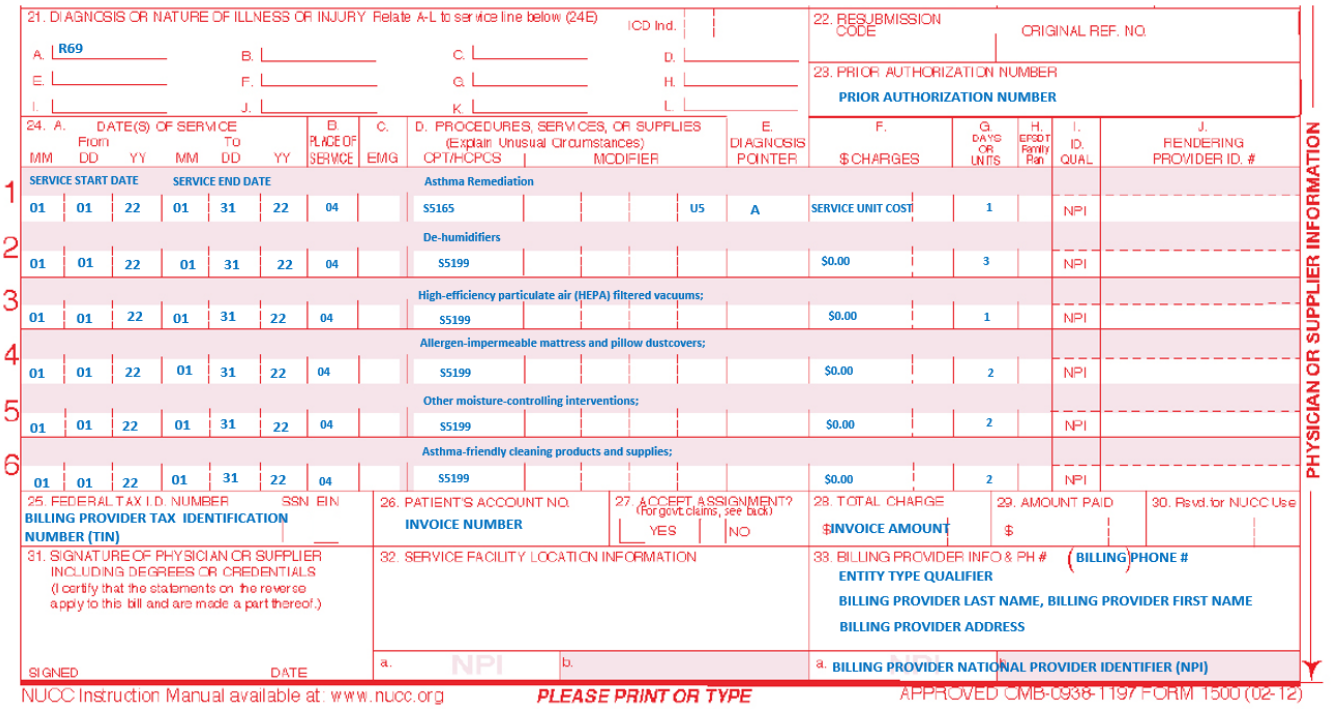
(b) Asthma Remediation:



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind.
A. R69 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
SERVICE START DATE	SERVICE END DATE			Asthma Remediation							
1 01 01 22	01 31 22	04		S5165	U5	A	SERVICE UNIT COST	1		NPI	
				De-humidifiers							
2 01 01 22	01 31 22	04		S5199			$0.00	3		NPI	
				High-efficiency particulate air (HEPA) filtered vacuums;							
3 01 01 22	01 31 22	04		S5199			$0.00	1		NPI	
				Allergen-impermeable mattress and pillow dustcovers;							
4 01 01 22	01 31 22	04		S5199			$0.00	2		NPI	
				Other moisture-controlling interventions;							
5 01 01 22	01 31 22	04		S5199			$0.00	2		NPI	
				Asthma-friendly cleaning products and supplies;							
6 01 01 22	01 31 22	04		S5199			$0.00	2		NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
BILLING PROVIDER TAX IDENTIFICATION NUMBER (TIN)

26. PATIENT'S ACCOUNT NO.
INVOICE NUMBER

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE
$INVOICE AMOUNT

29. AMOUNT PAID
$

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.

33. BILLING PROVIDER INFO & PH # (BILLING) PHONE #
ENTITY TYPE QUALIFIER
BILLING PROVIDER LAST NAME, BILLING PROVIDER FIRST NAME
BILLING PROVIDER ADDRESS
a. BILLING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI)

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Provider Portal: https://provider.molinahealthcare.com/Provider/Login

8.1.3. Modes of Submission

Claims should be submitted electronically through eAvaility Essentials, Molina's Provider Portal. All providers are encouraged to submit claims electronically.

- **Electronic**:
  - Availity at https://provider.molinahealthcare.com/Provider/Login , or
  - Alternatively, providers may also utilize our clearinghouse, Change Healthcare (CH), for submission, as follows:
    - CH's Telephone #: 1-877-469-3263
    - Molina's Payer ID # with CH: 38333
- **Mail** to:

  Molina Healthcare of California
  P.O. Box 22702
  Long Beach, CA 90801

Please keep the following in mind when submitting paper claims:

- Paper Claim submissions are not considered to be "accepted" until received at the appropriate Claims Box; Claims received outside of the designated Box will be returned for appropriate submission. PO PO
- Paper Claims are required to be submitted on original red and white CMS-1500 and CMS-1450 (UB-04) Claim forms.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.
- Claims must be typed with either 10- or 12-point Times New Roman font, using black ink.
- Link to paper Claims submission guidance from CMS: https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500

EDI (Clearinghouse) Submissions:

837P

- In the 2300 Loop, the CLM segment (Claim information) CLM05-3 (Claim frequency type code) must indicate one of the following qualifier codes:
  - "1"-ORIGINAL (initial Claim)
  - "7"–REPLACEMENT (replacement of prior Claim)
  - "8"-VOID (void/cancel of prior Claim)
- In the 2300 Loop, the REF *F8 segment (Claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

837I

- Bill type for UB Claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the "1" "7" or "8" goes in the third digit for "frequency".
- In the 2300 Loop, the REF *F8 segment (Claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

Provider Portal

Providers are required to register for and utilize Molina's Provider Portal – Availity Essentials. Molina's Provider Portal is an easy to use, online tool available to all of our Providers at no cost.

Availity Essentials portal: provider.MolinaHealthcare.com

Providers and third-party billers can use the no cost Availity Essentials portal to perform many functions online without the need to call or fax Molina.

Registration can be performed online and once completed, the easy-to-use tool offers the following features:

- Verify Member eligibility, covered services and view HEDIS needed services (gaps)
- Claims:
    - Submit Professional (CMS 1500) and Institutional (UB04) claims with attached files
    - Correct/Void Claims
    - Add attachments to previously submitted claims
    - Check claims status
    - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
    - Create and manage claim templates
    - Create and submit a claim appeal with attached files
- Prior Authorizations/Service Requests
    - Create and submit Prior Authorization/Service Requests
    - Check status of Authorization/Service Requests
    - Download forms and documents
    - Send/receive secure messages to/from Molina

Electronic Payment (EFT/ERA)

Participating Providers are required to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) payments and registering for Molina's Availity Essentials portal within 30 days of entering the Molina network.. Please refer to the Provider Manual for more information. Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the

Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery processes.

Below is the link to register with Change Healthcare ProviderNet to receive electronic payments and remittance advices. Additional instructions on how to register are available at EDI/ERA/EFT tab on Molina's website: www.MolinaHealthcare.com.

Any questions during this process should be directed to Change Healthcare Provider Services at wco.provider.registration@changehealthcare.com or 877-389-1160.

Contact Information

11.1. Credentialing:

Completed credentialing applications may be submitted to the Molina Healthcare point of contact the Provider is working with *or* to the applicable MHC Contracting mailbox address listed below:

- MHCSanDiegoContracts@MolinaHealthCare.Com
- MHCSacramentoContracts@MolinaHealthCare.Com
- IEContracting@MolinaHealthCare.Com
- MHCSanDiegoContracts@MolinaHealthCare.Com
- MHCImperial.Contra@MolinaHealthCare.Com

11.2. Contracting:

All Counties	Manager, Provider Contracts: Jeremy Encarnacion-Morrison Jeremy.Encarnacion-Morrison@molinahealthcare.com Contract Specialist: Mary Hernandez Mary.Hernandez2@molinahealthcare.com

11.3. Provider Services:

COUNTY	GROUP EMAIL	PROVIDER SERVICE REPRESENTATIVES
LOS ANGELES	MHC_LAProviderServices@MolinaHealthCare.Com	Provider Service Rep (LA): Arias, Clemente Clemente.Arias@molinahealthcare.com Provider Service Rep (LA): Diaz, Chris Christian.Diaz@molinahealthcare.com
RIVERSIDE / SAN BERNARDINO	MHCIEProviderServices@MolinaHealthCare.Com	Provider Service Rep (Riverside): Howard,Mimi Smimi.Howard@molinahealthcare.com Provider Service Rep (San Bernardino): McIver, Luana

COUNTY	GROUP EMAIL	PROVIDER SERVICE REPRESENTATIVES
		Luana.McIver@molinahealthcare.com Provider Service Rep (San Bernardino/Riverside): Lomeli, Vanessa Vanessa.Lomeli2@molinahealthcare.com
SAN DIEGO	MHCSanDiegoProviderServices@MolinaHealthCare.Com	Provider Service Rep (SD): Liciaga, Carlos Carlos.Liciaga@molinahealthcare.com Provider Service Rep (SD): Perez, Sal Salvador.Perez@molinahealthcare.com Provider Service Rep (SD): Givens, Briana Briana.Givens@molinahealthcare.com
SACRAMENTO/ IMPERIAL	Sacramento: MHCSacramentoProviderServices@MolinaHealthCare.Com Imperial: MHCImperialProviderServices@MolinaHealthCare.Com	Provider Service Rep (SAC):