LTSS

Care Coordination for LTSS

Care Coordination Processes

Managed care is designed to integrate acute, behavioral, social, environmental, and long-term services and supports (LTSS). Care coordination is the cornerstone to the program. Local, dedicated care coordination teams help members and providers navigate healthcare delivery systems and interface with Molina.

Molina HCS Staff work with Providers to assist with coordinating referrals, services and benefits for these Members.

Molina staff assists Providers by identifying needs and issues that may not be identified by Providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers, Members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

Care coordinators act as the member's advocate. They will assess for need, develop a care plan, and arrange for the delivery of the needed services.

Care Coordination for LTSS

Care Coordination is an overarching program comprised of Care Management, Complex Case Management, and Service Coordination.

- NF LOC assessments are completed:
  - Within 30 calendar days of member request for CB services,
  - Annually,
  - Within 5 business days of becoming aware of change in member's functional or medical status that may affect level of care determination.
- NF LOC assessment and service determination are completed as part of the CNA.
- NF LOC determination is completed by Second Level Reviewer then uploaded to State's program.
- Members from other MCOs with active Care Coordination Level 1 (CCL1), Care Coordination Level 2 (CCL2), NF LOC will be assigned immediately to a culturally aware Care Coordinator with the CNA scheduled within 7 days of enrollment.
  - NF LOC will be confirmed during this time.
- CCP will be completed with LTSS Members within 14 days of the CNA.
- Not Otherwise Medicaid Eligible (NOMEs) members can receive services if their NF LOC evaluation shows that they are receiving care in a nursing facility or if have the capacity to receive care under Community Benefits.

Agency Based Community Benefit (ABCB)

Covered Services

- Adult Day Health
- Assisted Living
- Behavior Support Consultation
- Community Transition Services
- Emergency Response
- Employment Supports
- Environmental Modifications (
- Nutritional Counseling

- Personal Care Services
- Home Health Aide
- Private Duty Nursing for Adults
- Respite
- Skilled Maintenance Therapy Services (OT/PT/ST)
- EPSDT Personal Care

Agency Based Community Benefit (ABCB)

ABCB Providers are to be audited on an annual basis to determine compliance with the requirements defined in the contract and the New Mexico Administrative Code (NMAC).

Molina will collaborate with the other MCOs to develop an audit schedule that ensures that all ABCB providers are audited only once per calendar year.

Providers are required to submit the requested documentation within fourteen (14) calendar days from the date of the letter. Upon completion of the audit, Providers will receive a notification of the results.

Providers are required to comply with all formal documentation requests, and usage of an audit tool. Providers will receive a non-compliance letter if failure to comply with the request.

Self-Directed Community Benefit Review (SDCB)

Self-Directed Community Benefit (SDCB) is an alternative to institutional care that facilitates greater Member choice, direction and control over services and supports in their home and community. The Member or their representative becomes the employer of record, hires their providers, and decides how much providers are paid (within a range rates provided by Human Services Division). **Who can choose Self-Directed?**

- Members who have been in Agency-Based Community Benefit for at least 120 days
- Members who meet Nursing Facility level of care

Members are responsible for implementing and directing their own SDCB services

Self-Directed Community Benefit (SDCB)

Covered Services

- Behavior Support Consultation
- Customized Community Supports
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Homemaker/Personal Care
- Nutritional Counseling

- Private Duty Nursing for Adults
- Related Goods
- Respite
- Respite RN
- Skilled Maintenance Therapy Services
- Specialized Therapies
- Transportation (non-medical)

Self-Directed Community Benefit Terms

- **FMA: Fiscal Management Agency** – entity contracted with the State that makes payment for services rendered, processes timesheets or invoices and bills Medicaid for services and goods approved on the Service and Support Plan.

- **Support Broker** – Assists member with executing service plan according to budget, arranging for and managing services, recruiting and hiring, approves timesheets, problem-solving. Develops, implements and monitors the SDCB care plan and budget. May be employed by Molina or work for approved support broker agency.

- **Self-Assessment** – tool used to determine if Member can be his/her own Employer of Record or if another person should be designated.

- **EOR: Employer of Record –** Must be legal representative of the Member directs the work, tracks expenditures and authorizes payment

Support Broker

Role of the Support Broker:

- Once the SDCB Member has identified a Support Broker, the Care Coordinator will enter the nursing facility level of care dates, Member demographics, and budget amount into PALCO. The Supports Broker receives an alert in PALCO.
- The Support Broker contacts the Member and conducts a face-to-face visit within 10 calendar days and completes the following:
    - Educates Member on how to use SDCB supports and services
    - Assists Member with developing and creating a Comprehensive Care Plan
    - Submits the care plan in PALCO for Care Coordinator to review.

Support Broker & PALCO

Who is PALCO?

- PALCO processes payments for approved goods and services
- Members are enrolled in PALCO system when they enroll in SDCB
- Care Coordinators and Support Brokers are trained to enter budget amounts, build and revise Care Plans, request reports, inquire about Member/EOR timesheets, view SDCB budget usage and balances

Support Broker Functions

- Educating Members on how to use supports and services
- Updates Member on program changes or updates
- Reviews, monitors and documents services and budget
- Assists Members with managing budgets and submitting revision requests
- Assists with approving and processing job descriptions
- Assists with completing employee forms
- Assists with approving timesheets and invoices for goods and services
- The Support Broker also assesses the adequacy of the Member’s back-up plan on at least an annual basis and any time there are changes to the schedule or providers.
- This includes changes in natural supports or back-up providers that may affect the back-up plan already in place.

Self-Assessment

Self-Assessment Process

- A self-assessment instrument developed by HCA
- Care Coordinator assists Member with completing self-assessment
- If self-assessment results determine that Member requires assistance to direct his or her services, the Care Coordinator will inform the Member of the need to designate an Employer of Record to assume functions on his or her behalf.

Monitoring Budgets

The SDCB Member/Employer on Record (EOR), Care Coordinator and Supports Broker are responsible for monitoring the SDCB budget.

Molina is responsible for arranging for initial and ongoing training of Members/EORs.

The Care Coordinator and Support Broker are responsible to ensure SDCB services are appropriate and to identify interventions to put in place to ensure needed goods and services are available for the remainder of the SDCB Care Plan year.

Home and Community-Based Services (HCBS)

Medicaid HCBS direct care staff will be trained on and understand the requirements of the HCBS Settings Rule

- The Centers of Medicare and Medicaid Services (CMS) issued a Final Rule for HCBS on January 16, 2014. Providers have until **March 17, 2023**, to make sure all settings where Medicaid HCBS are delivered meet the requirements of the HCBS Settings Rule.
- All Medicaid HCBS direct care staff must be prepared to assist members who reside in an ALF (Adult Living Facility)or an AFC (Adult Foster Care) with modifications* necessary to meet the HCBS Settings Rule requirements.

The purpose of the HCBS Settings Rule is to:

- Enhance the quality of HCBS
- Provide protections to all Medicaid recipients
- Ensure access to the benefits of community living
- Medicaid HCBS recipients to have the same right receiving HCBS
- Any modifications must be based on individual needs and assessments

Opportunity to:

- Engage in community life
- Work in competitive integrated settings
- Members can control personal resources

**A modification is considered a person-centered change that is made to improve the member's quality of life and enables them to make the choices of how they want to live.*

Overview of HCBS Settings Rule

The Home and Community-Based setting must provide a person-centered service plan that must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual regarding preferences for the delivery of such services and supports. The written plan must:

- Reflect the setting in which the individual resides is choses by the individual
- Support the individuals access to the greater community, including opportunities to seek employment and work in competitive integrated settings
- Engage in community life
- Control personal resources
- Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS
- For a full list of requirements, visit: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441#subpart-G
- Additional Resources: Exploratory Questions to Assist States in Assessment of Residential Settings**Exploratory** Questions to Assist States in Assessment of Non-Residential Home and Community-Based Service (HCBS) Settings

Overview of Existing HCBS Programs and Authorities

In addition to the HCBS Finaly Rule applying to 1915(c), 1915(I), 1915(j), and 1915(k) authorities, CMS issued guidance in December 2014 to states with Section 1115 waivers that include HBCS as part of the program design. The New Mexico Human Services Department's Medical Assistance Division (MAD) provides HBCS under the following four programs:

- 1915(c) Mi Via Waiver
- 1915(c) Developmental Disabilities Waiver
- Section 1115 Centennial Care Demonstration Waiver
- 1915(c) Medically Fragile Waiver

CMS issued guidance that states currently operating HCBS programs, regardless of the federal authority under which the programs operate, must submit a Statewide Transition Plan (STP) for approval. The STP must include the state's assessment of its regulations, standards, licensing requirements and provider requirements against the requirements in the HCBS Final Rule. The STP is also to describe the State's ongoing strategies to accomplish compliance with all federal requirements, including timeframes and deliverables.

For more information: **New Mexico STP**
Click here for: **Final Rule Medicaid HCBS**

Overview of HCBS Settings Rule

HCBS

Providers of HCBS are subject to the State plan amendment to implement the temporary economic recovery payments for HCBS. Uniform percent increase to contracted rates as approved in New Mexico's APRA HCBS Spending Plan. Monthly Capitation, Per encounter.

Home & Community Base Services (HCBS) program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization.

Recipients in the Developmental Disabilities 1915(c) Waiver and in the Medically Fragile 1915(c) Waiver will continue to receive HCBS through that waiver but are required to enroll with an MCO for all non-HCBS.

For Members receiving HCBS in a provider owned or controlled setting, the care coordinator shall assess Member experience and provider compliance with federal home and community-based (HCB) settings requirements during face-to-face visits with Members, using the process and tools approved by HCA.

HCBS Final Setting Rule Training

HCBS Final Settings Rule training is required by the New Mexico Human Care Authority for all providers contracted with Molina. The training is available on our Molina Healthcare of New Mexico website, along with the HCBS Final Rule Attestation.

Additionally, contracted providers are required to conduct annual onsite screenings.

The Care Coordination assessments and touchpoints will allow MCO's to gather information on the HCBS Final Settings Rule Requirements

Nursing Facility Level of Care (NF LOC)

Nursing Facility Level of Care (NF LOC)

NF LOC means the Member's functional level is such that two (2) or more Activities of Daily Living (ADLs) cannot be accomplished without consistent, ongoing, daily provision or assistance with prompting, of some or all of the following levels of service: skilled, intermediate or assisted. A Member must meet the NF LOC to be eligible for NF placement and community benefit services.

The Nursing Facility Level of Care (NF LOC) Communication Form is used by the MCOs and is sent to the nursing facility to request further Resident information.

For more information regarding the NF LOC process, visit: Nursing Facility Level of Care (NFLOC) | New Mexico Human Services Department (state.nm.us)

Important Reminder:

The Nursing Facility Level of Care (NF LOC) Notification Form is to be used for service authorization request.

Nursing Facility Admissions

Medicaid provides for medically necessary health services to eligible recipients in nursing facilities. Prior approval is required.

Admission Requests: Molina is to be notified within twenty-four (24) hours of a Member's admission or request for admission, including short term stays. Nursing Facility Level of Care (NF LOC) packets must be faxed within thirty (30) days of admission and sixty (60) days prior to expiration. If not submitted within a timely manner it will affect the Member's eligibility.

Readmissions: When a resident leaves the nursing facility for three or more midnights for an inpatient hospital stay, a readmission review is required. Within thirty (30) days the nursing facility must submit a re-admit approval request form, the hospital discharge summary and/or residents admission note back to the nursing facility.

- If NF LOC expiration is greater than thirty (30) days, additional days will be assigned from the re-admit date. The nursing facility sends the notification form to Molina along with supporting documentation
- If NF LOC expires in less than thirty (30 calendar days), the nursing facility will not submit a re-admit notification form. Instead, the nursing facility should submit a re-determination (annual or continued stay) request on the notification for along with supporting documentation.

Nursing Facility Transfers

Procedure for Transfers Between Nursing Facilities

- The nursing facility must notify Molina by telephone and ISD (via CIU) when a transfer is to occur from one nursing facility to another. The receiving nursing facility will provide Molina with the date of the transfer. Without this information, claims submitted by the receiving nursing facility will not be paid.
- If there are more than thirty (30) calendar days on the resident's current Level of Care, Molina will send the receiving nursing facility the completed notification form which will include the service authorization and date span on the current Level of Care.
- If there are less than thirty (30) calendar days remaining on the current Level of Care, the receiving nursing facility will request a Continued Stay request with all other required documents for Continued Stay. The days remaining on the current Level of Care will be added to the Continued Stay. The request should indicate that a transfer has occurred.
- Please write "TRANSFER" in the type of request box on the notification form.

Nursing Facility Discharges

Discharge Status Documentation Requirements

Nursing facilities are required to notify Molina within twenty (24) hours of a Member's Discharge. Receipt of an LNF denial for Members who would constitute an unsafe discharge, the following documentation must be submitted:

- A valid LOC order
- Physician orders are valid for sixty (60) days from date of receipt
- Current Minimum Data Set (MDS) for the time frame requested
- Submitted of a Continued Stay request for a resident in Discharge Status must acknowledge the resident's Discharge Status and document the facility's ongoing attempts in conjunction with the Care Coordinator's effort to find and develop appropriate community placement options for the resident.

Nursing facilities should notify their assigned Nursing Facility Care Coordinator or Reintegration Specialist as soon as possible to start the process of a safe reintegration.

Notification is also required for:

- Member left Against Medical Advice
- Hospital and/or Emergency Room encounters
- Death

Nursing Facility Minimum Data Sets

Minimum Data Set (MDS)

An MDS and other appropriate documentation must be completed for each resident for every situation requiring prior approval.

All locator fields must be clearly marked on the MDS.

Appropriate documentation must accompany the MDS including a valid order and must be signed by a: physician, nurse practitioner, clinical nurse, specialist or physician assistant; be dated; and indicate the LOC – either high NF (HNF) or low NF (LNF)

Nursing Facility Reminders

Initial Determinations	Services must be medically necessary
Redeterminations	All documentation must be received by Molina Healthcare with in sixty (60) calendar days prior to the new certification period for LNF and thirty (30) calendar days HNF
Retroactive Medicaid Eligibility	Written requests for prior approval based on resident's financial eligibility must be reviewed within thirty (30) calendar days of the date of the eligibility determination

Managed Care Policy Manual

The purpose for the Managed Care Policy Manual is to provide a reference for the policies established by HCA for the administration of the Medicaid managed care program and to provide direction to the Managed Care Organizations (MCOs) and other entities providing service under managed care. The Manual is intended to provide guidance; it is not intended to, nor does it create, any rights that are not contained in the Agreement of NMAC rules.

Link: [Managed Care Policy Manual | New Mexico Human Services Department (state.nm.us)]

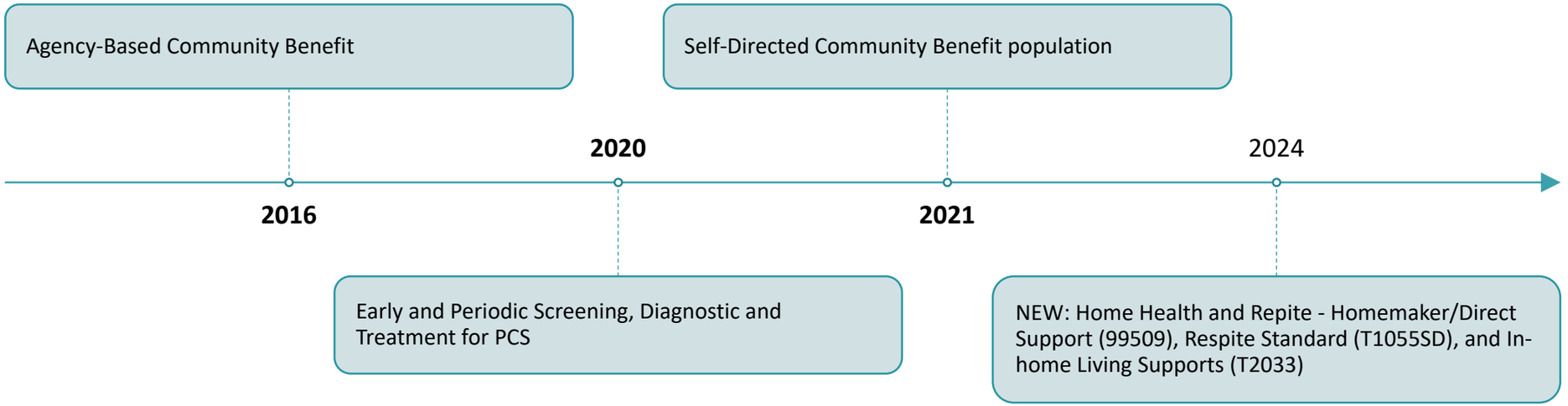
HUMAN SERVICES DEPARTMENT

Medical Assistance Division

Managed Care Policy Manual

Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) is a federal requirement from the 21st Century Cures Act, passed by Congress in 2016, and mandated to be in place by January 1, 2021. EVV is required for all Medicaid funded in-home personal care services, and home health care services as a verification that care services were provided. EVV is an electronic system called AuthentiCare that allows caregivers to clock-in and clock-out as required by federal law. EVV allows more accurate service tracking, reporting, and billing for caregiver services.



Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) Training & Payment

- Once a provider has become enrolled with and Molina, they should begin training on how to use the Electronic Visit Verification (EVV) system.
- Users can access the FISERV/AuthentiCare EVV database: https://www.authenticare.com/nmcc/login.aspx

Contact Information

Provider Administrators & Support Brokers

- Login Information: Login | AuthentiCare
- AuthentiCare Technical Support Center: 1-800-441-4667, Option 6, 6:00 AM –6:00 PM MST, M-F
- AuthentiCare Technical Support Email: authenticare.support@fiserv.com

Workers

- PCS/Home Health: Contact Provider Administrators for training and technical assistance
- SDCB: Contact EOR for training and technical assistance

Employer of Records (EORs)

- PCS/Home Health: Contact Provider Administrators for training and technical assistance

Electronic Visit Verification (EVV)

Providers have three (3) options when using the EVV system:

AuthentiCare		
Option 1: Caregivers will call a toll-free phone number to call into the AuthentiCare system to clock-in and clock-out.	Option 2: Caregivers may use a cell phone to launch the AuthentiCare application to clock-in and clock-out.	Option 3: Caregivers may use a tablet or computer to access the AuthentiCare application to clock-in and clock-out.

Electronic Visit Verification (EVV)

Manually Entered Web Claims

In April 2018 AuthentiCare deployed an enhancement that allows MCOs to review all manually entered claims. This enhancement requires Personal Care Service agencies to collect and maintain documentation for every manually entered transaction and use of an exception. Providers are required to provide detailed notes on each manually entered web claim. If additional information needed for any web-based claim, the provider will receive a request to submit supporting documentation to further justify the reason for the manual entry.

Important Reminders:

- Worker Relationships: You are required to identify the worker relationship (parent, spouse, or other, etc.) in AuthentiCare for each Member
- When logged into the AuthentiCare system, the agency can find helpful resources under the Customer Links tab on the home screen. Resources include the AuthentiCare User Manual Provider Documents, and the SDCB Training.

SDCB and Palco: EVV Service Codes

When your caregiver clocks-in or clocks-out, they are to use the EVV Service code that is approved within your care plan.

SDCB Service Code	SDCP Service Code Description
99509	Self-Directed Personal Care
99509E	Self-Directed Personal Care Exception
T1005HHA	Respite – Home Health Aide
T1005HHAE	Respite – Home Health Aide Exception
T1005LPN	Respite - LPN
T1005LPNE	Respite – LPN Exception
T1005RN	Respite – RN
T1005RNE	Respite – RN Exception
T1005SC	Respite- Substitute Care
T1005SD	Respite - Standard
T1005SDE	Respite – Standard Exception

Home Health: EVV Service Codes

When your caregiver clocks-in or clocks-out, they are to use the EVV Service code that is approved within your care plan.

Revenue Code	Procedure Code	Service	Activity Code	Same Day Unit Restrictions
0421	G0151	Physical Therapy Visit	N/A	6 units
0421	G0157	Physical Therapy Assistant	N/A	6 units
0441	G0153	Speech Language Therapy Visit	N/A	6 units
0431	G0152	Occupational Therapy Visit	N/A	6 units
0431	G0158	Occupational Therapy Assistant	N/A	6 units
0571	G0156	Home Health Aide	N/A	8 units
0551	G0300	Skilled Nursing LPN	21-LPN observation 22-Skilled Nursing LPN	8 units
0551	G0299	Skilled Nursing RN	23-RN management of POC 24-RN observation of patient 25-Skilled Nursing RN-training	8 units
0561	G0155	Social Worker Visit	N/A	6 units

PCS: EVV Service Codes

When your caregiver clocks-in or clocks-out, they are to use the EVV Service code that is approved within your care plan.

PCS Service Code	SDCP Service Code Description
99509	Personal Care- Consumer Directed
T1019	Personal Care Consumer Delegated
S5110	Personal Care-Consumer Directed Training
X9999	Supervisory Visit
S5125	EPSDT Personal Care
G9006	Consumer Directed Administrative Fee
G9012	Consumer Directed Advertisement Reimbursement
G9006U1/G9006U2	Stipend Service 100%/Stipend Service 50%
99509U1	Respite
T1003U1	Respite LPN
T1002U1	Respite RN

EVV: Now Available

URGENT ACTION REQUIRED: EVV Home Health and Medically Fragile Providers: Your claim submission process will change effective January 1, 2024, for the following Provider Types:

Home Health Providers associated with Provider Type 361 (Home Health Agency)

- Services include Skilled Nursing, Home Health Aide and Therapies

Medically Fragile Providers

- Services include Home Health Aide and Home Health Aide-Respite

The 21st Century Cures Act mandates that States shall implement Electronic Visit Verification (EVV) for all Home Health Services which require an in-home visit by a healthcare worker.

Changes will require Providers to use AuthentiCare, rather than the Medicaid Portal, to enter and submit claims.

Click here for more information.

Contact Us

Provider Escalation Steps

- **Do you have a question? We can help!**

1

Call Provider Services Contact Center

Phone: (855) 322-4078
Hours: Monday-Friday 8am-5pm MST

2

Contact Availity

Availity Essentials: Molina Provider Portal
Provider can inquire via **Secure Claims Messaging** or **Claims Inquiry Tool**
(please note: this tool will connect you to the dedicated Molina NM Analyst Team)

3

Reach out to your Provider Relations Representative

Providers should visit the Regional Map to locate their personal rep for their county:
Molina NM Rep Map
Providers can contact the provider services general box: MHNM.ProviderServices@molinahealthcare.com

4

Reach out to your Molina EVV team

Providers can contact the provider services general box: NMEVV@MolinaHealthCare.Com

Contact Health Plan Leadership Directly

Marlene Driscoll – Manager, Provider Relations: Marlene.Driscoll@MolinaHealthCare.Com

Thank you!