### Molina Healthcare

2020 Contracting and Credentialing Orientation



### **Agenda**

□ Contracting Overview
■ Medicaid ID Number
Non-Participating Provider Reimbursement
☐ Service Agreement
<b>□</b> W9
Ownership Control and Disclosure Form (OWN)
☐ Provider Information Form (PIF)
☐ Mississippi Participating Physician Application (PPA)
☐ Health Delivery Organization (HDO)
□ Review/Credentialing
□ Delegated Credentialing
□ Post Credentialing
□ Re-Credentialing
□ FAQs
□ Questions



### **Contracting Overview**

Providers who are interested in joining our network will need to complete and submit a **Provider Contract Request Form** (CRF). This request is for providers who are not billing under a Tax ID that is already contracted and participating in Molina's network.

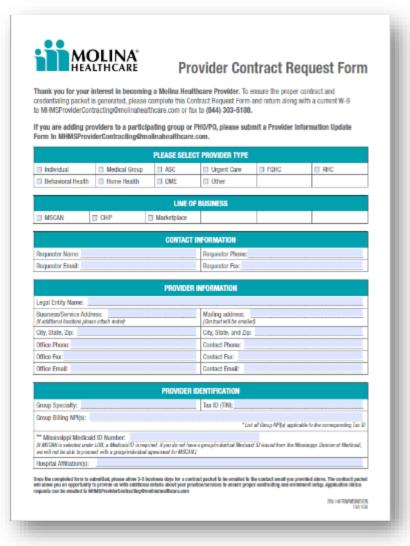
Please be thorough when completing this document. Providers can access the CRF at:

https://www.molinahealthcare.com/providers/ms/medicaid/forms/Pages/fuf.aspx

Upon completion of the form, please submit it via email to <a href="MHMSProviderContracting@Molinahealthcare.com">MHMSProviderContracting@Molinahealthcare.com</a>

Once Provider Contracting has received your completed CRF, a Contracting Specialist will send the contracting packet to the point of contact listed on the request.

You may contact **Jordan Black**<u>Jordan.Black@MolinaHealthcare.com</u> or **Sam Measels**<u>W.MeaselsIII@MolinaHealthcare.com</u> directly for additional questions.





#### **Medicaid ID Number**

All providers interested in joining our network for MSCAN must have an active Mississippi Medicaid ID number issued from the Mississippi Division of Medicaid (DOM) upon submission of the contract Request Form. We will not be able to proceed with a group or individual agreement for MSCAN until an active Mississippi Medicaid ID number is obtained.









### Non-Participating Provider Reimbursement

All Out-of-Network Providers (Physicians, Nurse Practitioners, Facilities, and Ancillary Providers) must obtain a Prior Authorization (PA) prior to rendering services. All Non-Participating Providers require authorization regardless of services or codes.

The Prior Authorization Guide and forms are located on our website at: <a href="https://www.molinahealthcare.com/providers/ms/medicaid/forms/Pages/fuf.aspx">https://www.molinahealthcare.com/providers/ms/medicaid/forms/Pages/fuf.aspx</a>

Non-Participating Providers are reimbursed at **50% of the current Mississippi Medicaid Fee-For-Service Fee Schedule** for covered Non-Emergent services, if accompanied by a valid prior authorization number.

Non-Participating Providers are reimbursed at 100% of the current Mississippi Medicaid Fee-For-Service Fee Schedule for covered Emergency Services. Prior authorization is not required for covered Emergency Services.



### Contracting

The contracting packet will always consist of the following documents:

- ✓ Service Agreement (HSA or PSA)
- ✓ W9
- ✓ Ownership Control and Disclosure Form (OWN)
- ✓ Provider Information Form (PIF) (For Individuals)
- ✓ If you are submitting a rendering provider that does not have CAQH, please submit a Participating Physician Application (PPA) (For individuals)
- ✓ Health Delivery Organization (HDO) (Only for facilities)





### **Service Agreement**

There are two Service Agreements:

- ☐ Hospital Services Agreement *For hospitals only*
- ☐ Provider Services Agreement *For all non-hospital providers*

The Agreements contain the following active Lines of Business (LOB):

- MEDICAID (MSCAN) Molina entered this LOB on 10/1/2018
- □ CHIP Molina entered this LOB on 11/1/2019
- MARKETPLACE Molina entered this LOB on 1/1/2020

Only the first page on the agreements has a place for provider demographics and signatures

\*\*\*Please do not document an effective date on the agreement. This is determined by the credentialing approval date\*\*\*

\*\*\*Please review your current agreement to ensure it includes all LOB's in the event the group is already contracted\*\*\*



#### **W9**

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## Ownership Control and Disclosure Form (OWN)





- ☐ The signature and date at the end of page 3 will need to be dated within 180 days of contract packet submission to Molina.
- ☐ Failure to complete this document may result in delays processing the complete Contracting packet. Typically, this document is returned incomplete.
- ☐ For questions regarding the form, please reach out to a member of the Provider Contracting team for assistance <a href="MHMSProviderContracting@MolinaHealthcare.com">MHMSProviderContracting@MolinaHealthcare.com</a>



# Ownership Control and Disclosure Form (OWN)

Page 1

Completion and submission of this form is a condition of participation and full and accurate disclosure of ownership and financial interest is required. A failure to submit the requested information may result in a refusal by Plan/Network to enter into an agreement or contract with individual and/or entity or in termination of any existing agreements.  Please answer all questions as of the current date. If additional space is needed please use an attached sheet. Federal statutes and regulations clearly prohibit Plan/Network from paying for items or services furnished, ordered or prescribed by excluded persons. Plan/Network is required to search the exclusions database not only by the name of the entity seeking to participate in the program, but also by the name of any owner or managing employee.  Under 42 CFR 455: Identifying information must be supplied as described in the below sub-sections. For additional detail, please see the federal CFR database. A link to this specific section is supplied below (relevant portions are subsections 455.100 through 455.106):  http://www.accurrections.com/Participate/Pa		OWNERS	HIP AND C	ONTROL [	DISCLOSUE	RE FORM		
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### Ownership Control and Disclosure Form

(OWN)

Page 2

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NAME AND TITLE	g interest in any subo	contract in whi	the disdosi	ng entity has dir	ect or indired	ct ownership	o of 5% or more.
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IV. CRIMI	INAL OFFENSES						
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List each officer and/o							
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List each officer and/o the disclosing entity v Medicaid or Title XVIII				ie are no owner	_		
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## Ownership Control and Disclosure Form (OWN)

Page 3

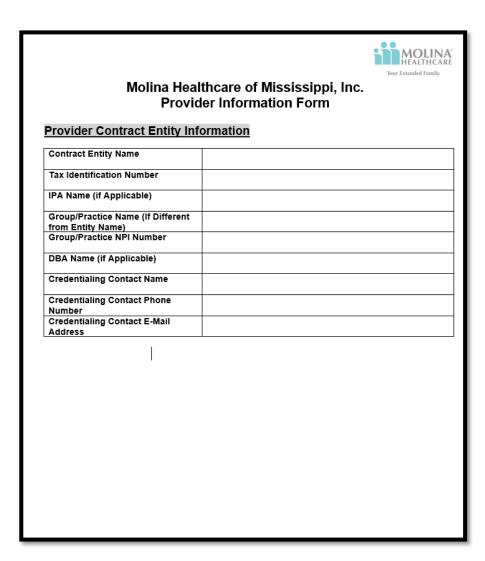
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VI. STATUS C		thin the next :	2		'ES		NO
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	And the second					_	NO
Is the facility operated by whole or by part of another			sed in	1	ES		NO
Has there been a past ba			ng for		ES	$\overline{\Box}$	NO
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If yes, when?  Any designated re	presentative	8 8	8				tatement.
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### **Provider Information Form (PIF)**

- ☐ This is a 3-page document that is used during credentialing for individuals who have an active and attested CAQH Profile.
- □ Page 1 is contracting group information.
- □ Page 2 allows the group to list the service locations for the individual, as well as the billing address for the group (if you need to list more than one service location, please use additional copies of this page).
- □ Page 3 is used to list the individual rendering provider's credentialing information.

\*\*\*Please ensure that all CAQH data is attested and that Molina has been granted access to view the profile.\*\*\* \*\*\*If a group has 10 or more providers, we can provide an Excel spreadsheet to accompany this form\*\*\*





### Mississippi Participating Physician Application (PPA)

check one: Mississipp	CONFIDENTIAL/PROPRIETAR DI Participating Physician
inal Application	Application
is application is submitted to: Molina Healtl	hcare, herein, this Managed Care Entity 1.
	CCTION A.
	nsure and Work History Information
ne questions being answered. Please do not use abbro	ore space is needed than provided on original, attach additional sheets and eviations when completing the application. If an item in the application of es of the following documents must be submitted with this application
rtificate • Cur ertification (if applicable) • ECI	te Sheet of Professional Liability Policy or Certification rriculum Vitae FMG (if applicable)
TIFYING INFORMATION	First: Middle:
other name under which you have been known (AK ing Address:	
ing Address.	City:
	State: ZIP:
phone Number:	E-Mail Address:
Number:	Pager Number:
ate: Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include a copy
rity#:	Alien Registration Card).  Gender <sup>2</sup> :
	Male Female
	Race/Ethnicity <sup>2</sup> (voluntary):
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edicine CTICE INFORMATION	
me (if applicable):	Department Name (if Hospital based):
fice Street Address:	Primary Office Mailing Address if different from Street Address
State: County: Zip:	City: State: County:
Number:	FAX Number:
ager/Administrator:	Telephone Number:
	Fax Number:
iated with Tax ID Number:	Federal Tax ID Number:
	Federal Tax ID Number:  ion of this application, the term "this Managed Care Entity" shall above.

- □ This form should be completed when a rendering provider requires credentialing with Molina and they do not currently have an active CAQH profile.
- The form is 12 pages in length and is needed to document details regarding the rendering provider and their previous work history.
- □ Please ensure all attestation pages on the PPA are signed and dated within 180 days of the contract packet submission.



### **Healthcare Delivery Organization (HDO)**

The HDO is a 5 page document that is used in the credentialing of facilities (i.e. Hospitals, ASC's, FQHC's\*, RHC's\* and PT/OT/SLP Facilities with more than one rendering provider working at these facilities). The following pages are part of the HDO and must be completed prior to submission.

- Page 1 Provides overall instructions for the HDO.
- Page 2 Must be completed at an organizational level for the group being contracted.
- □ Page 3 This page is site specific.
- Page 4 This page is where groups must list Accreditation/Certification information.
- □ Page 5 This is an attestation page for the HDO and must be signed and dated within 180 days of the submission of the contract packet.



### Review/Credentialing

Once your packet has been submitted, the following actions will occur:

- ✓ A Contracting Specialist will conduct an initial review of the submitted documents. In the event additional information/action is needed or we receive incomplete forms, the group will be notified.
- ✓ Upon review of the complete packet, the Contract Specialist will route the entire packet to the Molina Credentialing team to begin credentialing.
- ✓ The DOM standard by which the Coordinated Care Organizations (CCOs) are required to comply with is that within 90 days of receipt of a complete packet (to include having updated CAQH profiles) that credentialing of the group should be approved or denied.



### **Delegated Credentialing**

- Molina MS has Providers who are delegated for Credentialing.
- ☐ For more information on delegation, please email our Delegation Department at:

MHMSDO@MolinaHealthCare.Com





### **Post-Credentialing**

- ☐ Upon completion of credentialing, a credentialing letter will be generated by the Credentialing team and sent to the mailing address listed on the contract.
- □ A member of the Provider Contracting team will work with our Configuration Team to ensure the group and rendering providers are loaded into our claims system.
- ☐ Upon successful completion of the configuration, the group will be assigned a Provider ID number.
- ☐ The Senior Provider Services Representative for the county where the group is located will make outreach to schedule a New Provider Orientation.

If a provider or group receives the credentialing complete letter and have not received outreach from Provider Services, please email <a href="mailto:MHMSProviderServices@MolinaHealthcare.com">MHMSProviderServices@MolinaHealthcare.com</a>.



### Re-Credentialing

- ☐ Re-credentialing occurs every 36 months.
- □ Providers will receive notification 6 months in advance.
- Molina Healthcare follows NCQA guidelines for recredentialing.
- ☐ For additional information, email:

MHMSProviderContracting@Molinahealthcare.com



#### **FAQs**

Q: What is the timeline once a completed packet is received?

A: DOM Guidelines allow for 90 days from the date of receipt of a complete packet.

Q: What documents are needed for adding a new provider a group that is already contracted?

A: Please complete the Provider Information Update Form to add a new provider to an existing group. This form contains a large number of update options. A guide for how to complete the form is listed on the first couple of pages.

Q: What will be my effective date?

A: The effective date of the contract will be the date in which the first provider in the group passed credentialing. If adding a new provider to a group that has already completed credentialing through Molina, the effective date would be the date of email submission to request the addition.



#### **FAQs**

Q: What is the most common issue encountered when reviewing these packets?

A: Typically, providers fail to mark the N/A box on the Ownership forms in the event those are not required. This is minute, but it means we must return the document to the provider for correction before we can proceed.

Q: Once a provider/group is in the network, what will occur? Will the provider or group be notified?

A: Once credentialing is complete and the provider is loaded into our claims system, the Senior Provider Services Representative for the county where the group is located will make outreach to schedule a New Provider Orientation. For claims questions, please contact MHMSProviderServices@molinahealthcare.com.





