

DELEGATION - MEDICAL GROUP/IPA OPERATIONS

This section contains information specific to medical groups, Independent Practice Associations (IPA), and Vendors contracted with Molina to provide medical care or services to Members, and outlines Molina's delegation criteria and capitation reimbursement models. Molina will delegate certain administrative responsibilities to the contracted medical groups, IPAs, or vendors, upon meeting all of Molina's delegation criteria. Provider capitation reimbursement models range from fee-for-service to full risk capitation.

Delegation of Administrative Functions

Administrative services which may be delegated to IPAs, Medical Groups, Vendors, or other organizations include:

- Call Center
- Care Management
- Claims Administration
- Credentialing
- Non-Emergent Medical Transportation (NEMT)
- Utilization Management (UM)

Credentialing functions may be delegated to Capitated or Non-Capitated entities, which meet National Committee for Quality Assurance® (NCQA®) criteria for credentialing functions. Call Center, Claims Administration, Care Management and/or Utilization Management functions are generally only delegated to Vendors or full risk entities. Non-Emergent Medical Transportation (NEMT) may be delegated to Vendors who can meet Call Center, Claims Administration and/or NEMT requirements.

Note: The Molina Member's ID card will identify which group the Member is assigned. If Claims Administration and/or UM has been delegated to the group, the ID card will show the delegated group's remit to address and phone number for referrals and prior authorizations.

For a quick reference, the following table reflects the Claims and Referral/Authorization contact information for all medical groups/IPAs currently delegated for Claims payment and/or UM functions for the Medicaid lines of business.

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IPA / CAP Group Name	ID Card Acronym	CAP Lines of Business	Claims Remit to Address	Referral / Authorization Information
Kaiser Foundation Health Plan of the Northwest	KPNW	IMC-AH (IMC Apple Health) IMC-AHA (IMC Apple Health Adult) IMC-BD (IMC Apple Health Blind Disabled) IMC-PREM (IMC Apple Health w Premium)	Physical Health Services only: Waterpark 1 2500 Havana St Aurora, CO 80014 Behavioral Health Services including Mental Health and Substance use disorder: Molina Healthcare PO Box 22612 Long Beach, Ca 90801	For Physical Health Services KPNW: Phone: (800) 813-2000 Fax: (877) 800-5456 For Behavioral Health Services including Mental Health and Substance use disorder Molina Healthcare: Phone: (800) 869-7185 Fax: (800) 767-7188

IPA / CAP Group Name	ID Card Acronym	CAP Lines of Business	Claims Remit to Address	Referral / Authorization Information
Kaiser Foundation Health Plan of the Northwest	KPNW	AHPREM (Apple Health with Premium) AHFAM (Apple Health Family/Pregnancy Medical) AHA (Apple Health Adult) AHBD (Apple Health Blind Disabled)	Physical Health Services and Behavioral Health Services: Waterpark 1 2500 Havana St Aurora, CO 80014	Physical Health Services and Behavioral Health Services KPNW: Phone: (800) 813-2000 Fax: (877) 800-5456

IPA / CAP Group Name	ID Card Acronym	CAP Lines of Business	Claims Remit to Address	Referral / Authorization Information
Confluence Health	Confluence Health_CAP	AHPREM (Apple Health with Premium) AHFAM (Apple Health Family/Pregnancy Medical) AHA (Apple Health Adult)	PO Box 810 Wenatchee, WA 98807-0810 or EDI Payor # = 91064	Confluence Health: Phone: (800) 691-1224 Fax: (509) 665-3606

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IPA / CAP Group Name	ID Card Acronym	CAP Lines of Business	Claims Remit to Address	Referral / Authorization Information
Confluence Health	Confluence Health_CAP	IMC-AH (IMC Apple Health) IMC-AHA (IMC Apple Health Adult) IMC-PREM (IMC Apple Health w Premium)	Physical Health Services only: PO Box 810 Wenatchee, WA 98807-0810 or EDI Payor # = 91064 Behavioral Health Services including Mental Health and Substance use disorder: Molina Healthcare PO Box 22612 Long Beach, Ca 90801 or EDI Payor # = 38336	Physical Health Services: Confluence Health: Phone: (800) 691-1224 Fax: (509) 665-3606 For Behavioral Health Services including Mental Health and Substance use disorder Molina Healthcare: Phone: (800) 869-7185 Fax: (800) 767-7188

**AHBD or IMCAHBD - Apple Health Blind Disabled is not capitated with Confluence Health. Prior authorization request and claims should be submitted directly to Molina Healthcare.*

NOTE: The Member’s Molina Healthcare ID card will identify the group the Member is assigned to by the acronyms listed above. If Claims payment and/or UM has been delegated to the group, the ID card will show the delegated group’s remit address and phone number for prior authorizations.

The below table shows all contracted PCP capitated groups. These groups receive a per member per month capitation payment to manage all primary care services only for their assigned membership. When seeing a new member verify if the member is assigned to a PCP capitated group by looking at their ID card or verifying eligibility on the web portal. If the member is assigned to a PCP capitated group the member must be seen by their assigned PCP or a PCP change needs to be made to the appropriate PCP prior to services being rendered.

PCP CAPITATION GROUPS	ACRONYM
Community Health Associates Spokane	CAP - CHAS
Family Care Network	CAP - FCN
Pacific Physicians	CAP – Pacific Physicians
Pierce Unicare IPA	CAP – Pierce Unicare

Delegation Criteria

Molina is accountable for all aspects of the Member’s health care delivery, even when it delegates specific responsibilities to sub-contracted IPAs, Medical Groups, or Vendors. Molina’s

Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements.

Call Center

To be delegated for Call Center functions, Vendors must:

- Have a Vendor contract with Molina (Molina does not delegate call center functions to IPAs or Provider Groups).
- Have a Call Center delegation pre-assessment completed by Molina to determine compliance with all applicable State and Federal regulatory requirements.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Correct deficiencies within the timeframes identified in the correction action plan (CAP) when issues of non-compliance are identified by Molina.
- Protect the confidentiality of all PHI as required by Law.
- Have processes in place to identify and investigate potential Fraud, Waste and Abuse.
- Must have an automated call system that allows the Vendor to confirm Member benefits and eligibility during the call.
- Agree to Molina's contract terms and conditions for Call Center delegates.
- Submit timely and complete Call Center delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Current call center is able to demonstrate compliance with service level performance for average speed to answer, abandonment rate, and/or percentage of calls that are complaints meet CMS and/or state requirements, depending on the line(s) of business delegated.

A Vendor may request Call Center delegation from Molina through Molina's Delegation Oversight Manager or through the Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Call Center responsibilities is based on the Vendor's ability to meet Molina, State and Federal requirements for delegation.

Care Management

To be delegated for Care Management functions, Medical Groups, IPAs and/or Vendors must:

- Be certified by the National Committee for Quality Assurance (NCQA) for complex case management and disease management programs.
- Have a current complex case management and disease management program descriptions in place. Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Pass a care management pre assessment audit, based on NCQA and State requirements, and Molina business needs.

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- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Agree to Molina's contract terms and conditions for care management delegates.
- Submit timely and complete Care Management delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with all applicable federal and state Laws.

Note: Molina does not allow care management delegates to further sub-delegate care management activities.

A Medical Group, IPA, or Vendor may request Care Management from Molina through Molina's Delegation Oversight Manager or through the Medical Group, IPA, or Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Care Management responsibilities is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation.

Claims Administration

To be delegated for Claims Administration, Medical Groups, IPAs, and/or Vendors must do the following:

- Have a capitation contract with Molina and be in compliance with the financial reserves requirements of the contract.
- Be delegated for UM by Molina.
- Protect the confidentiality of all PHI as required by Law.
- Have processes in place to identify and investigate potential Fraud, Waste, and Abuse.
- Have a Claims Administration delegation pre-assessment completed by Molina to determine compliance with all applicable State and Federal regulatory requirements for Claims Administration.
- Correct deficiencies within timeframes identified in the correction action plan (CAP) when issues of non-compliance are identified by Molina.
- Must have an automated system capable of accepting electronic claims in an ICD 10 compliant format.
- Must have an automated system capable of providing Molina with the Encounter Data required by the state in a format readable by Molina.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Agree to Molina's contract terms and conditions for Claims Delegates.
- Submit timely and complete Claims Administration delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Within forty five (45) days of the end of the month in which care was rendered, provide Molina with the Encounter Data required by the state in a format compliant with HIPAA requirements.

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- Provide additional information as necessary to load Encounter Data within thirty (30) days of Molina's request.
- Comply with the standard Transactions and Code Sets requirements for accepting and sending electronic health care Claims information and remittance advice statements using the formats required by HIPAA.
- Comply with all applicable Federal and State Laws.
- When using Molina's contract terms to pay for services rendered by Providers not contracted with IPA or group, follow Molina's Claims Administration policies and guidelines, such as the retroactive authorization policy and guidelines for Claims adjustments and review of denied Claims.

A Medical Group, IPA, or Vendor may request Claims Administration delegation from Molina through Molina's Delegation Oversight Manager or through the Medical Group, IPA, or Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Claims Administration responsibilities is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation.

Credentialing

To be delegated for credentialing functions, Medical Groups, IPAs, and/or Vendors must:

- Pass Molina's credentialing pre-assessment with a score of at least 90%, which is based on NCQA credentialing standards.
- Have a multi-disciplinary Credentialing Committee who is responsible for review and approval or denial/termination of practitioners included in delegation.
- Have an Ongoing Monitoring process in place that screens all practitioners included in delegation against OIG, SAM, and published state Medicaid exclusion lists a minimum of every thirty days.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina
- Agree to Molina's contract terms and conditions for credentialing delegates
- Submit timely and complete Credentialing delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact
- Comply with all applicable federal and state Laws
- When key specialists, as defined by Molina, contracted with IPA or group terminate, provide Molina with a letter of termination according to Contractual Agreements and the information necessary to notify affected Members

Note: If the Medical Group, IPA, or Vendor is an NCQA® Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modification to the audit depends on the type of Certification or Accreditation the Medical Group, IPA, or

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Vendor has, but will always include evaluation of applicable state requirements and Molina business needs.

If the Medical Group, IPA, or Vendor sub-delegates Credentialing functions, the sub-delegate must be NCQA© accredited or certified in Credentialing functions, or demonstrate and ability to meet all Health Plan, NCQA©, and State and Federal requirements identified above. A written request must be made to Molina prior to execution of a contract, and a pre-assessment must be made on the potential sub-delegate, and annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and Recredentialing files, and a process to implement corrective action if issues of non-compliance are identified.

A Medical Group, IPA, or Vendor may request Credentialing delegation from Molina through Molina's Delegation Oversight Manager or through the Medical Group, IPA, or Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Credentialing responsibilities is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation.

Utilization Management (UM)

To be delegated for UM functions, Medical Groups, IPAs, and/or Vendors must:

- Have a UM program that has been operational at least one year prior to delegation, and includes an annual UM Program evaluation and annual Inter Rater Reliability audits of all levels of UM staff.
- Pass Molina's UM pre-assessment, which is based on NCQA, State and Federal UM standards, and Molina Policies and Procedures with a score of at least 90%.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Ensure that only licensed physicians/dentists medical necessity denial decisions.
- Ensure that only appropriate levels of clinical staff make medical necessity approval decisions.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Agree to Molina's contract terms and conditions for UM delegates.
- Submit timely and complete UM delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with the standard Transactions and Code Sets requirements for authorization requests and responses using the formats required by HIPAA.
- Comply with all applicable federal and state Laws.

Note: If the Medical Group, IPA, or Vendor is an NCQA© Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modifications to the audit depend on the type of Certification or Accreditation the Medical Group, IPA, or

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Vendor has, but will always include evaluation of applicable State requirements and Molina Business needs.

Molina does not allow UM delegates to further sub-delegate UM activities.

A Medical Group, IPA, or Vendor may request UM delegation from Molina through Molina's Delegation Oversight Manager or through the Medical Group, IPA, or Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate UM responsibilities is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation.

Quality Improvement/Preventive Health Activities

Molina does not delegate Quality Improvement activities to Provider organizations. Molina will include all network Providers, including those in Medical Groups, IPAs, or Vendors who are delegated for other functions (Claims, Credentialing, UM, etc.) in its Quality Improvement Program activities and preventive health activities. Molina encourages all contracted Provider organizations to conduct activities to improve the quality of care and service provided by their organization. Molina would appreciate receiving copies of studies conducted or data analyzed as part of the Medical Group, IPA, or Vendor's Quality Improvement Program.

Delegation Reporting Requirements

Medical Groups, IPAs or Vendors, contracted with Molina and delegated for various administrative functions must submit monthly and quarterly reports determined by the function(s) delegated to the identified Molina Delegation Oversight Staff within the timeline indicated by the Health Plan. For a copy of Molina's current delegation reporting requirements, please contact your Molina Provider Services Contract Manager.

Capitation Models

Molina Healthcare employs a variety of Capitation reimbursement models; only organizations or individuals with a significant number of Members to spread the financial risk are approved for capitation contracts.

Primary Care Capitation: An individual PCP or a group of PCPs receive a monthly prepaid amount from Molina Healthcare as compensation for a contractually defined set of services, which are designated as capitated by Molina Healthcare.

Full Risk/Global Capitation: IPA or PHO receives a monthly prepaid amount from Molina Healthcare as compensation for a contractually defined set of services, which are designated as capitated by Molina Healthcare. These services are typically global in nature (i.e., these groups have assumed financial responsibility for all covered health care services unless specifically carved out by Molina Healthcare). Financial responsibility for all services (including carve outs) is defined in the financial responsibility matrix attached to the full risk/global Capitation agreement.

Financial Viability of Capitated Organizations

Molina Healthcare is obligated to monitor the financial status of the groups to whom it has given financial risk. This is a contractual and business responsibility. We use all reasonable methods to prevent placing an organization at risk for more than they are able to manage. We work to ensure there is little risk to any Providers who would look to the organization for payment of Claims. Prior to the initial contracting under a capitation model with an organization, Molina Healthcare assesses the organization's financial condition by reviewing the two most recent years audited financial statements and year-to-date unaudited financial statements for the current year.

Physician Incentive Plan (PIP): Every year, Molina Healthcare is required to submit a report to HCA disclosing incentive terms for all Provider contracts. For Providers/Provider groups with substantial financial risk (any organization that could be adversely or positively affected financially by the referral volume of its Members), Molina Healthcare is required to disclose additional documentation. Organizations with substantial financial risk must provide information to Molina Healthcare including:

- Mode of payments to Providers and any payment plans considered to be PIPs
- Evidence of stop-loss protection
- Evidence of annual Member satisfaction surveys

Reporting Requirements of Organizations: Once contracted, Molina Healthcare expects all organizations, identified as bearing substantial financial risk on the PIP, to submit the following documents to Molina Healthcare:

Complete quarterly financial statements including:

- Balance Sheet
- Income Statement
- Statement of Cash Flows
- Audited annual financial statements

Organizations delegated for Claims may have additional reports required to assist Molina Healthcare in fulfilling its financial oversight responsibilities.

Capitation Operations

Joint Operations Committee Meetings: Molina Healthcare is available to meet as needed to address operational or contractual issues. On a quarterly basis, Molina Healthcare tries to meet with each of its organizations that operate under a capitation model. The purpose of the meetings is to:

- Identify any operational difficulties between the organization and Molina Healthcare and determine plans for a remedy
- Educate one another on changes to either the organization or Molina Healthcare
- Provide an opportunity for staff to meet their counterparts in order to facilitate more productive interactions

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The meetings are facilitated by the Provider Services Representative, but include any other Molina Healthcare staff who may be pertinent to issues at hand.

Funds Flow Document: Because the contract is a lengthy and somewhat complicated document, Molina Healthcare works with the capitated organization to write a Funds Flow document outlining:

- Payment rates
- Mode of payment
- Division of financial responsibility
- Any special payment arrangements

The purpose of this document is to provide all involved staff at the organization and Molina Healthcare with a guide for adhering to the terms of the contract.

Encounter Reporting

Each capitated organization delegated for Claims payment is required to submit encounter data for all adjudicated Claims. The data is used for many purposes, such as reporting to the Medicaid Statistical Information System (MSIS), Apple Health rate setting and risk adjustment, HCA's hospital rate setting, the quality improvement program and HEDIS reporting.

The encounter data reporting specifications can be found at

<http://www.molinahealthcare.com/providers/common/medicaid/ediera/edi/Pages/guidanceinfo.aspx>.