

MEDICAL GROUP/IPA OPERATIONS

This section contains information specific to medical groups and Independent Practice Associations (IPA) contracted with Molina Healthcare to provide medical care to Members, and outlines Molina Healthcare’s delegation criteria and capitation reimbursement models. Molina Healthcare will delegate certain administrative responsibilities to the contracted medical group/IPA upon meeting all of Molina Healthcare’s delegation criteria. Provider capitation reimbursement models employed by Molina Healthcare range from PCP capitation to full risk capitation.

DELEGATION OF ADMINISTRATIVE FUNCTIONS

Administrative services which may be delegated to IPAs, medical groups, or other organizations include:

- Claims payment
- Credentialing
- Utilization Management (UM)/Prior Authorization

Health Homes
Case Management

Credentialing functions may be delegated to capitated or non-capitated entities. The following table provides a summary of the full risk capitated medical group/IPAs identifying delegated responsibility for claims payment, credentialing and utilization management:

Full Risk Medical Group/IPA	ID card Acronym	Claims Remit to Address	UM Referral/ Authorization Phone #
Kaiser Foundation Health Plan of the Northwest	KPNW	500 NE Multnomah St., Suite 100, Portland, OR 97232	KPNW: (800) 813-2000
Wenatchee Valley Medical Center	WVMC	PO Box 810 Wenatchee, WA 98807-0810	WVMC: (800) 726-8808 Ext. 5571

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 to address and phone number for prior authorizations.

The following table shows all contracted PCP capitated groups. These groups receive a per member per month capitation payment to manage all primary care services 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
Columbia Medical Associates	CAP - CMA
Community Health Associates Spokane	CAP - CHAS
Family Care Network	CAP - FCN
Pacific Physicians	CAP – Pacific Physicians
Pierce Unicare IPA	CAP – Pierce Unicare
Swedish Ballard Community Health	CAP - SCH

DELEGATION CRITERIA

Molina Healthcare is accountable for all aspects of the Member’s health care delivery, even when it delegates specific responsibilities to sub-contracted medical groups/IPAs. Molina Healthcare’s Delegation Oversight Committee (DOC) must approve all delegation and sub-delegation arrangements.

Credentialing:

To be delegated for credentialing, medical groups/IPAs must:

- Be accredited by the National Committee for Quality Assurance (NCQA) for credentialing or pass with 90% or better Molina Healthcare’s credentialing pre-assessment, which is based on NCQA credentialing standards
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare
- Agree to Molina Healthcare’s contract terms and conditions for credentialing delegates
- Submit timely and complete credentialing reports to Molina Healthcare
- Comply with all applicable federal and state laws

NOTE: If the medical group/IPA sub-delegates any portion of the Credentialing and/or Primary Source Verification process to another entity, the medical group/IPA is responsible for ensuring their sub delegate can meet on an ongoing basis all Molina Credentialing requirements and provide the contract between the sub-delegate and the vendor.

A medical group/IPA may request credentialing delegation from Molina Healthcare through the medical group/IPA’s Contract Manager. Molina Healthcare will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for an onsite pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review. Final decision to delegate the credentialing process is based on the medical group/IPA’s ability to meet Molina Healthcare’s standards and criteria for delegation.

Utilization Management:

To be delegated for UM, medical groups/IPAs must:

- Have a UM program that has been operational at least one year prior to delegation
- Be NCQA accredited for utilization management or pass with 90% or better Molina Healthcare’s UM pre-assessment, which is based on NCQA UM standards,

Molina Healthcare of Washington, Inc.

- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare
- Agree to Molina Healthcare's contract terms and conditions for UM delegates
- Submit timely and complete UM delegate reports to Molina Healthcare
- 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

A medical group/IPA may request UM delegation from Molina Healthcare through the medical group/IPA's Contract Manager. Molina Healthcare 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 DOC for review. Final decision to delegate UM is based on the medical group/IPA's ability to meet Molina Healthcare's standards and criteria for delegation.

Claims:

To be delegated for Claims, IPAs and Provider Groups must do the following:

- Have a capitation contract with Molina Healthcare and be in compliance with the financial reserves requirements of the contract
- Be delegated for UM by Molina Healthcare
- Have an automated Claims payment system with eligibility, authorization, and Claims adjudication
- Have a Claims delegation pre-assessment completed by Molina Healthcare to determine compliance with all regulatory requirements for Claims payment, such as the use of the prudent layperson standard for payment of Claims for emergency services, and the payment of interest on Claims not paid within 60 days
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare
- Protect the confidentiality of all Claims information as required by law
- Have a system capable of providing Molina Healthcare with the encounter data required by the state in a format readable by Molina Healthcare
- Agree to Molina Healthcare's contract terms and conditions for Claims delegates
- Submit timely and complete Claims delegate reports to Molina Healthcare
- Within 45 days of the end of the month in which care was rendered, provide Molina Healthcare with the encounter data required by the state in a format compliant with HIPAA requirements
- Provide additional information as necessary to load encounter data within 30 days of Molina Healthcare'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 Healthcare's contract terms to pay for services rendered by Providers not contracted with IPA or group, follow Molina Healthcare's Claims policies and guidelines, such as the retroactive authorization policy and guidelines for Claims adjustments and review of denied Claims

Molina Healthcare of Washington, Inc.

- When key specialists, as defined by Molina Healthcare, contracted with IPA or group terminate, provide Molina Healthcare with the information necessary to timely notify affected members

A medical group/IPA may request Claims delegation from Molina Healthcare through the medical group/IPA's Contract Manager. Molina Healthcare 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 DOC for review. Final decision to delegate Claims is based on the medical group/IPA's ability to meet Molina Healthcare's standards and criteria for delegation.

Quality Improvement/Preventive Health Activities: Molina Healthcare will not delegate quality improvement activities to Provider organizations. Molina Healthcare will include all network Providers, including those in medical groups/IPAs who are delegated for other functions (Claims, Credentialing, UM) in its quality improvement program activities and preventive health activities. Molina Healthcare encourages all contracted Provider organizations to conduct activities to improve the quality of care and service provided by their organization. Molina Healthcare would appreciate receiving copies of studies conducted or data analyzed as part of the medical group/IPA's quality improvement program.

DELEGATION REPORTING REQUIREMENTS

Medical groups/IPAs, contracted with Molina Healthcare and delegated for various administrative functions, must submit monthly reports to Molina Healthcare's Delegation Manager. For a copy of Molina Healthcare's current delegation reporting requirements, please contact your Molina Healthcare 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

Molina Healthcare of Washington, Inc.

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

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 DATA 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), HO rate setting and risk adjustment, HCA's hospital rate setting, the HO quality improvement program and HEDIS reporting.

The encounter data reporting specifications can be found at http://www.molinahealthcare.com/medicaid/providers/common/edi/Pages/wa_comp_guide.aspx.

REPORTING BY MOLINA HEALTHCARE TO ORGANIZATIONS

Molina Healthcare makes every effort to provide its capitated organizations with information to manage the membership for which it has accepted responsibility. Reports sent to organizations will vary depending on the capitation model under which they are operating. Reports will be sent electronically via secure e-mail. The delivery method and format for data is established at the inception of the contract and modified as needed for the parties throughout the term of the contract. The samples included at the end of this section are standard reports. Molina Healthcare has some flexibility as to the data elements included in these reports. Most organizations load the report data into a variety of database programs allowing them flexibility to analyze and view information in ways useful to them. Requests for special reports should be addressed to the Contract Manager.

Eligibility Reports:

Electronic Reports - Each group receives an electronic report via secure e-mail with all Members assigned to PCPs in its organization by the tenth business day of each month.

Capitation Payment Reports: By the tenth day of each month, Molina Healthcare sends a report electronically to the capitated organization, detailing the amount paid as capitation for each Member assigned to the organization's PCPs. This report also shows the effects of any retroactive additions or terminations of Members from the organization (See the last pages of this section).

SAMPLE - ELECTRONIC ELIGIBILITY FILE

Molina Healthcare of Washington, Inc.

The following data elements appear in the electronic eligibility file. The second column contains sample data as it would appear.

PCPName	SATCHER, DAVID
PCPAssignEffDate	7/1/2012 12:00:00AM
CardID	BHP99999999901
CarrierMemberID	JJ010100SMITHA (PIC#)
MemSSN	999999999
MemFirstName	JOHN
MemMidName	J
MemLastName	SMITH
MemSex	M
MemDOB	3/20/1989 12:00:00AM
MemEnrollEffDate	7/1/2000 12:00:00AM
MemEnrollTermDate	12/31/2078 12:00:00AM
PaytoProvName	XYZ MEDICAL CLINIC
MemberAddress1	N 1999 WESTSIDE RD
MemberAddress2	APT #13
MemberCity	KIRKLAND
MemberState	WA
MemberZip	980340000
MemberPhone	4255555555
ProgramDesc	BHP+ (Basic Health Plan Plus)
MemLanguage	ENGLISH
CSHCN	Y/N Children with Special Health Care Needs Indicator
RateCode	XXXX
ServLocName	XXXXXXXXXXXXXXXXXXXXXXX