Molina Healthcare

2020 Contracting and Credentialing Orientation

Agenda

- ❑ Contracting Overview
- ❑ Medicaid ID Number
- ❑ Non-Participating Provider Reimbursement
- ❑ Service Agreement
- ❑ 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 MHMSProviderContracting@Molinahealthcare.com

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** Jordan.Black@MolinaHealthcare.com or **Sam Measels** W.MeaselsIII@MolinaHealthcare.com 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.

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

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

- Please complete one W9 for each Service Location where services will be rendered.
- Please ensure the W9 has been signed and dated upon submission.
- The EIN listed on this form must match the Tax ID listed on the agreement, and must also mirror the EIN used with Medicaid Registration.

Ownership Control and Disclosure Form (OWN)

- It is imperative to complete this document in its entirety.
- 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 MHMSProviderContracting@MolinaHealthcare.com

Ownership Control and Disclosure Form (OWN)

Page 1

Molina Healthcare, Inc.

OWNERSHIP AND CONTROL DISCLOSURE FORM

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.ecfr.gov/cgibin/retrieveECFR?gp=&SID=52a7c7bdf3680f796026e8cabf525dd7&n=42y4.0.1.1.13&r=PART&ty=HTML#42:4.0.1.1.13.2.139.3

Complete this form for all locations contracted or being contracted with Molina Healthcare, Inc. (Molina) where Molina members will be seen. Only one form is needed if multiple locations are owned by the same parent company.

I. Identifying Information	
Owner Type (check one) ☐ Individual Ownership ☐ Organization Ownership ☐ Federal/State Owned	
DOING BUSINESS AS:	ORGANIZATION NAME:
FEDERAL TAX ID: SSN (If Individual Ownership):	MINORITY WOMEN OWNED BUSINESS ENTERPRISE (MWOBE):

II. Ownership and Control Information

List each office and/or individual, organization, corporation or entity that has direct or indirect ownership or controlling interest, separately or in combination, amounting to an ownership interest of 5% or more of the provider entity. Attach additional pages as necessary. If there are no individuals or entities with 5% or more ownership/control interest, complete for managing employees.

NAME AND TITLE	% OF OWNERSHIP	DOB	SSN	NPI	LICENSE #	TAX ID#	ADDRESS

List those persons named that are related to each other (spouse, parent, child or sibling). Attach additional pages if necessary.

NAME AND TITLE	RELATIONSHIP	DOB

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Ownership Control and Disclosure Form (OWN)

Page 2

OWNERSHIP AND CONTROL DISCLOSURE FORM (Cont'd)

Does any owner of the disclosing entity also have an ownership or controlling interest of 5% or more in any other entity? Attach additional pages if necessary.

☐ NOT APPLICABLE. See box at beginning of form, OR no owner or managing employee has ownership or controlling interest of 5% or more in any other entity.

NAME AND TITLE	% OF OWNERSHIP	DOB	SSN	NPI	LICENSE #	TAX ID #	ADDRESS

III. SUBCONTRACTOR INFORMATION

List each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. Attach additional pages if necessary.

☐ NOT APPLICABLE. See box at beginning of form, OR there are no owners or managing employees that have controlling interest in any subcontract in which the disclosing entity has direct or indirect ownership of 5% or more.

NAME AND TITLE	DOB	SSN	NPI	LICENSE #	TAX ID#	ADDRESS

Please provide the ownership name and address of any subcontractor with whom you have had a business transaction totaling more than $25,000 during the most recent 12-month period.

NAME AND TITLE	DOB	SSN	NPI	LICENSE #	TAX ID #	ADDRESS

IV. CRIMINAL OFFENSES

List each officer and/or individual who has ownership or control interest in the disclosing entity, or is an agent or managing employee of the disclosing entity who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XVIII, XIX or XX since the inception of those programs. Attach additional pages if necessary.

☐ NOT APPLICABLE. See box at beginning of form, OR there are no owners or managing employees that have been convicted of a criminal offense.

NAME AND TITLE	DOB	SSN	NPI	LICENSE #	TAX ID#	ADDRESS

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Ownership Control and Disclosure Form (OWN)

Page 3

OWNERSHIP AND CONTROL DISCLOSURE FORM (Cont'd)

V. SUSPENSION OR DEBARMENT

Have you, or any of your employees, or any individuals who have ownership and/or controlling interest in the disclosing entity ever been placed on the Federal Office of Inspector General Health and Human Services (OIG/HHS) exclusions list or otherwise been suspended or debarred from participation in Medicare, Medicaid or Title XXVIII, XIX or XX service programs. If yes, list each person below. Attach additional pages as necessary. The current lists of excluded individuals can be found at: https://exclusions.oig.hhs.gov/ and https://www.sam.gov/portal/SAM/#1

☐ NOT APPLICABLE. See box at beginning of form, OR there are no owners or managing employees that have been suspended, excluded, and debarred from participation in Medicare, Medicaid or other service programs.

NAME AND TITLE	DOB	SSN	NPI	LICENSE #	TAX ID #	ADDRESS

VI. STATUS CHANGES

Is a change of ownership anticipated within the next year?	☐ YES	☐ NO
If yes, list date of change in operations.		
Is the facility operated by a management company or leased in whole or by part of another organization?	☐ YES	☐ NO
Has there been a past bankruptcy or do you anticipate filing for bankruptcy within the next year?	☐ YES	☐ NO
If yes, when?		

Any designated representative may complete and sign this form on the organization's behalf.

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with Plan/Network. By signature I certify that the information provided within, is true and correct and I fully understand the consequences as explained above.

Printed (or typed) NAME and
Title of person completing this form: ______________________________ Date: ____________

Signature: ____

Completely fill in the form above in Adobe Acrobat or Adobe Reader, and then electronically sign by clicking in the box above. You cannot make changes to this form once it has been electronically signed and you cannot save a partially completed form. If you do not have Adobe Reader or Adobe Acrobat, print this form and fill it in by hand. Signature stamps not accepted.

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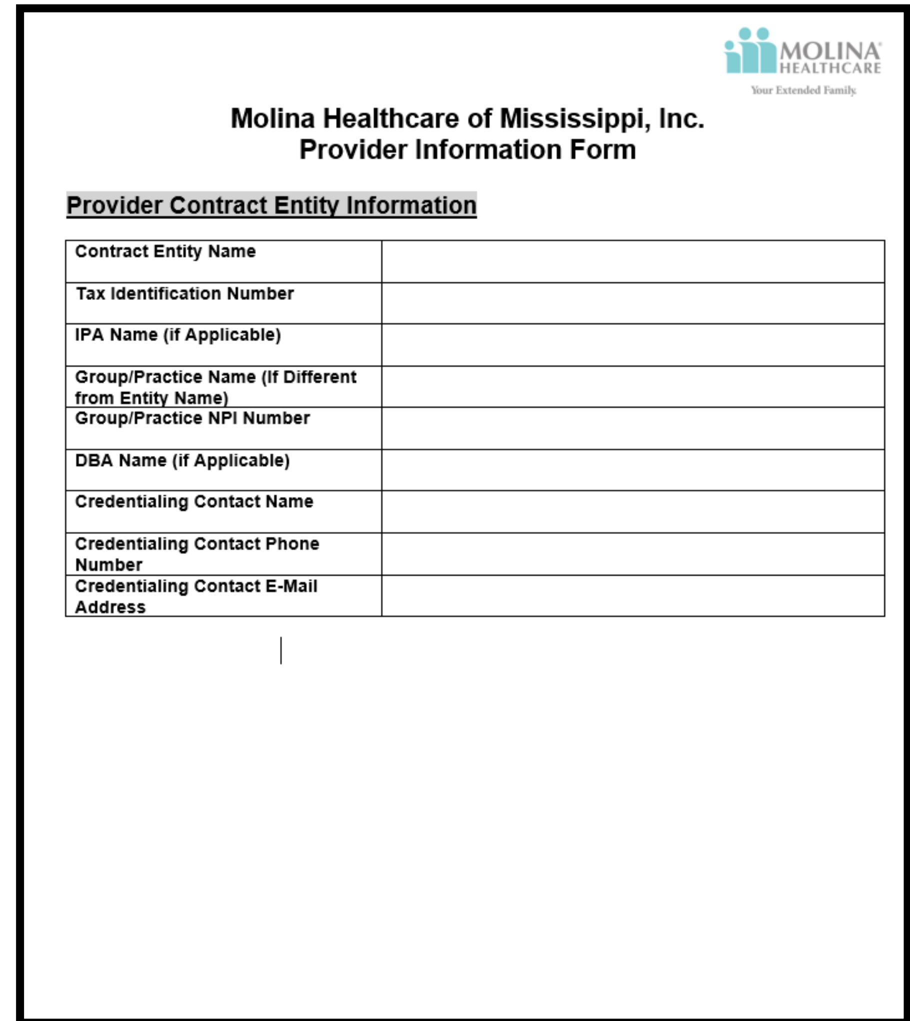
Provider Information Form (PIF)

- 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



MOLINA HEALTHCARE
Your Extended Family.

Molina Healthcare of Mississippi, Inc.
Provider Information Form

Provider Contract Entity Information

Contract Entity Name	
Tax Identification Number	
IPA Name (if Applicable)	
Group/Practice Name (If Different from Entity Name)	
Group/Practice NPI Number	
DBA Name (if Applicable)	
Credentialing Contact Name	
Credentialing Contact Phone Number	
Credentialing Contact E-Mail Address	

Mississippi Participating Physician Application (PPA)

CONFIDENTIAL/PROPRIETARY

Please check one:

☐ Original Application
☐ Reappointment

Mississippi Participating Physician Application

This application is submitted to: Molina Healthcare, herein, this Managed Care Entity[1].

SECTION A.

Practice, Educational, Licensure and Work History Information

I. INSTRUCTIONS

This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the questions being answered. Please do not use abbreviations when completing the application. If an item in the application does not apply to you, write N/A in the box provided. **Current copies of the following documents must be submitted with this application.**

- State Medical License(s)
- DEA Certificate
- Board Certification (if applicable)
- Face Sheet of Professional Liability Policy or Certification
- Curriculum Vitae
- ECFMG (if applicable)

II. IDENTIFYING INFORMATION

Last Name: | First: | Middle:

Is there any other name under which you have been known (AKA/Maiden Name)? Name(s):

Home Mailing Address: | City: | State: | ZIP:

Home Telephone Number: | E-Mail Address:

Home Fax Number: | Pager Number:

Birthday Date: | Birth Place (City/State/Country): | Citizenship (If not a United States citizen, please include a copy of Alien Registration Card).

Social Security #: | Gender[2]: ☐ Male ☐ Female

Specialty: | Race/Ethnicity[2] (voluntary):

Subspecialties:
Internal Medicine

III. PRACTICE INFORMATION

Practice Name (if applicable): | Department Name (if Hospital based):

Primary Office Street Address: | Primary Office Mailing Address if different from Street Address:

City: State: County: Zip: | City: State: County: Zip:

Telephone Number: | FAX Number:

Office Manager/Administrator: | Telephone Number: | Fax Number:

Name Affiliated with Tax ID Number: | Federal Tax ID Number:

[1] As used in the information Release/Acknowledgements Section of this application, the term "this Managed Care Entity" shall refer to the entity to which the application is submitted as identified above.
[2] This information will be used for consumer information purposes only.

Mississippi Participating Physician Application – 11/99 **Page 1 of 12**

- ❑ 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.

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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

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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 MHMSProviderServices@MolinaHealthcare.com.

Re-Credentialing

- Re-credentialing occurs every 36 months.
- Providers will receive notification 6 months in advance.
- Molina Healthcare follows NCQA guidelines for re-credentialing.
- For additional information, email: MHMSProviderContracting@Molinahealthcare.com

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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.

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