Molina Healthcare

2020 Contracting and Credentialing Orientation - Marketplace

MOLINA® HEALTHCARE

Agenda

- ❑ Contracting Overview
- ❑ 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

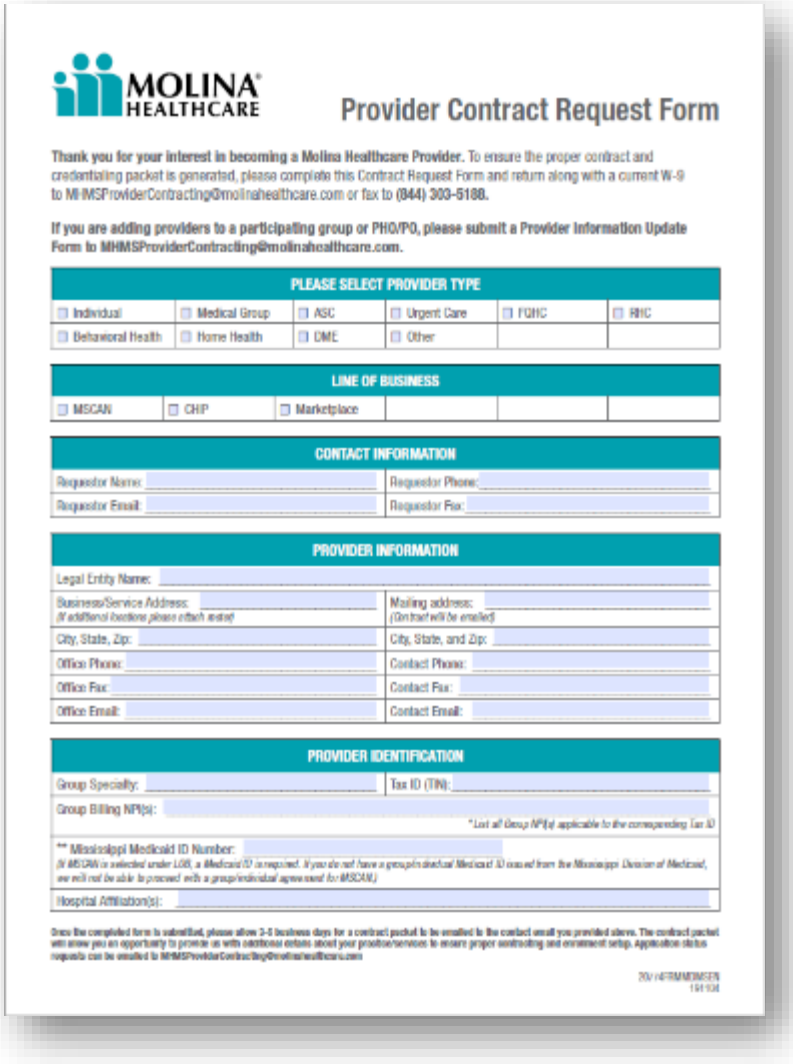
Providers who are interested in joining our network will need to complete and submit a **Provider Contract Request Form** (CRF). This request is for providers who are not billing under a Tax ID that is already contracted and participating in Molina's network.

Please be thorough when completing this document. Providers can access the CRF at: https://www.molinahealthcare.com/providers/ms/marketplace/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.



MOLINA HEALTHCARE

Provider Contract Request Form

Thank you for your interest in becoming a Molina Healthcare Provider. To ensure the proper contract and credentialing packet is generated, please complete this Contract Request Form and return along with a current W-9 to MHMSProviderContracting@molinahealthcare.com or fax to **(844) 303-5188.**

If you are adding providers to a participating group or PHO/PO, please submit a Provider Information Update Form to MHMSProviderContracting@molinahealthcare.com.

PLEASE SELECT PROVIDER TYPE

☐ Individual	☐ Medical Group	☐ ASC	☐ Urgent Care	☐ FQHC	☐ RHC
☐ Behavioral Health	☐ Home Health	☐ DME	☐ Other		

LINE OF BUSINESS

☐ MSCAN	☐ CHIP	☐ Marketplace			

CONTACT INFORMATION

Requestor Name:	Requestor Phone:
Requestor Email:	Requestor Fax:

PROVIDER INFORMATION

Legal Entity Name:	
Business/Service Address: *(If additional locations please attach roster)*	Mailing address: *(Contract will be emailed)*
City, State, Zip:	City, State, and Zip:
Office Phone:	Contact Phone:
Office Fax:	Contact Fax:
Office Email:	Contact Email:

PROVIDER IDENTIFICATION

Group Specialty:	Tax ID (TIN):
Group Billing NPI(s):	**List all Group NPI(s) applicable to the corresponding Tax ID*
** Mississippi Medicaid ID Number: *(If MSCAN is selected under LOB, a Medicaid ID is required. If you do not have a group/individual Medicaid ID issued from the Mississippi Division of Medicaid, we will not be able to proceed with a group/individual agreement for MSCAN.)*	
Hospital Affiliation(s):	

Once the completed form is submitted, please allow 3-5 business days for a contract packet to be emailed to the contact email you provided above. The contract packet will allow you an opportunity to provide us with additional details about your practice/services to ensure proper contracting and enrollment setup. Application status requests can be emailed to MHMSProviderContracting@molinahealthcare.com

Non-Participating Provider Reimbursement

Non-network Providers may provide Emergency Services for a Member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or State Laws or regulations.

Except for Emergency Services and out-of-area Urgent Care Services, Marketplace Members must receive Covered Services from Participating Providers; otherwise, the services are not covered. Marketplace Members will be one-hundred percent (100%) responsible for payment and the payments will not apply to towards Deductibles or Annual Out-of-Pocket Maximum.

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

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only one of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
___ - ___ - ____

or

Employer identification number
__ - _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here Signature of U.S. person ▶ Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at www.irs.gov/fw9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding? on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Cat. No. 10231X Form **W-9** (Rev. 12-2014)

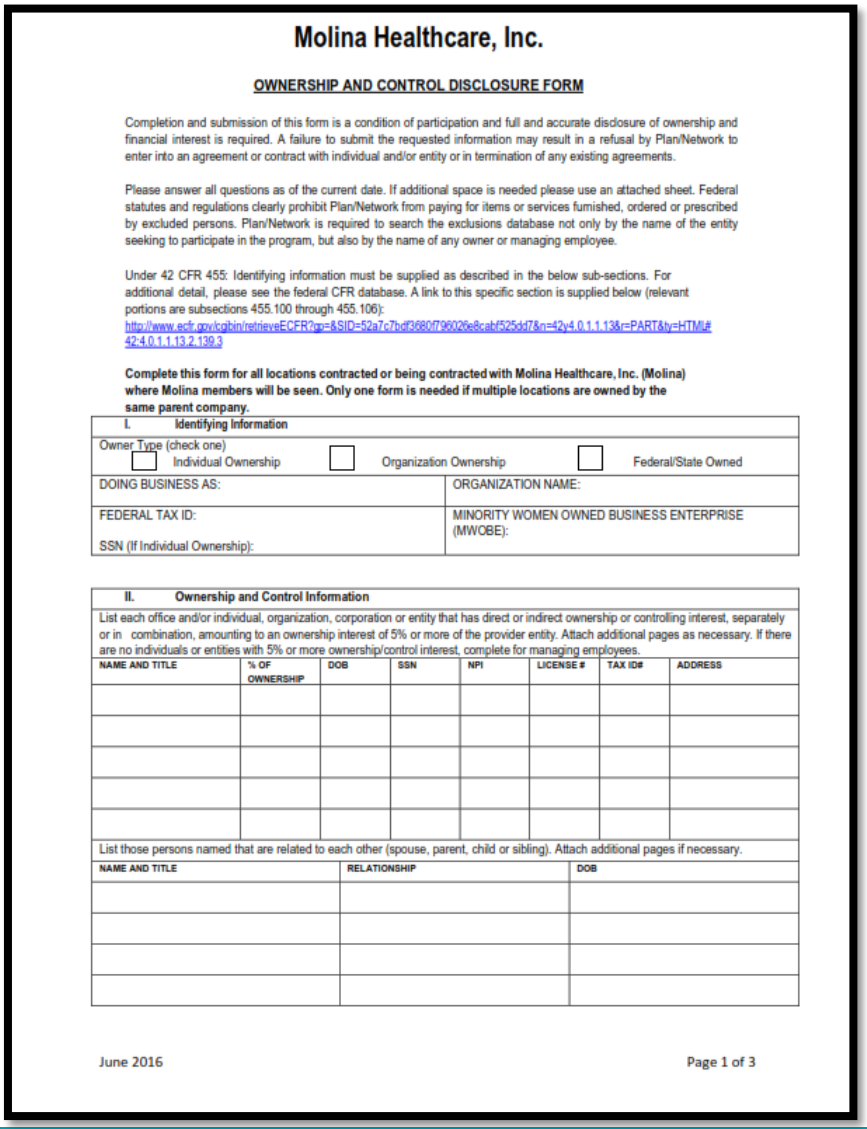
- ❑ Please complete one W9 for each Service Location where services will be rendered.
- ❑ Please ensure the W9 has been signed and dated upon submission.
- ❑ The EIN listed on this form must match the Tax ID listed on the agreement, and must also mirror the EIN used with Medicaid Registration.

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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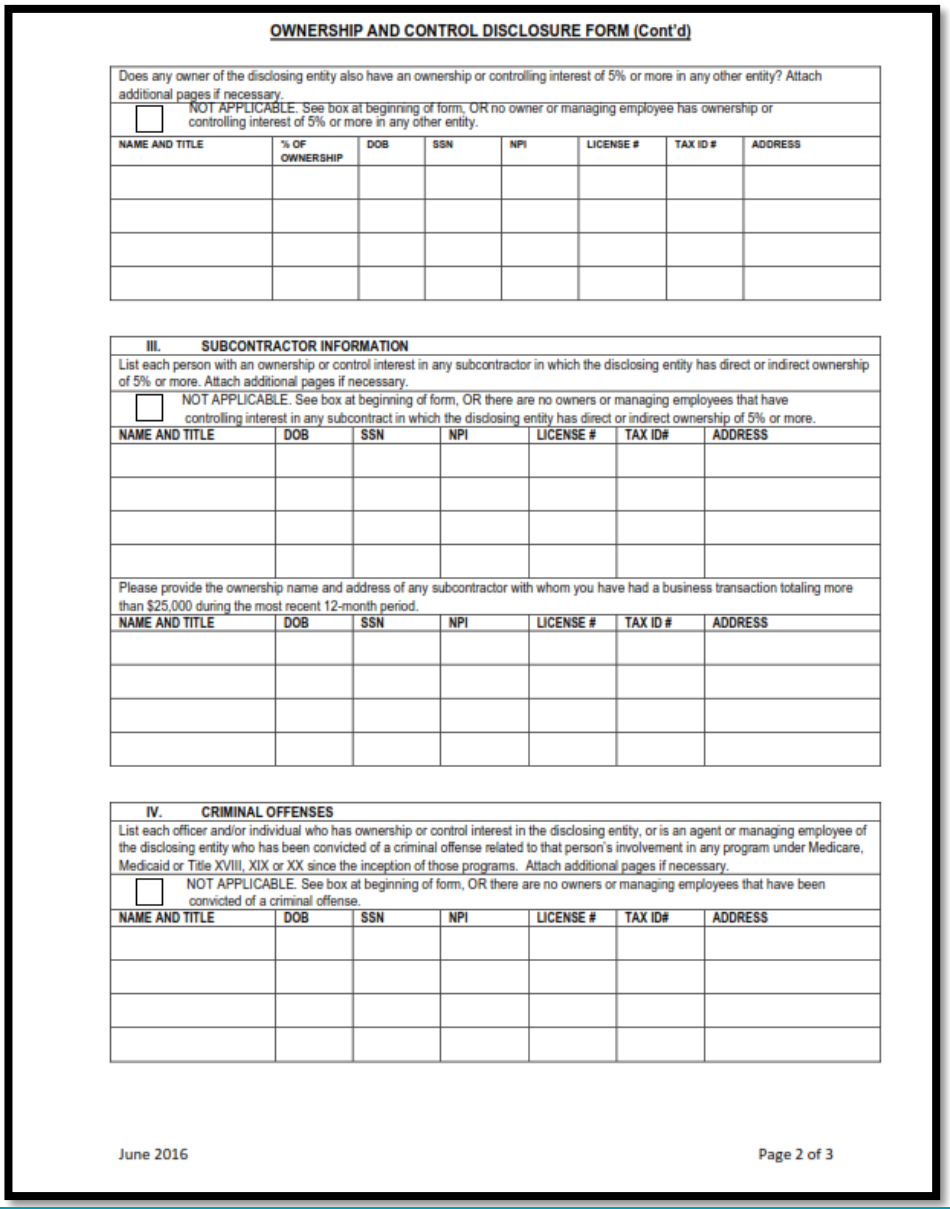
Ownership Control and Disclosure Form (OWN)

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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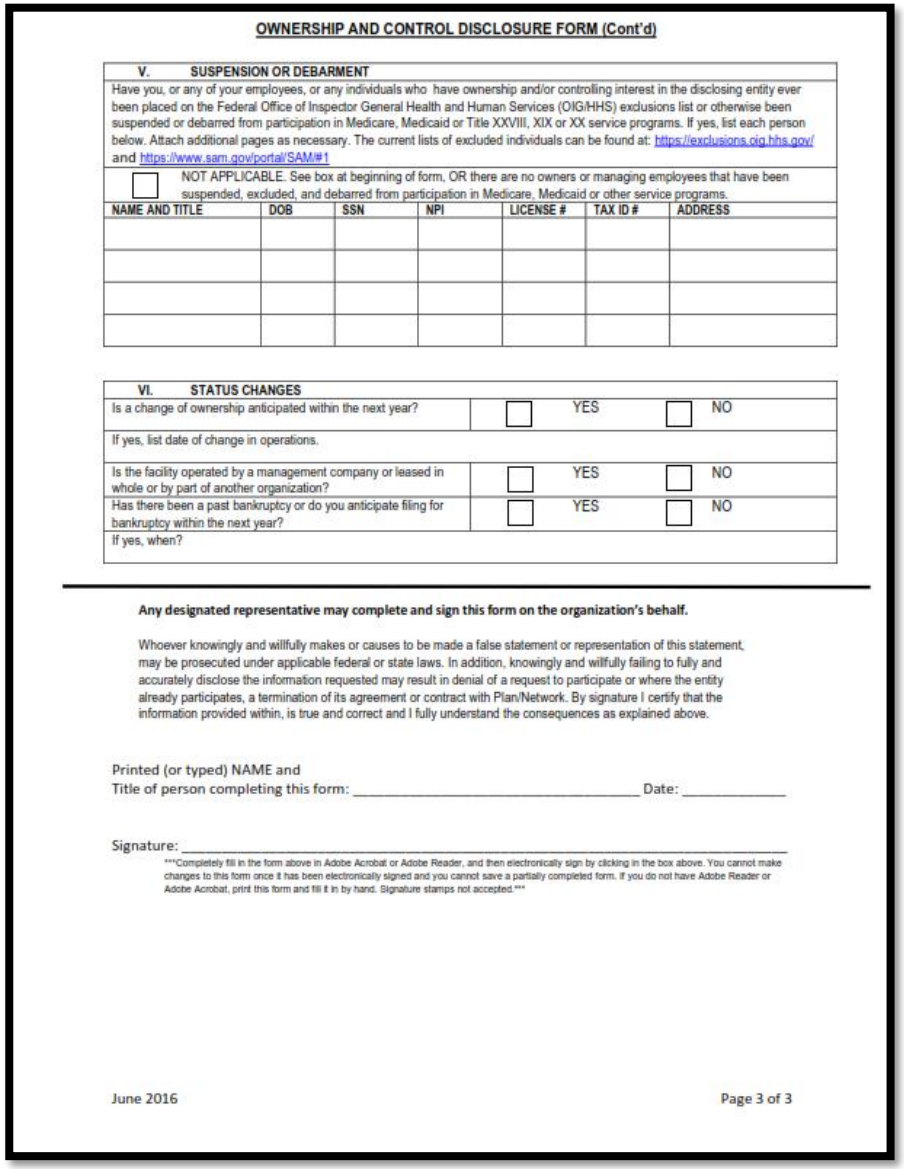
Ownership Control and Disclosure Form (OWN)

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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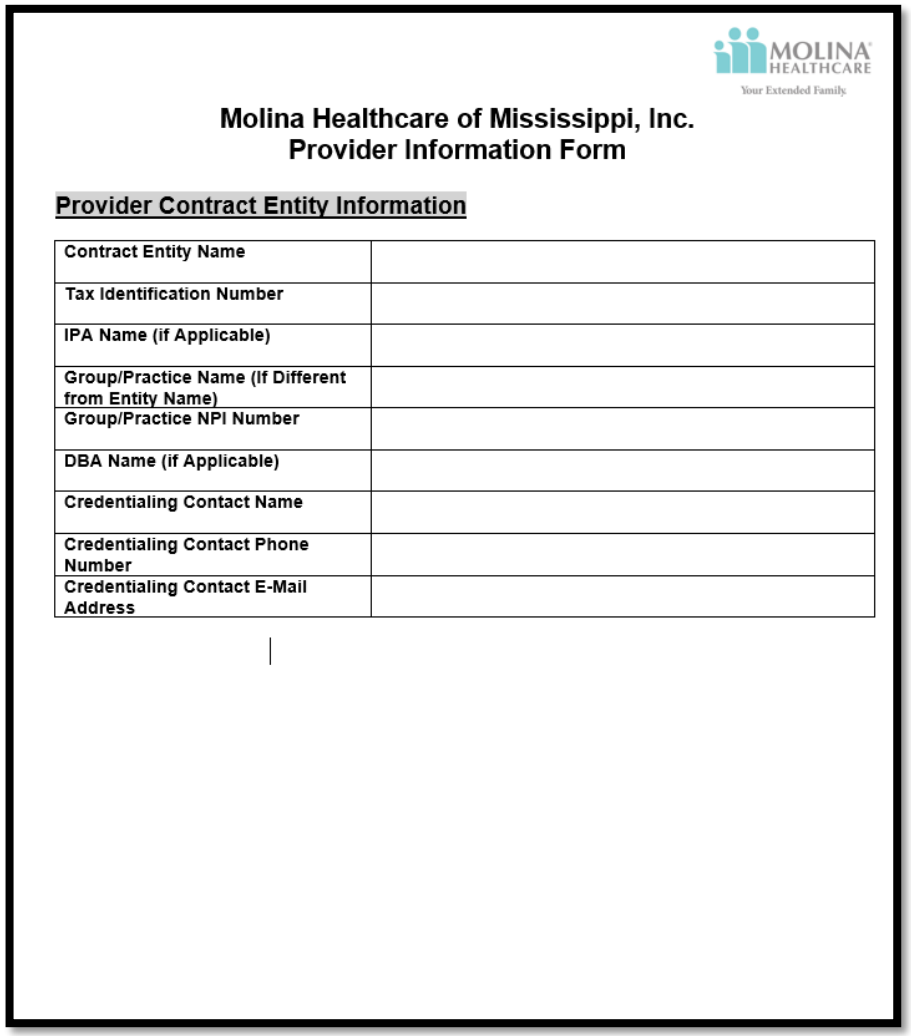
Provider Information Form (PIF)

- 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



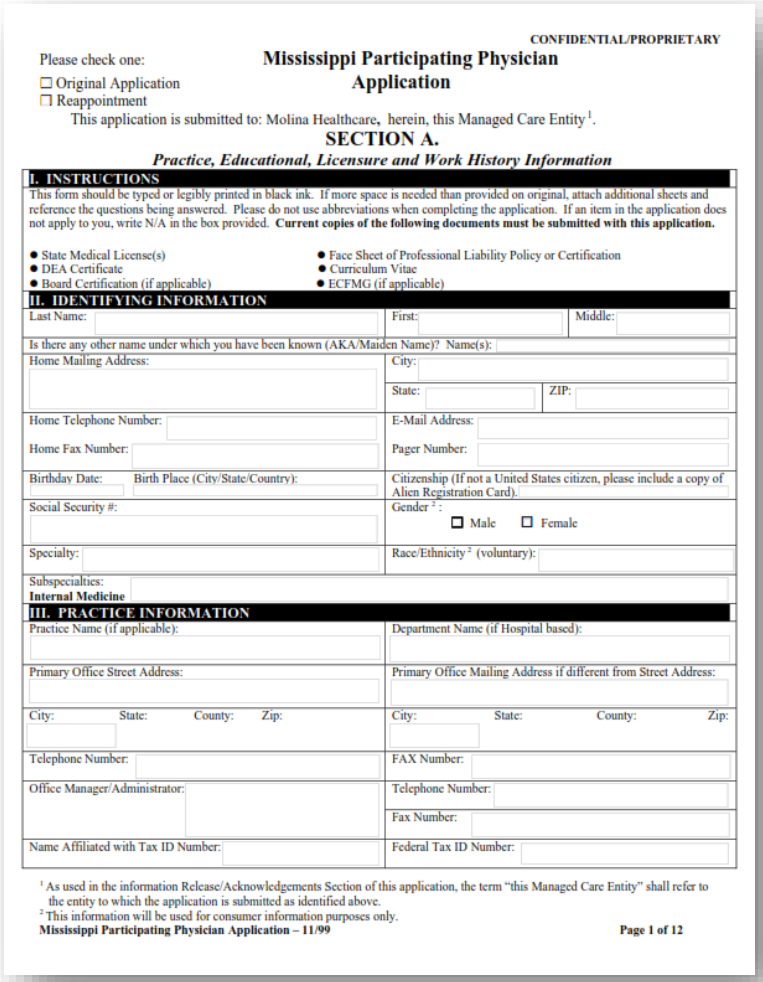
MOLINA HEALTHCARE
Your Extended Family

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.

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 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**

FAQs

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

A: State 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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