Section 13. Delegation

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

Delegation of Administrative Functions

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

- Call Center
- Claims payment
- Credentialing
- Transportation
- Utilization Management (UM)

Credentialing functions may be delegated to capitated or non-capitated entities, which meet NCQA criteria for credentialing functions. Utilization Management (UM) and/or Claims payment responsibility is generally only delegated to capitated entities. Transportation may be delegated to Vendors who can meet Transportation, as well as Claims Payment requirements.

Note: The member's Molina Healthcare ID card will identify which group the member is assigned. 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 referrals and prior authorizations (See section 2).

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.

Medical Group/IPA Full Name	ID card Acronym	Claims Remit to Address	UM Referral/ Authorization Phone #

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, or Vendors.

Molina Healthcare's Delegation Oversight Committee (DOC) must approve all delegation and sub-delegation arrangements.

Credentialing

To be delegated for credentialing functions, medical groups or IPAs must:

- Be accredited by the National Committee for Quality Assurance (NCQA) for credentialing or pass Molina Healthcare's credentialing pre-assessment, which is based on NCQA credentialing standards, with a score of at least 90%
- 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
- When key specialists, as defined by Molina Healthcare, contracted with IPA or group terminate, provide Molina Healthcare with a letter of termination according to contractual agreements and the information necessary to notify affected members

Note: If the medical group/IPA 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. Evaluation should be done prior to execution of a contract, 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 may request credentialing delegation from Molina Healthcare through Molina Healthcare's Delegation Manager (or this process can be initiated by 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 the credentialing process is based on the medical group/IPAs ability to meet Molina Healthcare's standards and criteria for delegation.

Utilization Management

To be delegated for UM functions, medical groups or 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 Molina Healthcare's UM pre-assessment, which is based on NCQA UM standards, with a score of at least 90%
- 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

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

A medical group or IPA may request UM delegation from Molina Healthcare through Molina Healthcare's Provider Services 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 or IPAs ability to meet Molina Healthcare's standards and criteria for delegation.

Claims

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

- Have a capitation contract with Molina Healthcare and be in compliance with the financial reserves requirements of the contract
- Except for Transportation Vendors, be delegated for UM by Molina Healthcare
- Pass Molina Healthcare's claims pre-assessment, which is based on State and Federal Claims Payment standards, with a score of at least 90%
- 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 Claims for emergency services, and the payment of interest on Claims not paid within Michigan regulated timeframes
- 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

Note: Molina Healthcare does not allow Claims delegates to further sub-delegate Claims activities.

A medical group/IPA may request Claims delegation from Molina Healthcare through Molina Healthcare's Delegation Manager (or this process can be initiated by 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.

Non-Emergency Transportation

To be delegated for Transportation functions, State or National Vendors must do the following:

- Pass Molina Healthcare's Transportation pre-assessment, which is based on State and Federal Transportation requirements, with a score of at least 90%

- Have automated systems that allow for scheduling of transportation appointments, confirmation of member eligibility, and availability of transportation benefits

- Have processes in place to ensure protection of member PHI

- Have processes in place to identify and investigate potential Fraud, Waste, and Abuse

- Have a network of vehicles and drivers that meet state and federal safety requirements

- Ensure on at least an annual basis that vehicles continue to meet state and federal vehicle safety requirements

- Ensure that drivers continually meet state and federal safety requirements

- Have a process in place for reporting of all accidents, regardless of harm to member, to Molina Healthcare within 48 hours

- Agree to Molina Healthcare's contract terms and conditions for Transportation delegates, including applicable Claims delegation requirements

- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare

- Submit timely and complete Transportation delegation reports to Molina Healthcare

- Comply with all applicable federal and state laws

Note: If the Transportation Vendor delegates to other sub-contractors, the Transportation Vendor must have a process to ensure that their sub-contractors meet all Health Plan and State and Federal requirements identified above. Evaluation should be done prior to execution of a contract, and annually thereafter. Evaluation should include review of compliance with driver requirements, vehicle requirements, Health Plan, State and Federal requirements, and a process to implement corrective action if issues of non-compliance are identified.

A Vendor may request Transportation delegation from Molina Healthcare through Molina Healthcare's Delegation Manager (or this process can be initiated by the Vendor'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 Transportation is based on the vendor's ability to meet Molina Healthcare's standards and criteria for delegation.

Call Center

To be delegated for Call Center functions, State or National Vendors must do the following:

- Have a Vendor contract with Molina Healthcare (Molina does not delegate call center functions to IPAs or Provider Groups)

- Pass Molina Healthcare's Call Center pre-assessment, based on CMS, URAC and State standards, with a score of at least 90%

- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare

- Protect the confidentiality of all PHI as required by law

- Have a system that allows Vendor Call center employees to confirm member benefits and eligibility during the call

- Agree to Molina Healthcare's contract terms and conditions for Call Center delegates

- Submit timely and complete Call Center delegate reports to Molina Healthcare

- Current call center is able to demonstrate that service level performance for average speed to answer, abandonment rate, and percentage of calls that are complaints meet CMS and/or URAC standards, depending on the line(s) of business delegated

A Vendor may request Call Center delegation from Molina Healthcare through Molina Healthcare's Delegation Manager (or this process can be initiated by the Vendor'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 Call Center responsibilities is based on the vendor's ability to meet Molina Healthcare's standards and criteria for delegation.

Quality Improvement/Preventive Health Activities

Molina Healthcare will not delegate quality improvement 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/IPAs quality improvement program.

Delegation Reporting Requirements

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