Fully Integrated Managed Care Provider Training
Presented by

MOLINA HEALTHCARE

COMMUNITY HEALTH PLAN of Washington™

March 1, 2016
Molina’s History

Founded in 1980 by Dr. C. David Molina

Single clinic

Commitment to provide quality healthcare to those most in need and least able to afford it

National company that touches over 3.5 million Medicaid beneficiaries

28 states, 2 commonwealths + Washington DC
Recognized for Quality, Innovation and Success

Molina Healthcare, Inc.
- Molina Healthcare plans have been ranked among America’s top Medicaid plans by U.S. News & World Report and NCQA
- FORTUNE 500 Company by Fortune Magazine
- Business Ethics magazine 100 Best Corporate Citizens
- Alfred P. Sloan Award for Business Excellence in Workplace Flexibility in 2011
- Ranked as the 2nd largest Hispanic owned company by Hispanic Business magazine in 2009
- Recognized for innovation in multi-cultural health care by The Robert Wood Johnson Foundation
- Dr. J. Mario Molina, CEO of Molina Healthcare, recognized by Time Magazine as one of the 25 most influential Hispanics in America
Molina in Washington

- 663,000 Members as of February 2016
  - 631,000 Medicaid members
  - 10,000 Medicare (DSNP)
  - 22,000 Exchange
- NCQA accredited
- Serving WA for more than 30 Years
  - Statewide: 37 of 39 counties
Molina Mission and Values

**Mission Statement**
To provide quality health care to persons receiving government assistance.

**Vision Statement**
We envision a future where everyone receives quality health care. We strive to become the Plan of Choice (for members, communities, providers, and employees).
Medicaid Programs

Molina Healthcare, in partnership with our robust network of providers and community partners, serves members throughout all of Washington State excluding Jefferson and Klickitat counties providing coverage for Apple Health, Medicare D-SNP and Marketplace plans.
FIMC and Care Management

We’ve always managed these members using an integrated approach

- Integrated teams – includes RNs and BH specialists (MH/CDP), BH MD
- Team-based consultation and co-management
- Single care plan incorporating all health domains

Exchange of information foundational to coordinated care

- Examples:
  - King County RSN data exchange
  - Snohomish County EMS
  - PreManage/EDIE

Community-based Care Coordination/Case Management

- Extensive Health Homes experience
Case Management Programs

- Community Based Face to Face Care Coordination
  - CHW
  - Health Homes
- Telephonic Case Management
- Telephonic Disease Management
- In person and Telephonic Transitions of Care
- 24/7 Nurse Advice line
Case Management Process

- Comprehensive Health Risk Assessment
- Specialized Assessments, including disease specific, depression, and quality of life
- Goal Setting in collaboration with the member
- Motivational interviewing techniques to encourage the member toward improved health outcomes
- Removal of barriers to care and services including navigating the health plan system
Benefits of Case Management for Providers

• Reinforce and supplement the information PCP’s provide their Molina patient;
• Improve medical compliance and management efforts;
• Encourage patients to make healthy lifestyle changes and stay on track of their health-related goals;
• Remove barriers to care and refer them to needed services;
• Partner with their PCP in developing and implementing a case/disease management treatment care plan;
• Provide PCP’s with updates on progress and/or areas of concern, problems identified, and/or progress made;
• Offer incentives to Molina patients to support healthy behaviors.
Molina Provider Engagement Team

- Provider Services
- Quality Improvement
- Heath Care Services
- Contracting
- Community Engagement
ABOUT CHPW

• History • Provider Network • Mission • Vision for Integrated Care
About CHPW

Community Health Plan of Washington (CHPW) was founded in the fall of 1992, by Community Health Centers in WA State. They voted to create a not-for-profit managed care company.

Our plan membership grew from 14,000 members in 1993 to over 300,000 currently.

CHPW is the only not-for-profit health plan in the state and has brought together shared values for equal access to health care, years of experience in community organizing, and effective health care administration.

[Logo of Community Health Plan of Washington]
About CHPW

Our Provider Network:

• 19 Community Health Centers with more than 130 Clinic’s
• More than 2,500 Primary Care Providers
• More than 14,000 contracted Specialists
• More than 100 Hospitals
About CHPW

Our **Mission** is to deliver accessible managed care services that meet the needs and improve the health of our communities, and make managed care participation beneficial for community-responsive providers.
Embracing the Vision

CHPW supports the Vision of Integrated Care

• Our Community Health Centers are based on this concept.
• Behavioral Health Services are offered in our clinics.
• CHPW developed the MHIP programs that improve quality, and save resources.
• CHPW performs the highest in most of measures reported by Qualis.

*CHPW secured an office space in Vancouver Wa –image on next slide.*
CHPW South Western WA Office

Stone Mill Center
120 NE 136 Ave., Suite C1
Vancouver, WA
• Apple Health • Community HealthFirst • Community HealthEssentials

CHPW LINES OF BUSINESS
CHPW Lines of Business

Washington Apple Health, continues to expand coverage in 2016 to individuals and families who have incomes below 138% of the Federal Poverty Level (FPL).

Community HealthFirst™ Medicare Advantage Plans

Our affordable Medicare Advantage HMO plans provide members valuable extended coverage and services.

Community HealthEssentials

CHPW’s individual commercial insurance plan offered inside the Washington Health Benefits Exchange in 2016.
Footprint – statewide
CHPW Apple Health FIMC and Behavioral Services Member ID Cards

The member ID card below represents a member who would have both Behavioral Health and Medical benefits through CHPW.

The member ID card below represents a member who would have Behavioral Health benefits through CHPW. Note that Medical benefits could be covered by another MCO, i.e., Foster Care members would be enrolled with Coordinated Care.
● Clinical Care Criteria ● Utilization Review

CARE MANAGEMENT
Care Management

CHPW’s Care Management Team uses clinical and evidence-based guidelines as tools in the care management process.

We monitor the care management process with care-usage reviews as well as analysis that identifies potential for care coordination, disease management, and members who may be at risk for improper use of care resources.

Our providers can access care management resources for patients in several ways, through prior authorization requests, our customer service department or through a case management referral.
Care Management

Clinical Care Management Criteria

• CHPW uses several resources to determine whether a specific intervention is medically necessary.

• Each case is assessed using appropriate criteria, also taking into account individual case information.

CHPW relies on the nationally recognized Milliman Care Guidelines as the primary source for evidence-based recommendations for clinical coverage.

In addition, CHPW has created Clinical Coverage Criteria (CCCs) for situations not addressed by Milliman Care Guidelines.
Care Management

Utilization Review Determinations

When making utilization review determinations, CHPW’s Medical Directors will take into consideration the:

• enrollee's age,
• social situation,
• co-morbidities, and
• availability of services within the community

For more information, go to http://chpw.org/for-providers/care-and-case-management/
• MHIP
• Health Homes

PROGRAMS
WASHINGTON STATE'S MENTAL HEALTH INTEGRATION PROGRAM (MHIP)

Purpose of MHIP is to integrate high quality mental health screening and treatment into primary care settings.

Almost 200 community health centers and community mental health centers in the state of Washington participate in this program funded by the state legislature with additional support for King County clinics provided by Public Health—Seattle and King County and Community Health Plan of WA.

Over 35,000 individuals have received integrated mental health services through this program since its inception in January 2008.

More information is available on a public website:
integratedcare-nw.org
Health Homes

Health Home services are available for eligible individuals with Medicaid or dual coverage with Medicaid and Medicare.

Eligible individuals have high service needs and complex chronic conditions like asthma, diabetes, cancer, and depression.

The state determines eligibility and identifies those individuals for CHPW.
Health Homes

The goal is to make things easier for those eligible by increasing coordination between health and social service providers.

Health Home services include:

• Care management
• Care coordination and health education
• Transitional care
• Individual and family support
• Referrals to community support services
• Use of health information technology to coordinate services
Health Homes

Questions?

• If you have questions about eligibility, call CHPW customer service at 1 (800) 440-1561 (TTY Relay: Dial 7-1-1), from 8 a.m. to 5 p.m. (PST) Monday through Friday.

• For other questions about the program, you can also contact CHPW’s Health Home mailbox at healthhomes@chpw.org.

• If you have questions regarding specific Health Home claims payment status or remittance advice, contact CHPW’s Claims Investigation Unit at cs.claimsdistribution@chpw.org.
Fully Integrated Managed Care (FIMC)
Early Adopter Region Begins Transition to Statewide Fully Integrated Managed Care

2014 Legislative Direction: 2SSB 6312

By January 1, 2020, the community behavioral health program must be fully integrated in a managed care health system that provides mental health services, chemical dependency services, and medical care services to Medicaid clients.

2020: Fully Integrated Managed Care System Across the State

Transition Period

- Apple Health Managed Care Plans
- Behavioral Health Organizations
- Integrated Purchasing in “Early Adopter (EA)” Regions – County Authority elect EA approach

2016 Regional Service Areas (RSAs)
Current State – Fragmented Financing and Care
Future State – Integrated Financing = Integrated Care
Two Contracts Cover All Enrollees

Medicaid Covered Services
- Physical Health (e.g. Apple Health)
- Mental Health
- Substance Use Disorder (SUD)
  - NOTE: MH and SUD = Behavioral Health (BH)

Wrap Around Benefits
- Behavioral Health services NOT covered or funded by Medicaid
- These services are funded by state General Fund, Federal Block grants
- Examples of services:
  - SUD & MH residential, withdrawal etc

Enrollees
- Apple Health Medicaid children, families, adults, blind/disabled
- Medicaid enrollees not eligible for managed care (includes foster care kids and those eligible for both Medicare & Medicaid)
- These enrollees will receive only Behavioral Health Services (BHSO)
What’s New for Fully Integrated Managed Care

- Community Based Care Coordination delivered by contracted providers
- Allied Services Coordination Plan (Community partners)
- Collaboration protocols with Allied Services Partners
What Does Better Look Like?

Better medical care and outcomes for people living with chronic mental illness

Better identification and treatment of behavioral health conditions in primary care

Better integration of fragmented system through care coordination – no falling through cracks

Better inclusion of Social Determinants of Health

Triple Aim
- Better health outcomes
- Lower total cost of care
- Better Patient/Provider experience
# Provider Network

## Primary Care
- Integrated Delivery Systems (Legacy Health, Peace Health)
- Primary Care Clinics (i.e. Pediatrics, Family Practice, Internal Medicine, Naturopath)

## Mental Health
- Inpatient Psychiatric Hospitals – MCOs do not administer this benefit
- Community Mental Health Agencies
- Behavioral Health Providers-Group Practices
- Individual Behavioral Health Providers

## Substance Use
- Substance Use Disorder (SUD)/ Chemical Dependency Agencies
- Inpatient and Outpatient Treatment
- Involuntary and Voluntary Facilities

## Community Providers
- Beacon Health- Behavioral Health Administrative Services Organization (BH-ASO) for providing crisis service response 24 hours a day/7 days a week/365 days a year
How to work with each MCO

- Credentialing
- Provider Directories
- Provider Data
- Access to Care
- Provider Portals
- Claims and Billing

- PA - Referral requirements
- Appeals and Grievances
- Specific Requirements
  --Balance Billing
  --Advanced Directives
  --SUD Release
  --CLAS
  --Core Provider Agreement (CPA)
Credentialing
FIMC Credentialing

• Behavioral health care providers (BHP’s) in delivering mental health services in the State of Washington as part of the Fully Integrated Managed Care Model are credentialed according to NCQA requirements and CHPW credentialing policies and procedures.

• Practitioners associated with a Community Mental Health Clinic (CMHC) do not require individual credentialing as the CMHC is credentialed at the facility level.

• Practitioners that are licensed, certified or registered by the State of Washington and who practice independently (without supervision) must be credentialed (individual or facility) per NCQA requirements.
Credentialing Process & Inquiries

CHPW uses **ProviderSource**: Your group could enter data and manage practitioner records in ProviderSource. The application is free for provider organizations and uses your OneHealthPort login.

To start a new credentialing application, email **Provider.Credentialing@chpw.org**. In your email, note if your provider records are available in ProviderSource, or attach your providers Washington Practitioner Application.

**Non-Delegated Credentialing Groups** should send their credentialing inquiries to: **Provider.Credentialing@chpw.org**

**Delegated Credentialing Groups** should send their rosters and credentialing inquiries to: **DelegatedCredentialing@chpw.org**
Provider Directories
CHPW Provider Directory

To access our Provider Directory, including Mental and Behavioral Health Providers, please go to: [http://chpw.org/provider-search/](http://chpw.org/provider-search/)

From website: Steps to find a Mental or Behavioral Health Provider:

Enter Zip, City or County here and enter Behavioral or Mental here:

Example results for Behavioral Health Provider search:

Uncheck this box and click here:
Provider Network

Molina’s Provider Directory, including Behavioral Health Providers, can be found online at: https://providersearch.molinahealthcare.com/.

In the upper box, select “WA” from the state selection box, select the city or enter a zip code and the distance radius.

In the lower box, select “Medicaid” in the coverage box & the appropriate provider type.
Provider Data
Reporting Provider Changes/Updates

**CHPW and Molina** providers must give notice **at least 60 days in advance** of any provider changes such as:

- Provider Terms
- Provider Adds/Updates
- Tax ID Changes
- Group and/or Individual NPI
- Billing and/or Pay to addresses
- Clinic locations (where services are rendered)

For **CHPW** send changes and updates to: Provider.Changes@chpw.org
For **Molina** send changes and updates to: mhwproviderinformation.qnxtchanges@molinahealthcare.com

**Note:** Claims processing errors, rejections, denials and/or delays are often due to outdated and/or incorrect Provider information in our systems.
Access to Care
PCP Access Standards

CHPW and Molina access standards comply with the Healthcare Care Authority (HCA) and the National Committee for Quality Assurance (NCQA) requirements. According to our contracts with HCA and our commitment towards quality improvement, MCO network of Primary Care providers must also adhere to these standards.

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Appointment Wait Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care Appointment</td>
<td>Within 30 calendar days of request</td>
</tr>
<tr>
<td>Second Opinions</td>
<td>Within 30 calendar days of request</td>
</tr>
<tr>
<td>Routine Primary Care</td>
<td>Within 10 calendar days of request</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Available by phone 24 hours/seven days</td>
</tr>
<tr>
<td>After-Hours Care</td>
<td>Available by phone 24 hours/seven days</td>
</tr>
<tr>
<td>Office Waiting Time</td>
<td>Should not exceed 30 minutes</td>
</tr>
<tr>
<td>Care Transitions – PCP Visit</td>
<td>Within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program</td>
</tr>
<tr>
<td>Care Transitions – Home Care</td>
<td>If applicable, Transitional health care by a home care nurse or home care registered counselor within 7 calendar days of discharge from a substance use disorder treatment program, if ordered by the enrollee’s primary care provider or as part of the discharge plan</td>
</tr>
</tbody>
</table>
Behavioral Health Standards

CHPW and Molina access standards comply with the Healthcare Care Authority (HCA) and the National Committee for Quality Assurance (NCQA) requirements. According to our contracts with HCA and our commitment towards quality improvement, MCO network of Behavioral health providers must adhere to these standards.

<table>
<thead>
<tr>
<th>Behavioral Health Appointment Types</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life threatening</td>
<td>Immediately</td>
</tr>
<tr>
<td>Non-life threatening</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Routine care</td>
<td>Within 10 calendar days</td>
</tr>
</tbody>
</table>
Provider Portals
Molina Provider Web Portal

Molina’s provider web portal is an easy-to-use online tool designed to meet your needs. Following are many of the useful features:

• Member Information and Eligibility
• Member Roster
• HEDIS® Profile
• Service Requests/Authorizations
• Claims
• Account Management
• Forms/Links
Molina Web Portal User Access

How to Register:

2. Click on the “New Provider Registration” link under the Provider Web Portal Login box.
3. Under Admin User Responsibility, select “To continue with registration, click here” and you will be taken to the registration page.

**Registration is easy as 1, 2, 3!**
1. Select your Line of Business
2. Select your Provider Type
3. Tax ID Number & Molina Provider ID

Contact Provider Service Representative for Molina Provider ID if needed.

If you have any questions, please contact your Provider Services Representative or the Provider Services Department at (888) 858-5414.
Provider Portals

Health Information Portal (HIP)

Registered users have access to the following information:

- Eligibility and Benefit Details
- Member Rosters
- Capitation Rosters
- View Referrals & Authorizations
- View Claim Status

*Once registered, providers can access HIP through a single sign-in at:*

- OneHealthPort, or
- [https://hip.chpw.org/login.asp](https://hip.chpw.org/login.asp)

Support Phone Number: 1 (800) 440-1561
Provider Portals

CHPW - JIVA Care Management Portal

The portal is the preferred method for you to submit and track all Care Management requests.

Request or check the status of the following:

- Eligibility/Referrals/Prior Authorizations
- Notify CHPW of Inpatient Admissions

To register for JIVA, contact:

- Email: Portal.Support@CHPW.org

To access website, go to: https://jiva.chpw.org
Claims and Billing
Timely Filing & Claims Submission

Timely Filing = 365 days from Date of Service

Where to Send Claims

Paper Claims:
CHPW Claims
PO Box 269002
Plano TX, 75026-9002

Electronic Claims Submission:
Availity Payor ID: CHPWA

Electronic Transactions:
Emdeon Payor ID: SB613

Claims Status:

WA Apple Health
Customer Service
1 (800) 440-1561

Medicare Advantage
Customer Service
1 (800) 942-0247
Electronic Transactions

CHPW supports the following Electronic Transactions:

**270:** Eligibility, coverage or benefit inquiry
**271:** Eligibility, coverage or benefit information
**276:** Health care claim status report
**277:** Health care information status notification
**834:** Benefit enrollment and maintenance
**835:** Health care claim payment advice
**837:** Health care claim

**ACH payments:** Automated clearing house (ACH) payments are electronic payments often referred to as direct deposit or electronic funds transfer (EFT).

To enroll, email: [EDI.Support@chpw.org](mailto:EDI.Support@chpw.org).
Submitting Claims

• EDI Claims Submission – Medicaid & Medicare
  ✔ Accepts All Claim Types
  ✔ Accepts Coordination of Benefit Claims as Medicaid Secondary Payer Payor ID# 38336
  Telephone (877) 469-3263
• Medicaid/MarketPlace Claims Submission Address
  Molina Healthcare of Washington
  PO Box 22612
  Long Beach, CA 90801

• EDI Claim Submission Issues
  Please call the EDI customer service line at (866) 409-2935 and/or submit an email to:
  EDI.Claims@Molinahealthcare.com
  Leave a detailed message with your name and contact information

• Claims can also be submitted via the Molina Provider Portal.
Electronic Funds Transfer & Remittance Advice (EFT/ERA)

Molina has partnered with our payment vendor, Alegeus Technologies, for Electronic Funds Transfer and Electronic Remittance Advice. Access to the ProviderNet portal is FREE to our participating providers and we encourage providers to register after receiving their first check from Molina. You can register at: [https://providernet.adminisource.com/Start.aspx](https://providernet.adminisource.com/Start.aspx)

Benefits of signing up for EFT/ERA:
- Administrative rights to sign-up/manage your own EFT Account
- Ability to associate new providers within your organization to receive EFT/835s
- View/print/save PDF versions of your Explanation of Payment (EOP)
- Historical EOP search by various methods (i.e. Claim Number, Member Name)
- Ability to route files to your ftp and/or associated Clearinghouse

If you have questions regarding the registration process, please contact ProviderNet at: (877) 389-1160 or email: wco.provider.registration@emdeon.com
Plan Referrals and Prior Authorizations
Plan Authorized Referral

CHPW requires a **Plan Authorized Referral** as follows:

- **Non-Par Specialist** will always require a **Plan** Authorized Referral.

- **Non-Par Primary Care Provider/Clinic** will always require a **Plan** Authorized Referral from CHPW.

- **Contracted Primary Care Provider/Clinic** – member presents to your clinic, and they are not assigned to your organization, including an Urgent Care or After Hours Clinic (billed with POS 11) – your group would need to request a Plan Authorized Referral from CHPW prior to rendering services.

**Note:** CHPW does not issue retro-referrals; thus a referral must be obtained prior to rendering services. If not obtained, claims will deny correctly. Providers have appeal rights; however, if you are unable to support your appeal with extenuating circumstances, your denial would likely be upheld.
Plan Authorized Referral

The CHITA form is used to submit a request for a Plan Authorized Referral – fax to:

Apple Health (206) 613-8873
Medicare Advantage (206) 652-7065.

Preferred method to request a Plan Authorized Referral is through our Care Management Portal (JIVA).

To access this form and other forms and tools, please go to [www.chpw.org](http://www.chpw.org):

From the Home Page:
Click “For Providers”
Click “Forms and Tools”
Prior Authorization (PA) Requests

Providers could request Prior Authorizations one of two ways as follows:

• Complete and submit a CHPW Prior Auth form via fax to:
  --Apple Health (Medicaid) 206 613-8873
  --Community HealthFirst (Medicare Advantage) 206 652-7065

• Submit requests through CHPW’s care management portal (JIVA)
Prior Authorization (PA) Requests

CHPW and Molina follow Medicare and Medicaid guidelines on standard response times as follows:

**Medicaid (Apple Health)**
Standard PA Requests: 5 days – 14 days
Urgent PA Requests: 24hrs - 72hrs

**Medicare Advantage (Community HealthFirst)**
Standard PA Requests: 14 days – 28 days
Urgent PA Requests: 72hrs – 14 days

Turnaround times are extended if additional information is required. To avoid delays, providers must submit complete information with the initial request.
Prior Authorization (PA) Lists

CHPW offers the following Prior Authorization Lists:

- PA Hard Copy List (non-code driven)
- PA Help List (code driven)

CHPW recommends that providers use the hard copy PA List as a primary tool found here: [http://chpw.org/for-providers/prior-authorization-and-medical-review/](http://chpw.org/for-providers/prior-authorization-and-medical-review/). The PA “help list” could be found in the same location through this link.

Please note that providers will be more familiar with specific drugs and/or services than CHPW Customer Service Reps; thus it is best to submit a PA request if you are uncertain that a PA is required.
Pre-Service Authorization Requests

- Prior Authorization/Pre-Service Review Guide is located at http://www.molinahealthcare.com/providers/wa/medicaid/Pages/home.aspx
  - CLICK – Frequently Used Forms from the Forms dropdown menu
  - Specialty service specific information also available here for Residential Inpatient Treatment

- Molina Prior Authorization by CPT Code Guide
  - Provides prior authorization requirements based on specific procedure code, place of service, etc.

- Molina Behavioral Health Prior Authorization Guide
  - Located within the Provider Web Portal
  - Provides high-level guidance on prior authorization requirements for behavioral health services
  - https://provider.molinahealthcare.com/provider/login
Prior Authorization

• For most efficient processing, all requests should include, if applicable:
  • Appropriate service location (inpatient residential, etc.)
  • Planned date of service/service date range
  • ICD-10 diagnosis code(s)
  • CPT, HCPCS or revenue code(s)

• No authorization required for most outpatient services with in- network specialists.
Behavioral Health Prior Authorization

**Frequently Used Numbers**

To request an authorization or check the status of a request:

Provider Web Portal
Healthcare Services (Prior Authorization): (800) 869-7175

To fax in a request for services:
Prior Authorization Fax: (800) 767-7188 or (505) 924-8284

For any prior authorization *escalated* issues that cannot be resolved through the prior authorization line, contact the supervisors:

  Donna Jeter-Francis (425) 424-1175 (Authorization process)
  Matt Ryerson (425) 398-2615 (Clinical)
  Tim Reitz (888) 562-5442 ext. 142635 (Manager)
Provider & Member Appeals
Medicaid Appeals

The appeals process has 4 steps:

**Step 1:** CHPW Appeal  
**Step 2:** State Hearing  
**Step 3:** Independent Review  
**Step 4:** Review Judge Decision

**Step 1:**

- Enrollees have 90 calendar days from the CHPW denial letter to file an appeal.
- Enrollee may chose someone, including an attorney (at the members expense) or provider, to represent them.
- Enrollee **must complete and sign** a **consent form** if they chose a representative to appeal on their behalf.
Medicaid Appeals

• CHPW will respond within 72 hours in writing to acknowledge receipt of the appeal.

• CHPW will submit a decision in writing within 14 calendar days, unless CHPW notifies the enrollee that more time is needed, but within a maximum of 30 days.

If the member disagrees with CHPW’s decision, the member can request a State Hearing – Step 2

The member can continue to appeal through to Step 4.

Step 4 appeal decision is final.

*Post Service: Providers have the right to appeal on their own behalf.
Appeal Timelines

• Participating providers have 24 months from the date of the denial to file a Level 1 appeal.

• If they disagree with the decision in Level 1, they have 60 days to file a Level 2 appeal.

• Unless the Providers contract includes a provision for the right to arbitration, Level 2 is the final appeal option with the Plan.

• Currently CHPW extends a courtesy to non-par providers who can file an appeal within 90 days from the date of the denial.

Provider and Member appeals and grievances may be mailed, faxed or emailed:
Address: 720 Olive Way, Ste 300 – Seattle, WA 98101
Fax: 206 613-8984
Email: appealsgrievances@chpw.org
Submitting Provider Appeals

For information regarding what is needed to submit a provider appeal, please visit our Provider Manual, available online at:
http://www.molinahealthcare.com/providers/wa/medicaid/manual/Pages/provman

Preferred submission methods:
   Fax: (877) 814-0342
   Email: MHWProviderServicesInternalRep@Molinahealthcare.com

Appeals may also be submitted via mail:
   Molina Healthcare of Washington
   Provider Services Department
   PO Box 4004
   Bothell, WA 98041-4004
Member Appeals

• A Member or Member Representative may request an appeal for a denied service or authorization within 90 calendar days of the denial. The appeal rights and process for FIMC remain the same with the exception of the WrapAround Services. The MCO will resolve appeals related to WrapAround services within three (3) calendar days of receipt.

• For more information regarding the Member Appeal process please visit our website at:
• Balance Billing • Advance Directives • Substance Use Disorder (SUD) Release
• CLAS • Core Provider Agreement (CPA)

Specific Requirements
Balance Billing

• Providers must accept payment by CHPW or Molina as payment in full.

• Balance billing is not permitted unless the provider and member fully complete and sign an HCA 13-879 form--Agreement to Pay for Healthcare Services. See WAC and HCA Memo in final bullet below for additional information.

• Services must be rendered within 90 days from signing the HCA 13-879 form, otherwise a new form must be completed and signed.

• The HCA 13-879 form must be translated into the member’s primary language if he or she has limited English proficiency, and if necessary, an interpreter must be provided for the member. If an interpreter is used to complete and sign the form, the interpreter’s signature must also be obtained.

• All other requirements for the HCA 13-879 form apply, as outlined in WAC 182-502-0160, 42 CFR 447.15, and HCA Memo #10-25.
Advance Directives

**CHPW and Molina** are required to educate and inform employees, providers, and members about a patient’s rights to an Advance Directive.

An Advance Directive gives written instructions about a patient’s medical care in the event that the patient is unable to express his or her medical wishes.

For the State of Washington there are three types of Advance Directives:

- **Health Care Directive/Living Will**-specifies an individual’s wishes about end of life care.
- **Durable Power of Attorney**-names another person to consent to, stop, or refuse treatment if an individual is incapable of doing so.
- **Mental Health (MH) Advance Directive** – allows a person with capacity to state mental health treatment preferences in a legal document that will govern during periods of incapacity (see section below for more information on MH Advance Directive).
Advance Directives

To be valid, a Mental Health Advance Directive must:

• be in writing;
• include language indicating a clear intent to create a directive;
• be dated and signed by the patient, or be dated and signed in the patient’s presence at his or her direction;
• state whether the directive may or may not be revoked during a period of incapacity;
• be witnessed in writing by at least two adult witnesses; and
• conform substantially to the statutory format.
Authorization to Release Substance Use Disorder Treatment Information Form

An Authorization to Release Substance Use Disorder Treatment Form (shown on next slide) must be completed and signed to release protected substance use disorder treatment (alcohol or drug treatment) information (Part 2 Protected Records) as required by state and federal privacy laws.

Authorization will allow Community Health Plan of Washington (the Plan) to release Part 2 Protected Records to person(s) or organization(s) that are specifically name on the form by the member/patient.
Authorization to Release Substance Use Disorder Treatment Information Form

For other forms and tools, please go to [www.chpw.org](http://www.chpw.org):

From the Home Page:
Click “For Providers
Click “Forms and Tools”

or copy/paste the following link to your browser:
Authorization to Release Substance Use Disorder Treatment Information Form

[Form content]

Molina Healthcare

[Form content]

NOTICE TO PATIENTS: COMPLIANCE WITH PROTECTION OF HEALTH INFORMATION REGULATIONS

[Form content]

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Authorization to Release Substance Use Disorder Treatment Information Form

Molina Healthcare

Consent for the Release of Confidential Information

I authorize

(Name of Patient/Member)

ABC Recovery Center and the Washington State Division of Behavioral Health and Recovery

(Name or general designation of alcohol/drug program or organization making disclosure)

to disclose to the following persons or organizations, which I also authorize to disclose to one another:

Washington State Health Care Authority, Molina Healthcare, TRG - BH ASO, and my current primary care physician (TPC - insert from Molina ID Card)

(Nature and amount of the information to be disclosed, as limited as possible)

The purpose of the disclosure authorized in this is to: Support coordination of care, payment, and health care operations.

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 43 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I have been provided a copy of this form.

Date: __________________________

Signature of Patient/Member

Describe authority to sign on behalf of patient/member

Signature of person signing form if not patient/member

According to CFR 42 § 2.31, a properly completed consent for release of confidential information must contain each of the following items:

1. The name or general designation of the program(s) or organization making disclosure;
2. The name of the individual or organization that will receive the disclosure;
3. The name of the patient who is the subject of the disclosure;
4. The purpose or need for disclosure;
5. A description of how much and what kind of information will be disclosed;
6. The patient’s right to revoke the consent and the exceptions to the right to revoke or, if the exceptions are included in the program’s notice, a reference to the notice;
7. The date, event or condition upon which the consent expires if not previously revoked;
8. The signature of the patient and/or other authorized person; and
9. The date on which the consent is signed.

The program’s or organization’s ability to condition treatment, payment, enrollment or eligibility of benefits on the patient agreeing to sign the consent, by stating either that the program or organization will not condition these services on the patient signing the consent, or the consequences for the patient refusing to sign the consent.

This is a legal document. Any change to this document, once the patient/member has signed it, requires their initials and the date of the amendment as an indication of their approval for the change.

A revocation requires only that a line be drawn through the document, with the word “Revoked”, and the date and time of revocation. The patient need not initial a revocation. A patient may request revocation by any means, including the telephone, provided their identity is confirmed.
What is Cultural and Linguistically Appropriate Services (CLAS)?

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States.

Molina Healthcare of Washington (MHW) assesses the cultural, ethnic, racial and linguistic needs and preferences of its members on an ongoing basis. Information gathered during quarterly monitoring and annual network assessment is used to identify and eliminate cultural and/or linguistic barriers to care through the implementation of programs and interventions. The plan works to ensure that limited-English-proficient members have equal access to quality health care through culturally and linguistically appropriate providers, staff and written materials.
Cultural and Linguistically Appropriate Services (CLAS)

Molina Healthcare of Washington
Endorses all 15 CLAS standards and is focusing on the following three:

• Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

• Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

• Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

For any additional questions, please contact our Quality Improvement Department at: 1-(888) 562-5442 ext. 147181
Culturally and Linguistic Appropriate Service (CLAS)

CHPW supports providers in meeting CLAS standards and meets them ourselves by:

1. Training on key items, like the standards and tools we recommend for good care.
2. Resources to use with CHPW members in need of language assistance.
3. How to gain additional resources on CLAS and culturally competent care.

A complete training program on CLAS standards could be found here: [http://chpw.org/for-providers/training/](http://chpw.org/for-providers/training/). This is a mandatory training program for providers.
Language Assistance

CHPW interpretation services are available as follows:

– **Apple Health**: The Health Care Authority’s vendor provides this service at (800) 535-7358.

– **Medicare**: CHPW provides this service at (866) 998-0338 with the following log in:
  
  • Enter Account Number: 14767
  • Enter PIN Number: 0044
  • Enter Cost Center: 44
HCA Core Provider Agreement

CMS Requirement

Providers with an NPI that do not have a Core Provider Agreement with the HCA will need to register as a non-billing provider by completing and submitting the Non-Billing Provider Application to the HCA.

The HCA Medicaid Enrollment Application and Agreement for Non-Billing Individual Providers could be found here:


To fax:
Attn: Provider Enrollment
360 725-2144

To mail, send to:
Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562
HCA Core Provider Agreement (CPA)

Important Facts:

• This new requirement is effective **July 1, 2016**.

• Encounters without a CPA or Non-Billing Agreement will count against the Plan.

• HCA will provide CHPW with a list of current providers who have a CPA or Non-Billing Agreements.

• CHPW will identify contracted providers who do not have an agreement with the HCA and will notify them to complete a Non-Billing Agreement Form.
Thank you.