ASES
Asegurando tu Salud
Administración de Seguros de Salud de Puerto Rico

Puerto Rico Government Health Plan

Provider Manual

MOLINA® HEALTHCARE
OF PUERTO RICO, INC.

(888) 558-5501

Section 1. Addresses and Phone Numbers

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding member claims, benefits, eligibility/identification, selecting or changing Primary Care Providers (PCPs), and member complaints. Member Services Representatives are available 7:00 am to 7:00 p.m. Monday through Friday, excluding Commonwealth holidays.

Member Services
Address: Molina Healthcare of Puerto Rico, Inc. Attn: Member Services 654 Plaza, Suite 1600 654 Avenida Munoz Rivera San Juan, PR 00918
Phone: (877) 335-3305 (Spanish)
TTY: (787) 522-8281 (English)

Claims Department

The Claims Department is located at our main office in Puerto Rico. All hard copy (CMS-1500, UB-04) claims must be submitted by mail to the address listed below. Electronically filed claims directed to Molina Healthcare must use Payor ID number - **81794.** To verify the status of your claims, please call our Provider Claims Representatives at the numbers listed below:

Claims
Address: Molina Healthcare of Puerto Rico, Inc. PO Box 364828 San Juan, PR 00936-4828
Phone: (888) 558-5501

Claims Recovery Department

The Claims Recovery Department manages recovery for overpayment and incorrect payment of claims.

Claims Recovery
Address: Molina Healthcare of Puerto Rico, Inc. Attn: Claims Recovery 654 Plaza, Suite 1600 654 Avenida Munoz Rivera San Juan, PR 00918
Phone: (888) 558-5501

Credentialing Department

The Credentialing Department verifies all information on the Practitioner Application prior to contracting and re-verifies this information every three years. The information is then presented to the Professional Review Committee to evaluate a provider's qualifications to participate in the Molina Healthcare network.

Credentialing
Address: Molina Healthcare of Puerto Rico, Inc. Attn: Credentialing 654 Plaza, Suite 1600 654 Avenida Munoz Rivera San Juan, PR 00918
Phone: (888)-558-5501
Fax: (800) 457-5213

24-Hour Nurse Advice Line

This telephone-based nurse advice line is available to all Molina Healthcare members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available (24) hours a day, seven (7) days a week to assess symptoms and help make good health care decisions.

HEALTHLINE (24-Hour Nurse Advice Line)
Spanish Phone: (888) 620-1515
TTY: (787) 522-8281 (English)

Healthcare Services (UM) Department

The Healthcare Services (formerly UM) Department conducts concurrent review on inpatient cases and processes Prior Authorization requests. The Healthcare Services (HCS) Department also performs Case Management for members who will benefit from Case Management services.

Healthcare Services Authorizations & Inpatient Census
Address: Molina Healthcare of Puerto Rico, Inc. Attn: Healthcare Services 654 Plaza, Suite 1600 654 Avenida Munoz Rivera San Juan, PR 00918
Phone: (888) 558-5501
Fax: (855) 378-3641

Health Management Level 1 and Management Department

The Health Education and Health Management Department provides education and health information to Molina Healthcare members and facilitates provider access to the programs and services.

Health Education & Management
Phone: (877) 335-3305
Fax: (855) 378-3641

Behavioral Health

Molina Healthcare has partnered with First Healthcare (FHC) to deliver Behavioral Health services to our members. Molina Healthcare of Puerto Rico, Inc. maintains a Crisis line, available twenty-four (24) hours per day, seven (7) days per week. Providers and Members can also obtain information about accessing Behavioral Health services by contacting us at the number and address below.

Behavioral Health
Phone: (888) 558-5501
(24) Hours per day, (365) day per year: (888) 558-5501

Dental Services

Dental services covered under the Government Health Program are offered through Delta Dental, Molina Healthcare's dental vendor.

Dental Services
Phone: (888) 558-5501

Pharmacy Services Department

The Pharmacy Services Department conducts review of Prior Authorization requests.

Pharmacy Services
Address: Molina Healthcare of Puerto Rico, Inc. Attn: Pharmacy PA 654 Plaza, Suite 1600 654 Avenida Munoz Rivera San Juan, PR 00918
Phone: (888) 558-5501
Fax: (844) 606-7171

Pharmacy Claims

MC-21 Corporation will serve as the Pharmacy Benefit Manager. The Pharmacy Network and claims processing are managed by MC-21. Pharmacies with questions related to network status and claims processing issues are urged to reach out to MC-21 directly.

Pharmacy Claims (MC-21)
Phone: (888) 311-6001

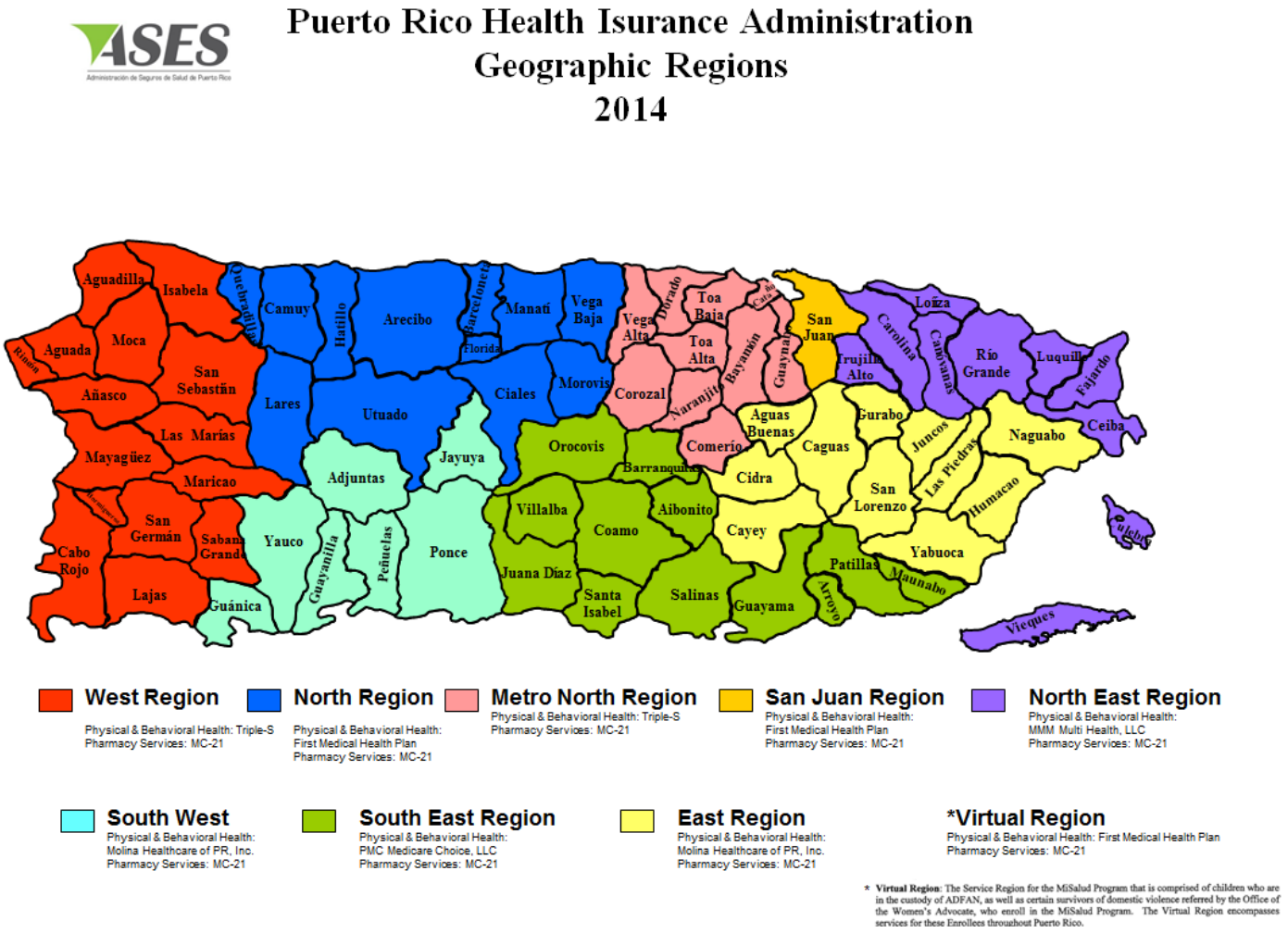
Provider Services Department

The Provider Services Department handles telephone and written inquiries from providers regarding address and Tax-ID changes, provider denied claims review, contracting, and training. The department has Provider Services Representatives who serve all of Molina Healthcare of Puerto Rico's provider network.

Provider Services
Address: Molina Healthcare of Puerto Rico, Inc. Attn Provider Services 654 Plaza, Suite 1600 654 Avenida Munoz Rivera San Juan, PR 00918
Phone: (888) 558-5501 (Spanish)
Fax: (787) 200-3251

Molina Healthcare of Puerto Rico, Inc. Service Area

The Molina Healthcare service area includes the South West and East regions.



Section 2. Enrollment, Eligibility and Disenrollment

Enrollment

Enrollment in Government Health Program (GHP)

The Government Health Program (GHP) is the program which implements Title XIX of the Social Security Act (Medicaid). It is administered by the Puerto Rico Health Insurance Administration known in Spanish as the Administracion de Seguros de Salud de Puerto Rico (ASES). The Medicaid Program or its agent takes applications and determines the eligibility of individuals and families for GHP.

Only GHP recipients who are included in the eligible populations and living in counties with authorized Health Plans are eligible to enroll and receive services from Molina Healthcare. Molina Healthcare of Puerto Rico, Inc. participates in GHP.

To enroll with Molina Healthcare, the member, his/her representative, or his/her responsible parent or guardian must complete and submit an application to the Medicaid Program.

The member and his/her family will be assigned to the Government Health Plan that services the area where the member resides.

No eligible member shall be refused enrollment or re-enrollment, have his/her enrollment terminated, or be discriminated against in any way because of his/her health status, pre-existing physical or mental condition, including pregnancy, hospitalization or the need for frequent or high-cost care.

Effective Date of Enrollment

Effective Date of Eligibility for Medicaid and CHIP Eligibles is the eligibility period specified on the Form MA-10 which is the first day of the month in which the Potential Enrollee submits its eligibility application with the Medicaid Program Office and they shall be eligible to be enrolled as of that date. For Medicaid and CHIP eligible members, the eligibility period specified on the MA-10 may be a retroactive eligibility period which is up to ninety (90) Calendar Days.

Newborn Enrollment

Molina contacts expectant members sixty (60) days prior to the expected delivery date to encourage the mother to choose a PCP for her newborn. When a Molina member gives birth the newborn will automatically be enrolled with Molina Healthcare. The Mother will be notified of the auto-assignment and will have ninety (90) days from the date of assignment to change plans. Coverage will be retroactive to the time of birth.

PCP's are required to notify Molina Healthcare via the Pregnancy Notification Report (included in Appendix B of this manual) immediately after the first prenatal visit and/or positive pregnancy test of any member presenting themselves for healthcare services.

Inpatient at time of Enrollment

Regardless of what program or health plan the member is enrolled in at discharge, the program or plan the member is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the member is no longer confined to an acute care hospital.

Eligibility Verification

Medicaid Programs

The Commonwealth of Puerto Rico, through ASES determines eligibility for the Medicaid Programs. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between providers and Molina Healthcare places the responsibility for eligibility verification on the provider of services. Molina Healthcare will not reimburse providers for services if the member was not eligible with Molina Healthcare on the date the service(s) were rendered.

Eligibility Listing for Medicaid Programs

Providers who contract with Molina Healthcare may verify a member's eligibility and/or confirm PCP assignment by checking the following:

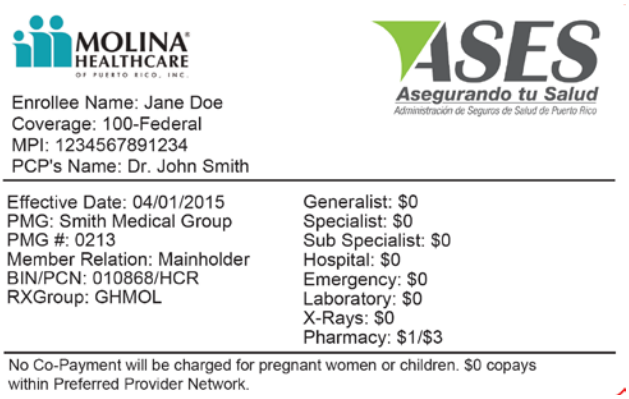
- Molina Healthcare Provider Services at (888) 558-5501
- Molina Healthcare, Inc. Provider Portal https://provider.molinahealthcare.com

Possession of a Medicaid ID Card does not mean a recipient is eligible for Medicaid services. A provider should verify a recipient's eligibility each time the recipient receives services. The verification sources can be used to verify a recipient's enrollment in a managed care plan. The name and telephone number of the managed care plan are given along with other eligibility information.

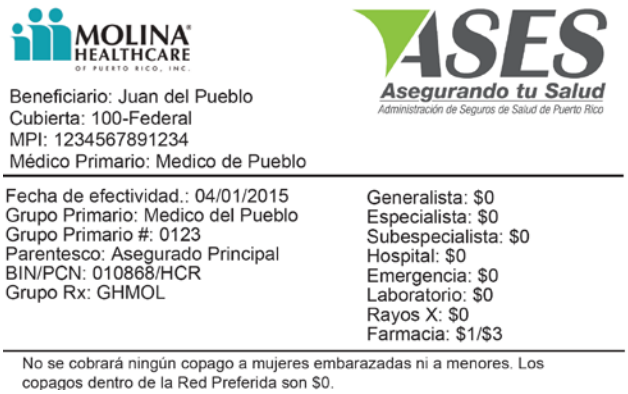
Identification Cards

Molina Healthcare of Puerto Rico, Inc. Sample Member ID card

English:



Spanish:



Members are reminded in their Member Handbooks to carry ID cards with them when requesting medical or pharmacy services. It is the provider's responsibility to ensure Molina Healthcare members are eligible for benefits and to verify PCP assignment, prior to rendering services. Unless an emergency condition exists, providers may refuse service if the member cannot produce the proper identification and eligibility cards.

Disenrollment

Voluntary Disenrollment

Members have the right to request to change plans for any reason within the first 90 days of enrollment and at the end of each 12 month enrollment period thereafter. Members may request to change plans for cause at any time. Circumstances that constitute cause for disenrollment include the member moving out of the Service Area, Molina does not provide covered services Member seeks based on moral or religious objections, member needs services that are not available within the Molina network, member's eligibility changes, or other reasons per 42 CFR 438.56(d)(2). Members can change plans by calling Molina Member Services at (877) 335-3305. Molina will provide assistance to members requesting to disenroll from the Molina plan, and will refer the member to ASES or its agent for disenrollment determination.

Voluntary disenrollment does not preclude members from filing a grievance with Molina Healthcare for incidents occurring during the time they were covered.

Involuntary Disenrollment

Under very limited conditions and in accordance with ASES guidelines, members may be involuntarily disenrolled from a managed care program. With proper written documentation and approval by ASES or its Agent; the following are acceptable reasons for which Molina Healthcare may submit Involuntary Disenrollment requests to ASES:

- Member has moved out of the Service Area
- Member death or incarceration
- Member's continued enrollment seriously impairs the ability to furnish services to this member or other members
- Member demonstrates a pattern of disruptive or abusive behavior that could be construed as non-compliant and is not caused by a presenting illness
- Member's utilization of services is fraudulent or abusive
- Member is placed in a long-term care nursing facility, , or intermediate care facility for the developmentally disabled
- Member's Medicaid eligibility category changes, or member otherwise becomes ineligible to participate in GHP

PCP Dismissal

A PCP may request the dismissal of a member from his/her practice based on member behavior. Reasons for dismissal must be documented by the PCP and may include:

- A member who continues not to comply with a recommended plan of health care. Such requests must be submitted at least sixty (60) calendar days prior to the requested effective date.
- A member whose behavior is disruptive, unruly, abusive or uncooperative to the extent that his or her assignment to the provider seriously impairs the provider's ability to furnish services to either the member or other members.

This Section does not apply if the member's behavior is attributable to a physical or behavioral condition.

PCP and PMG Assignment

Molina Healthcare will offer each member a choice of PMGs and PCPs. Molina Healthcare will make the following recommendations to members in choosing a PCP:

- Female members will be recommended to choose an OB/GYN as a PCP
- Members under twenty-one (21) years of age will be recommended to choose a pediatrician as a PCP
- Members with Chronic Conditions including heart failure, kidney failure, or diabetes will be recommended to choose an internist as a PCP.

After making a choice, each member will have a single PCP and a single PMG. Molina Healthcare will assign a PCP and a PMG to those members who did not choose a PCP and PMG at the time of Molina Healthcare selection. Molina Healthcare will take into consideration the member's last PCP (if the PCP is known and available in Molina Healthcare's contracted network), closest PCP to the member's home address, keeping Children/Adolescents within the same family together, age (adults versus Children/Adolescents) and gender (OB/GYN). Molina Healthcare will assign all members that are reinstated after a temporary loss of eligibility of 60 days or less to the PCP and PMG assigned prior to loss of eligibility, unless the member specifically requests another PCP, the PCP no longer participates in Molina Healthcare or is at capacity, or the member has changed geographic areas.

Members must choose a PCP for each insured member in the family. The PCP may be different for each individual in the family, but they must belong to the same PMG.

Molina Healthcare will allow pregnant members to choose the Health Plan's obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP. Molina Healthcare shall assign a pediatrician or other appropriate PCP to all pregnant members for the care of their newborn babies no later than the beginning of the last trimester of gestation. If Molina Healthcare was not aware that the member was pregnant until she presented for delivery, it will assign a pediatrician or a PCP to the newborn baby within one (1) business day after notification of birth. Providers shall advise all members of the members' responsibility to notify Molina Healthcare and ASES of their pregnancies and the births of their babies.

PCP and PMG Changes

Members may change their PMG and/or PCP for any reason during the first ninety (90) calendar days from the enrollment date. Members may also change their PCP and/or PMG for any reason once every twelve (12) months following the ninety (90) days after the effective date of enrollment.

Members may change their PCP or PMG at any time if there is Good Cause. The following are considered Good Cause for a change:

1. Member moves out of the region
2. For moral or religious reasons, the provider does not render the services the member needs
3. The member needs services that must be rendered at the same time as other services and not all services are available. Not receiving all of the services as ordered may put the member at unnecessary risk
4. Other reasons may include, but are not limited to:
    - Poor quality of services
    - Lack of access to covered services
    - Lack of providers with experience to address the member's health care needs

Section 3. Member Rights and Responsibilities

This section explains the rights and responsibilities of Molina Healthcare members as written in the Molina Healthcare of Puerto Rico Member Handbook. Puerto Rico law requires that health care providers or health care facilities recognize member rights while they are receiving medical care and that members respect the health care provider's or health care facility's right to expect certain behavior on the part of patients.

Member Rights:

As a Molina Healthcare member, you have the following **rights**:

- You have the right to demand to be kept informed and receive information about:
    - The Government Health Plan,
    - health care facilities,
    - health care professionals,
    - health services covered,a
    - access to contracted services,
- To be treated with respect and with due regard for your dignity and privacy
- To select freely your Primary Medical Group, your Primary Care Physician, laboratory, x-rays, hospital, specialist and sub-specialists available within the Preferred Network of Primary Medical Group
- To contact your Primary Care Physician or specialist freely and under strict confidentiality
- The ability to receive emergency services 24 hours a day, 7 days a week
- To receive information about treatment alternatives and options available and, that these alternatives and options be presented to you in a manner appropriate to your condition and ability to understand
- To participate in decisions regarding your health care, including the right to refuse treatment
- To request a second opinion if you are interested in confirming a diagnosis or treatment plan
- To express with Advance Directives, either verbally or in writing, your wishes as to what treatment and services you want to be provided or do not want to be provided if you become unable to make such decisions
- To be free from any form of restraint or seclusion used as a means of limitation, discipline, convenience or retaliation
- To receive copies of your medical records
- To receive high quality services

- To receive continuity of health care
- To have access to adequate health services
- To file complaints and appeals, when you understand that your rights have been violated by denial of, limitation of, or improper collection for services
- To not be discriminated against for any reason
- To have the freedom to choose the pharmacy or dentist of your preference among those that are in-network
- To choose an authorized representative to be involved as appropriate in making care decisions
- To provide informed consent
- To be free from harassment by Molina Healthcare or our in-network providers with respect to contractual disputes between Molina Healthcare and our providers
- To participate in understanding physical and behavioral health problems and developing mutually agreed upon treatment goals
- To not be held liable for:
    - Molina Healthcare's debt in the event of insolvency
    - Covered Services provided to you for which ASES does not pay Molina Healthcare
    - Covered Services provided to you for which ASES or Molina Healthcare does not pay the provider that furnished the services
    - Payments of covered services under a contract, referral or other arrangement to the extent that those payments are in excess of the amount you would owe if Molina Healthcare provided the services directly; and
- Only be responsible for cost-sharing or co-pays as permitted by Puerto Rico, which are applicable to you

Member Responsibilities:

Molina Healthcare members have the following **responsibilities**:

- To learn about Government Health Program coverage, its limits and exclusions
- To give your physician all your health-related information
- To inform your doctor of any changes in your health
- To follow medical treatment as recommended by your Primary Care Physician, specialist or sub-specialist
- To inform your physician when you do not understand an instruction or do not clearly understand what you are being told
- To inform your physician when there is a reason why you cannot comply with the recommended treatment
- To recognize when you need to make changes to your lifestyle to benefit your health

- To participate in any decisions regarding your health
- To communicate either verbally or in writing any Advance Directive you want to be fulfilled regarding your decision on medical treatment for the extension of your life
- To maintain appropriate behavior, so your behavior does not affect or prevent other patients from receiving necessary medical care
- Maintain appropriate behavior, so your behavior does not affect the operation of Molina Healthcare's Service Centers or prevent other beneficiaries from receiving the services provided at the Service Centers.
- Provide all the information on other health insurance plans you may have.
- Inform ASES of any fraud or improper action related to services, providers and health facilities.

Section 4. Benefits and Covered Services

This section provides an overview of the medical benefits and Covered Services for Molina Healthcare of Puerto Rico Members. Additional detail regarding which services are covered can be obtained by contacting Molina Healthcare at (888) 558-5501 or by accessing benefit details available on our Provider Portal at: https://provider.molinahealthcare.com

GHP Overview/Description

The Government Health Plan ("GHP" and formerly referred to as "La Reforma" or "MI Salud") is the government health services program offered by the Commonwealth of Puerto Rico, and administered by ASES, which serves a mixed population of Medicaid Eligible, CHIP Eligible, and Other Eligible Persons, and emphasizes integrated delivery of physical and Behavioral Health Services. The GHP offers the broadest benefit coverage through a coordinated care model.

Under this model there is a Preferred Provider Network within each Primary Medical Group (PMG). Members select a PMG and a PCP (from within the PMG) and can freely visit any provider within the Preferred Provider Network without the need for referrals or paying Copayments.

Under the Government Health Plan, members do not need the Primary Care Physician's approval, or countersignature, on the prescriptions ordered by providers within the selected PMG's Preferred Provider Network. Members can freely choose dentists and pharmacies, as long as they are in Molina Healthcare's network.

In addition, members can receive mental health services within the same facility of the PMG. The Government Health Plan requires integrated physical and mental health services, so members can receive these services in one place.

Please contact Molina Healthcare if you would like additional information.

The MHPR Preferred Provider Network (PPN) and General Network

Molina Healthcare of Puerto Rico (MHPR) is committed to improving access to specialty care for our Members.

- Primary care and preventive services are available from contracted primary care providers participating with MHPR in Primary Medical Groups (or "PMGs").
- Along with the PMGs, MHPR's Preferred provider Network (or "PPN") is our contracted provider network of specialists and other providers available on an "open access" basis for Members assigned to all of our contracted PMGs in the East and Southwest regions.
    - Example – Should MHPR have four hospitals and 500 specialists and ancillary providers in the PPN, all of those PPN providers will be listed and available to Members assigned to PMG #1, PMG#2, PMG#3 etc.
- The MHPR General Network will be composed of hospitals, ancillary and other providers that are (i) not part of the PMGs and PPN, and/or (ii) located outside of the East and Southwest service regions.
- Member Access and PCP processes are streamlined as follows:

- No referrals will be needed to see a PPN provider; Referrals are required outside of the PPN.
- As a Managed Care Organization we encourage a written consultation be provided first to the specialist by the PCP and subsequently by the specialist to the PCP in order to maintain proper and effective communication for the benefit of the member's care.
- No copays will apply to the PPN and General Network for Medicaid and CHIP members (Commonwealth membership will continue to pay applicable co-pays when going outside of the PPN).
- Prescriptions will not require a co-signature of the PCP if written by a contracted provider within the PPN.

- MHPR's provider directory will list the contracted PMGs along with our PPN and General Network providers.

- The usual processes for referrals, co-pays and required co-signatures for prescriptions will apply for Members obtaining services from providers in the General Network or out-of-network providers.

Member Cost Sharing

Cost Sharing is the Deductible, Copayment, or Coinsurance that members must pay for Covered Services provided under the Government Health Plan. It is the provider's responsibility to collect the copayment and other member Cost Share from the member. The amount of the copayment and other Cost Sharing will be deducted from the Molina Healthcare payment for all claims involving Cost Sharing. Providers may not charge members fees for covered services beyond copayments or coinsurance.

There may be co-payments or co-insurance for some services, depending upon the type of membership and whether services are accessed within the PPN or within the general network. The table below gives an overview of co-payments and co-insurance rates which may be changed by ASES. The Cost Sharing amount that members will be required to pay for each type of Covered Service may be summarized on the member's ID card. Additional detail regarding cost sharing available on the Provider Web Portal (https://provider.molinahealthcare.com) or by contacting Molina Healthcare at (888) 558-5501.

CO-PAYS & CO-INSURANCE - Effective on July 1st, 2013								
Services	**Federal**		**CHIP**	**Commonwealth Population**				***ELA**
	100	**110**	**230**	**300**	**310**	**320**	**330**	**400**
HOSPITAL								
Admissions	$0	$3	$0	$3	$5	$6	$20	$50
Nursery	$0	$0	$0	$0	$0	$0	$0	$0
EMERGENCY ROOM (ER)								
Emergency Room (ER) Visit	$0	$0	$0	$1	$5	$10	$15	$20
Non-emergency visit to a hospital	$3.80	$3.80	$0	$15	$15	$15	$15	$20

emergency room								
Trauma	$0	$0	$0	$0	$0	$0	$0	$0
AMBULATORY VISITS TO:								
Primary Care Physician (PCP)	$0	$1	$0	$0	$1	$2	$2	$3
Specialist	$0	$1	$0	$1	$1	$3	$4	$7
Sub-Specialist	$0	$1	$0	$1	$1	$3	$5	$10
Prenatal services	$0	$0	$0	$0	$0	$0	$0	$0
OTHER SERVICES								
High-Tech Laboratories**	$0	50¢	$0	$1	$1	$2	$3	20%
Clinical Laboratories**	$0	50¢	$0	$1	$1	$2	$3	20%
X-Rays**	$0	50¢	$0	$1	$1	$2	$3	20%
Special diagnostic Tests**	$0	$1	$0	$1	$2	$2	$6	40%
Therapy – Physical	$0	$1	$0	$1	$2	$2	$3	$5
Therapy – Respiratory	$0	$1	$0	$1	$2	$2	$3	$5
Therapy – Occupational	$0	$1	$0	$1	$2	$2	$3	$5
Vaccines	$0	$0	$0	$0	$0	$0	$0	$0
Healthy Child Care	$0	$0	$0	$0	$0	$0	$0	$0
DENTAL								
Preventive (Child)	$0	$0	$0	$0	$0	$0	$0	$0
Preventive (Adult)	$0	$1	$0	$0	$1	$2	$3	$3
Restorative	$0	$1	$0	$0	$1	$5	$6	$10
PHARMACY* **								
Generic (Children 0-18)	$0	$0	$0	$0	$0	$0	$0	$5
Generic (Adult)****	$1	$1	N/A	$1	$2	$3	$5	$5
Brand (Children 0-18)	$0	$0	$0	$0	$0	$0	$0	$10
Brand (Adult)****	$3	$3	N/A	$3	$4	$5	$7	$10

*Code 400 in ELA column refers to the population that subscribes as public employees of the Puerto Rico Government.

** Apply to diagnostic tests only. Copays do not applied to tests required as part of a preventive service.

***Copays apply to each drug included in the same prescription pad. Pharmacy exception (children 0- 18) does not apply to 400 ELA employees.

****Co-pays for children 0-18 years of age are not applicable for Medicaid, Commonwealth medically indigent eligible, and for children 0-18 enrolled in the CHIP Program in group ages 0-18.

Co-pays may apply to children ages over 18 years old as well as to adults.

Some benefits may have limitations. Please call the Provider Services Department for addition information or for a complete list of benefits at (888) 558-5501.

Government Health Plan Benefits

Service Covered by Molina Healthcare:

- Preventive Services
- Diagnostic Test Services
- Outpatient Rehabilitation Services
- Medical and Surgical Services
- Emergency Transportation Services
- Maternity and Pre-Natal Services
- Emergency Services
- Post Stabilization Services
- Hospitalization Services
- Behavioral Health Services
- Pharmacy Services
- Dental Services

New or Enhanced Benefits

- Members now have access to benefits for Smoking Cessation (counseling and medication)

Services covered under Special Coverage by Molina Healthcare (Applicable to Enrollees who are entitled to Medically Necessary treatment for Special Coverage qualifying condition):

- Coronary and intensive care services, without limit;
- Maxillary surgery;
- Neurosurgical and cardiovascular procedures, including pacemakers, valves, and any other instrument or artificial devices (Prior Authorization required);
- Peritoneal dialysis, hemodialysis, and related services (Prior Authorization required);
- Pathological and clinical laboratory tests that are required to be sent outside Puerto Rico for processing (Prior Authorization required);
- Neonatal intensive care unit services, without limit;
- Radioisotope, chemotherapy, radiotherapy, and cobalt treatments;

- Treatment of gastrointestinal conditions, treatment of allergies, and nutritional services in autism patients;
- The following procedures and diagnostic tests, when Medically Necessary (Prior Authorization required):
- Computerized Tomography;
- Magnetic resonance test;
- Cardiac catheters;
- Holter test;
- Doppler test;
- Stress tests;
- Lithotripsy;
- Electromyography;
- Single-photon Emission Computed Topography (“SPECT”) test;
- Orthopantogram (“OPG”) test;
- Impedance Plesthymography;
- Other neurological, cerebrovascular, and cardiovascular procedures, invasive and noninvasive;
- Nuclear imaging;
- Diagnostic endoscopies; and
- Genetic studies;
- Up to fifteen (15) additional (beyond the services provided under Basic Coverage) physical therapy treatments per Enrollee condition per year when indicated by an orthopedist, physiatrist or chiropractor after Contractor Prior Authorization;
- General anesthesia, including for dental treatment of special-needs children;
- Hyperbaric Chamber;
- Immunosuppressive medicine and clinical laboratories required for the maintenance treatment of post-surgical patients or transplant patients, to ensure the stability of the Enrollee's health, and for emergencies that may occur after said surgery; and
- Treatment for the following conditions after confirmed laboratory results and established diagnosis:
- HIV Positive factor and/or Acquired Immunodeficiency Syndrome (“AIDS”) (Outpatient and hospitalization services are included; no Referral or Prior Authorization is required for Enrollee visits and treatment at the Health Department's Regional Immunology Clinics or other qualified Providers);
- Tuberculosis;
- Leprosy;
- Lupus;
- Cystic Fibrosis;
- Cancer;
- Hemophilia;
- Special conditions of children, including the prescribed conditions in the Special Needs Children Diagnostic Manual Codes, except: Asthma and diabetes, which are included in the Disease Management program; Psychiatric Disorders; and Intellectual disabilities;
- Scleroderma;
- Multiple Sclerosis;
- Conditions resulting from self-inflicted damage or as a result of a felony or negligence by an Enrollee; and

- Chronic renal disease in levels three (3), four (4) and five (5). (Levels 1 and 2 are included in the Basic Coverage)

Services Not Covered by the GHP (Basic Coverage):

The following services are excluded from Basic Coverage; if you have any questions about the list or regarding your coverage please call Molina Healthcare.

- Services to Patients not eligible to the Government Health Plan.
- Services for non-covered illnesses or trauma.
- Services for automobile accidents covered by the Administration of Compensation for Automobile Accidents (ACAA, for its acronym in Spanish).
- Accidents on the job that are covered by the State Insurance Fund Corporation.
- Services covered by another insurance or entity with primary responsibility (third party liability).
- Specialized nursing services for the comfort of the Patient when they are not medically necessary.
- Hospitalizations for services that can be rendered on an outpatient basis.
- Hospitalization of a Patient for diagnostic services only.
- Expenses for services or materials for the Patient's comfort such as telephone, television, admission kits, etc.
- Services rendered by Patient's relative (parents, children, siblings, grandparents, grandchildren, spouse, etc.).
- Organ and tissue transplants, except skin, bone and corneal transplants.
- Weight control Treatments (obesity or weight increase for aesthetic reasons).
- Sports medicine, music therapy and natural medicine.
- Cosmetic surgery to correct physical appearance defects.
- Services, diagnostic tests ordered or provided by naturopaths, naturists, and iridologists.
- Health Certificates except for (i) venereal disease research laboratory tests, (ii) tuberculosis tests and (iii) any certification related to the eligibility for the Medicaid program. Mammoplasty or plastic reconstruction of breast for aesthetic purposes only.
- Outpatient use of fetal monitor.
- Services, Treatment or hospitalization as a result of induced, non-therapeutic abortions or their complications. Call Molina Healthcare Member Services to learn more on induced abortions.
- Rebetron or any other prescribed medication for Hepatitis C Treatment, both Treatment and medications are excluded from the Health Plan coverage. The medications as well as the Treatment will be provided by the Hepatitis Program of the Health Department. For additional information refer to the Hepatitis Section previously mentioned in this Handbook.
- Medications delivered by a provider that does not have a pharmacy license, with the exception of medications that are traditionally administered in a doctor's office such as an injection.
- Epidural anesthesia services.
- Services that are not reasonable or necessary according to the regulations accepted in the practice of medicine. Services rendered in excess to those normally required for

diagnostics, prevention, diseases, Treatment, injury or organ system dysfunction or pregnancy condition.

- Mental health services that are not reasonable or necessary according to the accepted regulations for the practice of medical Psychiatry or the services rendered in excess to those usually required for the diagnostic, prevention and Treatment of a mental illness.
- Educational tests, educational services.
- Peritoneal dialysis or hemodialysis services (Covered under the Special Coverage).
- Hospice care for adults
- New or experimental procedures not approved by ASES to be included in the Basic Coverage.
- Custody, rest and convalescence once the disease is under control or in irreversible terminal cases (hospice care for Members under 21 is part of basic coverage).
- Services covered under the Special Coverage.
- Services received outside the territorial limit of the Commonwealth of Puerto Rico, except for emergency services for Medicaid or CHIP beneficiaries.
- Judicial order for evaluations for legal purposes.
- Travel expenses, even when ordered by the Primary Care Physician are excluded.
- Eyeglasses, contact lenses and hearing aids (for members over age 21).
- Acupuncture services.
- Procedures for sex changes, including hospitalizations and complications.
- Treatment for infertility and/or related to conception by artificial means including tuboplasty, vasovasectomy, and any other procedure to restore the ability to procreate.
- Expenses incurred for the Treatment of conditions resulting from services not covered under the GHP (maintenance Prescriptions and required clinical laboratories for the continuity of a stable health condition, as well as any emergencies which could alter the effects of the previous procedure, are covered).

Prescription drugs

Prescription drugs are covered by Molina Healthcare, via the PBM, MC-21 Corporation. Members must use their Molina Healthcare ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, and its limitations, is available by contacting Molina Healthcare at (888) 558-5501. For claims issues, MC-21 can be contacted directly at (888) 311-6001.

When prescribing medicines, providers should refer to the ASES Preferred Drug List (PDL) (available at http://abarcahealth.com/clients/government/ases) as a first option at the moment of prescribing. In order to prescribe a Formulary medication that is not on the PDL, providers will need to obtain Prior Authorization from Molina Healthcare before issuing a prescription. Providers may not outright deny prescribing a medication because it is not included on the PDL. Instead, a Prior Authorization should be sought when the non-PDL medication is medically necessary. When listed on the Formulary and PDL, generic drugs should be prescribed instead of their brand name counterparts.

Special Medications

Certain Medications for the treatment of HIV/AIDS are excluded from the ASES PDL and instead, providers should refer members to CPTET Centers (Centros de Prevencion y Tratamiento de Enfemedades) or community-based organizations, where the member may be screened to determine whether the member is eligible for the AIDS Drug Assistance Program

("ADAP"). Those medications are: Viread® , Emtriva®, Truvada®, Fuzeon®, Atripla®, Epzicom®, Selzentry®, Intelence®, Isentress®, Edurant®, Complera®, and Stribild®.

Any medications for the treatment of Hepatitis C are excluded from coverage. These medications can be provided by the Health Department, upon referral to the Health Department by a Network Provider.

Access to Behavioral Health Services

Molina Healthcare has partnered with First Healthcare (FHC) to deliver Behavioral Health services to our members. Members in need of Behavioral Health Services can be referred by their PCP for services or Members can self-refer by calling Molina Healthcare of Puerto Rico at (888) 558-5501. Molina Healthcare is available 24 hours a day, 7 days a week for behavioral health needs. The services members receive will be confidential. Providers may contact FHC directly with clinical and claims questions at (855) 580-2208.

Covered Behavioral Health/Mental Health services:

Molina Healthcare covers the following mental health services:

- Evaluation, screening and Treatment to individuals, couples, families and groups.
- Ambulatory services rendered by psychiatrists, psychologists and social workers.
- Hospital and ambulatory services for substance abuse and alcoholism.
- Intensive ambulatory services.
- Emergency and crisis intervention services available 24 hours a day, 7 days a week.
- Detoxification services for beneficiaries that use illegal drugs, have had suicidal attempts or accidental poisoning.
- Administration of and Treatment with Buprenorphine (requires Preauthorization).
- Clinics for injectable extended-release medications.
- Escort, professional assistance and ambulance services when the services are necessary.
- Prevention services and secondary education.
- Pharmacy coverage and Access to medications within 24 hours.
- Laboratory tests that are medically necessary.
- Treatment for Patients diagnosed with Attention Deficit Disorder (ADD) with or without hyperactivity (ADHD). This includes, but is not limited to, visits to neurologists and tests related to the Treatment of this diagnosis.
- Consultations and coordination with other Agencies.
- Substance abuse Treatment.

Mental Health Hospitalization Services:

- Partial hospitalization services for cases referred by a psychiatrist for primary phase diagnosis and Treatment, according to the parity provisions of Law 408 of October 2, 2000.
- Hospitalization that presents a mental pathology that is not drug abuse when referred by a psychiatrist for primary phase diagnosis and Treatment, according to the parity provisions of Law 408 of October 2, 2000.

Emergency Behavioral Health Services

Members are directed to call “911” or go to the nearest emergency room if they need emergency behavioral health services. Examples of emergency behavioral health problems are:

- Danger to self or others
- Not being able to carry out daily activities
- Things that will likely cause death or serious bodily harm

Out of Area Emergencies

Members having a behavioral health emergency who cannot get to a Molina Healthcare approved providers are directed to do the following:

- Go to the nearest hospital or facility
- Call the number on ID card
- Call member’s PCP and follow-up within (24) to (48) hours

For out-of-area emergency care, plans will be made to transfer Members to an in-network facility when member is stable.

Emergency Transportation

When a Member’s condition is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes, but is not limited to, ambulance, air or boat transports.

Examples of conditions considered for emergency transports include, but are not limited to, acute and severe illnesses, untreated fractures, loss of consciousness, semi-consciousness, having a seizure or receiving CPR during transport, acute or severe injuries from auto accidents, and extensive burns.

Sea, air and land transportation will be covered within Puerto Rican territory limits in cases of emergency. These services do not require Preauthorization or precertification.

Emergency transportation services are covered in the US for members who are Medicaid or CHIP eligible, if the emergency transportation is associated with an Emergency Service in the US.

Non-emergency Transportation Services (NEMT)

Molina Healthcare will be offering *limited* transportation services if certain conditions apply. This benefit requires prior authorization and will be available on a case-by-case basis to assist our members in accessing care if the ASES-established transportation process or other free transportation resources cannot meet the member’s need. These limited services will be provided through TranCita, Molina Healthcare’s transportation partner. TranCita will need 72 hours advance notice to schedule trips. To check on the availability of this benefit, and to schedule transportation contact Molina Healthcare at (888) 558-5501.

In addition to this limited benefit, each Municipality in Puerto Rico has a variety of free transportation services available to assist members in getting to medical appointments. To access the services and ask about free non-emergency medical transportation options members may:

- Contact the local Municipal office
- Ask the PCP or PMG

- Call Molina Healthcare Member Services

Family Planning Services

Family planning services coverage is provided to ensure that women have the benefits of a healthy and safe sexual and reproductive life by providing access to quality services for family planning and contraception, with full respect for a woman's rights and her free choice. The benefits of family planning and contraception through the promotion of health, are designed to facilitate the exercise of responsible sexuality and protection, within a framework of respect for the rights of people.

Specific services include:

- Counseling
- Pregnancy Testing
- Diagnosis and Treatment of Sexually Transmitted Diseases
- Infertility Assessments
- At least one of every class of FDA approved oral contraceptive medication as specified in ASES's PDL (prescribed by an OB/GYN)
- Other FDA-Approved contraceptive medication or methods when medically necessary and approved through a prior authorization or an exception process and the prescribing provider can demonstrate at least one of the following situations (prescribed by OB/GYN):
    - Contraindication with drugs that are in the PDL that the member is already taking and there are no other methods in the PDL that can be used by the member;
    - History of adverse reaction by the member to the covered contraceptive methods as specified by ASES; or
    - History of adverse reaction by the member tot eh contraceptive medications that are on the PDL

Preventive Care

Immunizations

Adult members may receive immunizations as recommended by the Centers for Disease Control and Prevention (CDC) and prescribed by the member's PCP. Child members may receive immunizations in accordance with the recommendations of the Advisory Committee of Immunization Practices and prescribed by the child's PCP.

Immunization schedule recommendations from the Advisory Committee of Immunization Practices are below.

Molina Healthcare covers immunizations not covered through the health department.

The following is a list of immunizations required for children and adolescents.

Immunization	**Ages**
Hepatitis B (Hep B)	Birth, 1-2 months, and 6-18 months
Rotavirus (RV)	2 months, 4 months and 6 months
Diphtheria, Tetanus, Pertussis (DTaP)	2, 4, 6, 15 – 18 months and one between the ages of 4 and 6 years
• Haemophilus influenza type b (HIB)	2, 4, 6 and 12 – 15 months
Pneumococcal (PCV)	2, 4, 6 and 12 – 15 months
Inactivated Poliovirus (IPV)	2, 4, 6 -18 months and one between the ages 4 – 6 years

Influenza	6 months – 18 years, yearly (consult your PCP)
Measles, Mumps, Rubella (MMR)	12 – 15 months and one between the ages of 4 and 6 years
Varicella	12 -15 months and one between the ages of 4 – 6 year
Hepatitis A (Hep A)	Two (2) doses between 12 and 24 months
Tetanus, Diphtheria, Pertussis (Tdap)	11 – 12 years
Human Papilloma Virus (HPV)	Three (3) doses between 11 – 12 years
Meningococcal (MCV)	11 – 12 years

Prenatal Care

Stage of Pregnancy	**How often to see the doctor**
1 month – 6 months	One (1) visit a month
7 months – 8 months	Two (2) visits a month
9 months	One (1) visit a week

Well Child Visits

The federal guidelines outlined below specify the minimum requirements included in each Well Child Care (WCC) exam for each of the following age groups; (0-18) months, (2-6) years, and (7-20) years. During Well Child visits, providers are required to deliver the following:

EPDST	Infants (0-18) months	Children (2-6) years	Adolescents (7-20) years
Physical Exam and Health History	• History • Height • Weight • Head Circumference • Physical exam (all of these) • Immunizations • Vision Screening • Tuberculosis Screening • Hearing Screening • Dental/Oral Health Screening • Lead Screening • Diagnostic/Lab tests-if applicable	• History • Height • Weight • Physical exam (all of these) • Immunizations • Vision Screening • Tuberculosis Screening • Hearing Screening • Dental/Oral Health Screening • Lead Screening • Diagnostic/Lab Tests-if applicable	• History • Height • Weight • Physical exam (all of these) • Immunizations • Vision Screening • Tuberculosis Screening • Hearing Screening • Dental/Oral Health Screening • Diagnostic/Lab Tests-if applicable
Development and Behavior Assessment	• Gross motor • Fine motor • Social/emotional • Nutritional (any one of these)	• Gross motor • Fine motor • Communication • Self-help skills • Cognitive skills • Social/emotional • Regular physical activity • Nutritional (any one of these)	• Social/emotional • Regular physical activity • Nutritional (any one of these)
Mental Health Assessment	Mental health (must be addressed)	Mental health (must be addressed)	• Mental health • Substance abuse (either one of these)

Health Education/ Anticipatory Guidance	• Injury prevention • Passive smoking (either one of these)	• Injury prevention • Passive smoking (either one of these)	• Injury prevention • STD prevention • Smoking/tobacco (any one of these)

We need your help conducting these regular exams in order to meet the HEDIS (Health Care Effectiveness Data Information Set) targeted standards. If you have questions or suggestions related to well child care, please call our Health Education line at (800) 472-9483.

Emergency Care Services

Emergent care services are covered by Molina Healthcare without an authorization. This also includes non-contracted providers outside of Molina Healthcare's service area.

(24) Hour Nurse Advice Line

Members may call the Nurse Advise Line anytime they are experiencing symptoms or need health care information. Registered nurses are available (24) hours a day, seven (7) days a week, to assess symptoms and help make good health care decisions.

HEALTHLINE (24-Hour Nurse Advice Line)
Spanish Phone: (888) 620-1515
TTY: (787) 522-8281 (English)

Molina Healthcare is committed to helping our members:

- Prudently use the services of your office
- Understand how to handle routine health problems at home
- Avoid making non-emergent visits to the emergency room (ER)

These registered nurses do not diagnose. They assess symptoms and guide the patient to the most appropriate level of care following specially designed algorithms unique to the Nurse Advice Line. The Nurse Advice Line may refer back to the PCP, a specialist, 911 or the ER. By educating patients, it reduces costs and over utilization on the health care system.

Health Management Programs

Molina Healthcare of Puerto Rico wants you to be aware of health management programs offered to assist with care management. We have programs that can help you manage your patient's condition. These include programs, such as:

- Asthma
- Diabetes type 1 or 2 (pediatric and adult)
- Hypertension
- Coronary Artery Disease
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression

- Medication Therapy Management Program (Medicare)
- Weight Management Program (Obesity)
- Pregnancy
- Chronic Renal Disease Level 1 and Level 2
- Smoking Cessation (counseling and treatment)

A Care Manager/Nurse is on hand to teach your Patients about their disease. He/she will manage the care with the member's assigned PCP and provide other resources. There are many ways a member is identified to enroll in these programs. One way is through medical or pharmacy claims. Another way is through Nurse Advice Line or doctor referral. Members can also ask Molina to enroll them. It is the member's choice to be in these programs. A member can choose to get out of the program at any time.

For more info about our programs, please call:

- Provider Services Department at (888) 558-5501
- (English) TTY at (787) 522-8281
- Visit www.MolinaHealthcare.com/PuertoRico

Pregnancy Health Management Program

We care about the health of our pregnant members and their babies. Molina's pregnancy program will make sure member and baby get the needed care during the pregnancy. You can speak with trained Nurses and Care Managers. They can give your office/member the support needed and answer questions you may have. You will be mailed a workbook and other resources which are also available to the member. The member will also learn ways to stay healthy after child birth. Special care is given to those who have a high-risk pregnancy. It is the member's choice to be in the program. They can choose to be removed from the program at any time. Molina Healthcare is requesting your office to complete the Pregnancy Notification form (refer to appendix B for form) and return it to us as soon as pregnancy is confirmed.

Although pregnancy itself is not considered a disease state, a significant percentage of pregnant females on Medicaid are found to be at moderate to high-risk for a disease condition for the mother, the baby or both. The Motherhood Matters [SM] pregnancy management program strives to reduce hospitalizations and improve birth outcome through early identification, trimester specific assessment and interventions appropriate to the potential risks and needs identified. The Motherhood Matters [SM] program does not replace or interfere with the member's physician assessment and care. The program supports and assists physicians in the delivery of care to members.

Motherhood Matters [SM] Program Activities

Motherhood Matters [SM] Pregnancy Health management Program encompasses clinical case management, member outreach and member and provider communication and education. The Prenatal Case Management staff works closely with the provider community in identification, assessment, and implementation of appropriate intervention(s) for every member participating in the program. The program activities include early identification of pregnant members, early screening for potential risk factors, provision of telephonic and written trimester appropriate education to all pregnant members and families, referral of high-risk members to prenatal case management, and provision of assessment information to physicians.

- Prenatal Case Management – Members assessed to be high risk are contacted via telephone for further intervention and education. A care plan is developed and shared with the physician to ensure that all educational and care needs are met. Prenatal case

management registered nurses, in conjunction with the treating physician, coordinate health care services, including facilitation of specialty care referrals, coordination of home health care and DME service and referral to support groups or community social services. The case management data base generates reminders for call backs for specific assessments, prenatal visits, postpartum visits and well-baby checkups.

- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Health Management Unit.
- Member Outreach – Motherhood Matters [SM] Program is promoted to members through various means including, program brochures in new member Welcome Packets, other member mailings, member newsletters, provider newsletters, posters and brochures placed in practitioner's offices and marketing materials and collaboration with national and local community-based entities.

Health Management Level 1 and Health Management Programs

Molina Healthcare of Puerto Rico Health Management programs provide patient education information to Members and facilitate provider access to these chronic disease programs and services.

Program Eligibility Criteria and Referral Source

Health Management Programs are designed for Molina members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the plan's coverage or until the member opts out. Each identified member will receive specific educational materials and other resources in accordance with their assigned stratification level. Additionally, all identified members will receive regular educational newsletters. The program model provides an "opt-out" option for members who contact Molina Member Services and request to be removed from the program.

Multiple sources are used to identify the total eligible population. These may include the following:

- Pharmacy claims data for all classifications of medications;
- Encounter data or paid claim with a relevant CPT-4 or ICD-9 code;
- Member Services welcome calls made by staff to new member households and incoming member calls have the potential to identify eligible program participants. Eligible members are referred to the program registry;
- Practitioner/provider referral;
- Nurse Advice referral;
- Medical Case Management or Utilization Management; and
- Member self-referral due to general plan promotion of program through member newsletter, the Nurse Advice Line or other member communication.

Practitioner/Provider Participation

Contracted practitioners/providers are automatically notified whenever their patients are enrolled in a health management program. Practitioner/provider resources and services may include:

- Annual practitioner/provider feedback letters containing a list of patients identified with the relevant disease;
- Clinical resources such as patient assessment forms and diagnostic tools;
- Patient education resources;

- Provider Newsletters promoting the health management programs, including how to enroll patients and outcomes of the programs;
- Clinical Practice Guidelines; and
- Preventive Health Guidelines;

Additional information on health management programs is available from your local Molina QI Department at (787) 200-3300.

Breathe with ease

Molina Healthcare of Puerto Rico provides an asthma health management program called Breathe with ease, designed to assist members in understanding their disease. Molina Healthcare has a special interest in asthma, as it is the number one chronic diagnosis for our members. This program was developed with the help of several community providers with large asthma populations. The program educates the member and family about asthma symptom identification and control. Our goal is to partner with you to strengthen asthma care in the community.

Breathe with ease Program Activities

The first component of our program provides general asthma education to all identified asthma members, including an asthma newsletter. Our goal is to provide members with a basic understanding of asthma and related concepts, such as common triggers. We also encourage members to see their PCP regularly for asthma status checks, and important preventive and well-child care.

The second component of our program offers members identified as having high needs an opportunity to enroll in our more intensive asthma program. We identify these members through claims and pharmacy data, with a specific focus on ER utilization and inpatient admissions for asthma.

Additional Asthma Program Benefits

- Clinical Practice Guidelines – Molina Healthcare adopted the NHLBI Asthma Guidelines.
- Asthma Registry – Molina Healthcare established an asthma registry. The registry uses available claims and pharmacy information to identify and track asthma members in the program.
- Asthma Newsletters – Molina Healthcare distributes asthma newsletters to identified members.
- Care Reminders and Age-Appropriate Tools – Molina Healthcare provides individualized reminders and educational tools to members with asthma.
- Asthma Education – Asthma education is covered for all Molina Healthcare members. We encourage providers to refer patients to these services, especially for newly diagnosed asthmatics or those having difficulty managing their disease.
- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Health Management Unit.
- Asthma Profiles – A report or profile of patients with asthma is sent to the PCPs; this shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare asthma patients not included in the profile.

Healthy Living with Diabetes

Molina's *Healthy Living with Diabetes* health management program is a collaborative team approach comprised of patient education, clinical case management and provider education. The team works closely with contracted practitioners in the identification, assessment and implementation of appropriate interventions for non-pregnant adults diagnosed with diabetes.

The Healthy Living with Diabetes program includes:

- Clinical Practice Guidelines – Molina Healthcare adopted the American Diabetes Association (ADA) guidelines for diabetic care.
- Diabetes Registry – Molina Healthcare established a diabetes registry. The registry uses available claims and pharmacy information to identify and track diabetic members in the program.
- Diabetes Newsletters – Molina Healthcare distributes newsletters to diabetic members.
- Care Reminders and Age-Appropriate Tools – Molina Healthcare provides individualized reminders and educational tools to members with diabetes.
- Diabetes Education – Diabetes education is covered for all Molina Healthcare members. We encourage providers to refer patients to these services, especially for newly diagnosed diabetics or those having difficulty managing their disease.
- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Health Management Unit.

Diabetes Profiles – Molina Healthcare will send the PCP a report or profile of patients with diabetes. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare diabetic patients not included in the profile.

To find out more information about the health management programs, please call Provider Services Department at (888) 558-5501.

Heart Healthy Living – Cardiovascular Disease (CVD) Management Program

Molina's *Heart Healthy Living* health management program is a collaborative team approach comprised of patient education, clinical case management and provider education. The team works closely with contracted practitioners in the identification, assessment and implementation of appropriate interventions for members with CVD.

While CVD can encompass many different conditions that often co-exist, Molina Healthcare has chosen to target three subprograms: heart failure, coronary artery disease (CAD) and hypertension. The literature supports the selection of these three conditions as being responsive to interventions aimed at the development of adequate self-management skills in optimizing clinical outcomes and improving quality of life.

The Heart Healthy Living program includes:

- Clinical Practice Guidelines – Molina Healthcare adopted the National Heart, Lung and

Blood Institute (NHLBI) and the American Heart Association guidelines for cardiovascular care.

- Cardiovascular Disease Registry – Molina Healthcare established a CVD registry. The registry uses available claims and pharmacy information to identify and track cardiovascular members in the program.

- Cardiovascular Disease Newsletters – Molina Healthcare distributes newsletters to CVD members.

- Care Reminders and Tools – Molina Healthcare provides individualized reminders and educational tools to members with CVD.

- Cardiovascular Disease Education – CVD education is covered for all Molina Healthcare members. We encourage providers to refer patients to these services, especially for newly diagnosed heart disease or those having difficulty managing their disease.

- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Health Management Unit.

Cardiovascular Disease Profiles – Molina Healthcare will send the PCP a report or profile of patients with heart disease. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare CVD patients not included in the profile.

To find out more information about the health management programs, please call Member Provider Services Department at (888) 558-5501.

Healthy Living with COPD

Given the diversity of Molina Healthcare's membership a health management system created around COPD should improve the quality of life among our members and clinical outcomes in the future. Molina's *Healthy Living with COPD* disease management program strives to improve outcomes through continual, rather than episodic, care. The program provides the most intense follow-up with members at the greatest risk for poor outcomes. Providing a continuum of coordinated, comprehensive care reduces the incidence of acute episodes requiring emergency treatment and promotes improved quality of care for our members.

The Healthy Living with COPD program includes:

- Clinical Practice Guidelines – Molina Healthcare adopted the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines for COPD care.

- COPD Registry – Molina Healthcare established a COPD registry. The registry uses available claims and pharmacy information to identify and track COPD members in the program.

- COPD Newsletters – Molina Healthcare distributes newsletters to COPD members.

- Care Reminders and Appropriate Tools – Molina Healthcare provides individualized reminders and educational tools to members with COPD.

- COPD Education – COPD education is covered for all Molina Healthcare members. We encourage providers to refer patients to these services, especially for newly diagnosed members or those having difficulty managing their disease.

- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Health Management Unit.

COPD Profiles – Molina Healthcare will send the PCP a report or profile of patients with COPD. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. Molina Healthcare also requests the PCP provide us with the names of Molina Healthcare COPD patients not included in the profile.

To find out more information about the health management programs, please call Provider Services Department at (888) 558-5501.

Section 5. Transportation

Non-emergency Transportation Services (NEMT)

Molina Healthcare will be offering *limited* transportation services if certain conditions apply. This benefit requires prior authorization and will be available on a case-by-case basis to assist our members in accessing care if the ASES-established transportation process or other free transportation resources cannot meet the member's need. These limited services will be provided through TranCita, Molina Healthcare's transportation partner. TranCita will need 72 hours advance notice to schedule trips. To check on the availability of this benefit, and to schedule transportation contact Molina Healthcare at (888) 558-5501.

In addition to this limited benefit, each Municipality in Puerto Rico has a variety of free transportation services available to assist members in getting to medical appointments. To access the services and ask about free non-emergency medical transportation options members may:

- Contact the local Municipal office
- Ask the PCP or PMG
- Call Molina Healthcare Member Services

Emergency Transportation

When a Member's condition is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes, but is not limited to, ambulance, air or boat transports.

Examples of conditions considered for emergency transports include, but are not limited to, acute and severe illnesses, untreated fractures, loss of consciousness, semi-consciousness, having a seizure or receiving CPR during transport, acute or severe injuries from auto accidents, and extensive burns.

Sea, air and land transportation will be covered within Puerto Rican territory limits in cases of emergency. These services do not require Preauthorization or precertification.

Emergency transportation services are covered in the US for members who are Medicaid or CHIP eligible, if the emergency transportation is associated with an Emergency Service in the US.

Section 6. Provider Responsibilities

This section describes Molina Healthcare's established provider roles and standards on access to care, newborn notification process, and member marketing information for participating providers. In applying the standards listed below, participating providers have agreed they will not discriminate against any member on the basis of:

- Age
- Race
- Creed
- Color
- Religion
- Sex
- National origin
- Ancestry
- Sexual orientation
- Marital status
- Physical disability
- Mental or sensory handicap
- Place of residence
- Socioeconomic status
- Status as a recipient of Medicaid benefits

Additionally, participating providers or contracted medical groups/IPAs may not limit their practices because of a member's medical (physical or mental) condition or the expectation for the need of frequent or high cost care. If PCPs choose to close their panel to new members, Molina Healthcare must receive thirty (30) days advance notice from the provider.

Access to Care Standards

Molina Healthcare is committed to providing timely access to care for all members in a safe and healthy environment. Molina Healthcare will ensure providers offer hours of operation no less than offered to commercial members. Access standards have been developed to ensure that all health care services are provided in a timely manner. The PCP or designee must be available (24) hours a day, seven days a week to members for emergency services. This access may be by telephone. Appointment and waiting time standards are shown below. Any member assigned to a PCP is considered his or her patient.

For additional information about how Molina Healthcare audits access to care, please refer to Section 8 (Quality Improvement) of this manual.

Primary Care Practitioner (PCP)	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Adult Routine Physical Exams	Routine physical exams shall be provided for Enrollees age twenty-one (21) and over within thirty (30) Calendar Days of the Enrollee's request for the service, taking into account both the medical and Behavioral Health need and condition

Primary Care	Routine evaluations for Primary Care shall be provided within thirty (30) Calendar Days, unless the Enrollee requests a later time;
Covered Services	Covered Services shall be provided within fourteen (14) Calendar Days following the request for service
Pediatric Routine Care	Periodic screens ("EPSDT Checkups") in accordance with the Puerto Rico Medicaid Program's periodicity schedule and the American Academy of Pediatrics EPSDT periodicity schedule.
Newly Enrolled / Newborn	Initial health and screening visits to all newly enrolled CHIP Eligible children within ninety (90) Calendar Days and within twenty-four (24) hours of birth to all newborns; and, after the initial Checkup, annually.
After Hours Care	After-Hours Instruction/Standards
After hours emergency instruction	"If this is an emergency, please hang up and dial 911"
After-Hours Care	Available by phone twenty-four (24) hours/seven (7) days
Behavioral Health	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Non-life Threatening Emergency Care (Crisis)	Behavioral Health crisis services, face-to-face appointments shall be available within two (2) hours; and Detoxification services shall be provided Immediately according to clinical necessity
Urgent Care	Behavioral Health Care outpatient appointments for urgent conditions shall be available within twenty-four (24) hours
Routine Care	Within ≤ ten (10) calendar days
Other Providers	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)

Specialist	Specialist Services shall be provided within thirty (30) Calendar Days of the Enrollee's original request for service
Dental Providers	Dental services shall be provided within sixty (60) Calendar Days following the request, unless the Enrollee requests a later date
Diagnostic Laboratory, Diagnostic Imaging and Other Testing	Diagnostic laboratory, diagnostic imaging and other testing appointments shall be provided consistent with the clinical urgency, but no more than fourteen (14) Calendar Days, unless the Enrollee requests a later time. Diagnostic laboratory, diagnostic imaging and other testing, if a "walk-in" rather than an appointment system is used, the Enrollee wait time shall be consistent with severity of the clinical need
Prescription Fill Time	The in-person prescription fill time (ready for pickup) shall be no longer than forty (40) minutes. A prescription phoned in by a practitioner shall be filled within ninety (90) minutes
Follow-up Visits	The timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need
Urgent Diagnostic Laboratory, Diagnostic Imaging and Other Testing	Urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than forty-eight (48) hours
Urgent Care Providers - Primary Medical, Dental	Primary medical, dental, and Behavioral Health Care outpatient appointments for urgent conditions shall be available within twenty-four (24) hours
Emergency Providers	Emergency Services shall be provided, including Access to an appropriate level of care, within twenty-four (24) hours of the service request

Hours of Service

Network Providers are prohibited from having different hours and schedules for GHP Enrollees than what is offered to commercial Enrollees.

Behavioral Health Facilities are required to have opening hours covering twelve (12) hours per day, seven (7) days per week and shall have available one (1) nurse, one (1) social worker and one (1) psychologist/psychiatrist.

Preferential Turns

Network Providers are required to establish a system of Preferential Turns for residents of the island municipalities of Vieques and Culebra. (Preferential Turns refers to a policy of requiring Providers to give priority in treating Enrollees from these island municipalities, so that they may be seen by a physician within a reasonable time after arriving in the Provider's office.) This priority treatment is necessary because of the remote locations of these municipalities, and the greater travel time required for the residents to seek medical attention. This requirement was established in Laws No. 86 enacted on August 16, 1997 (Arts. 1 through 4) and Law No. 200 enacted on August 5, 2004 (Arts. 1 through 5).

Extended Schedule of Provider Medical Groups (PMGs)

PMGs shall be available for services or consultations Monday through Friday of each Week, from 8:00 a.m. to 6:00 p.m. (Atlantic Time).

In addition, each Provider that offers urgent care services, as well as any other qualified Provider willing to provide urgent care services, shall have sufficient personnel to offer urgent care services during extended periods Monday through Friday from 6:00 p.m. to 9:00 p.m. (Atlantic Time), in order to provide Enrollees greater access to their PCPs and to urgent care services in each Service Region.

PMGs may collaborate with each other to establish extended office hours at one (1) or multiple facilities.

Enrollee Special Coverage Registration Process

Physicians must notify Molina Healthcare immediately upon identification of a Molina Enrollee diagnosed with a condition that is within the scope of the Special Coverage Benefit. Providers must submit a treatment plan to Molina Healthcare at the time of request to enroll a member in Special Coverage.

In addition to the treatment plan, the physician shall submit to Molina Healthcare the Special Coverage Registration Form (available on the Molina website) within one (1) working day of the Enrollee having been screened and diagnosed with a qualifying condition (see Section 2, Benefits and Covered Services for a list of the diagnoses within the scope of the benefit). Providers shall enter all applicable information on the form. The form should be faxed to Molina Healthcare of Puerto Rico at (855) 378-3641.

The MHPR Preferred Provider Network (PPN) and General Network

Molina Healthcare of Puerto Rico (MHPR) is committed to improving access to specialty care for our Members.

- Primary care and preventive services are available from contracted primary care providers participating with MHPR in Primary Medical Groups (or "PMGs").

- Along with the PMGs, MHPR's Preferred provider Network (or "PPN") is our contracted provider network of specialists and other providers available on an "open access" basis for Members assigned to all of our contracted PMGs in the East and Southwest regions.

    - Example – Should MHPR have four hospitals and 500 specialists and ancillary providers in the PPN, all of those PPN providers will be listed and available to Members assigned to PMG #1, PMG#2, PMG#3 etc.

- The MHPR General Network will be composed of hospitals, ancillary and other providers that are (i) not part of the PMGs and PPN, and/or (ii) located outside of the East and Southwest service regions.

- Member Access and PCP processes are streamlined as follows:

    - No referrals will be needed to see a PPN provider; Referrals are required outside of the PPN.
    - As a Managed Care Organization we encourage a written consultation be provided first to the specialist by the PCP and subsequently by the specialist to the PCP in order to maintain proper and effective communication for the benefit of the member's care.
    - No copays will apply to the PPN and General Network for Medicaid and CHIP members (Commonwealth membership will continue to pay applicable co-pays when going outside of the PPN).
    - Prescriptions will not require a co-signature of the PCP if written by a contracted provider within the PPN.

- MHPR's provider directory will list the contracted PMGs along with our PPN and General Network providers.

- The usual processes for referrals, co-pays and required co-signatures for prescriptions will apply for Members obtaining services from providers in the General Network or out-of-network providers.

Member Cost Sharing

Cost Sharing is the Deductible, Copayment, or Coinsurance that members must pay for Covered Services provided under the Government Health Plan. It is the provider's responsibility to collect the copayment and other member Cost Share from the member. The amount of the copayment and other Cost Sharing will be deducted from the Molina Healthcare payment for all claims involving Cost Sharing. Providers may not charge members fees for covered services beyond copayments or coinsurance.

Additional information regarding Member Cost Sharing is available in Section 4 of this manual.

Relocations and Additional Sites

Providers should notify Molina Healthcare sixty (60) days in advance when they relocate or open an additional office. When this notification is received, a site review of the new office may be conducted before the provider's recredentialing date.

Site and Medical Record-Keeping Practice Reviews

As a part of Molina Healthcare's Quality Improvement Program, providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping

practices in their practices. For details regarding these requirements and other QI program expectations please refer to Section 8 of this manual.

Member Information and Marketing

Any written informational and marketing materials directed at Molina Healthcare members must be developed at the fourth (4th) grade reading level and have prior written consent from Molina Healthcare and the appropriate government agencies. Please contact your Provider Services Representative for information and review of proposed materials. Neither Molina Healthcare, nor any contracted providers nor medical groups/IPA may:

- Distribute to its members informational or marketing materials that contain false or misleading information
- Distribute to its members marketing materials selectively within the Service Area
- Directly or indirectly conduct door-to-door, telephonic, or other cold-call marketing for member enrollment

Role of Primary Medical Group (PMG) and Primary Care Physician (PCP):

The GHP Program uses a Coordinated Care Model in which patient (member) health is coordinated by a PCP. The PCP is responsible for evaluating the member periodically and coordinating all the health services the member may need. The PCP must keep an updated record of all of the services a member received.

The Primary Medical Group (PMG) was formerly known as an IPA. This group of physicians includes PCPs, specialists, sub-specialists, laboratories, x-ray facilities and hospitals. This group of providers forms the Preferred Provider Network (PPN) of the PMG. Members have the freedom to visit the PPN physicians and providers without a referral or co-payment.

The PCP is responsible to oversee and coordinate all aspects of the members' healthcare. The responsibilities of the PCP include:

- Perform medical assessments relevant to member health
- Provide, coordinate and manage all health services and treatments that the member needs, including coordination with Behavioral Health personnel, in a timely manner and in accordance with the guidelines, protocols and practices generally accepted in medicine
- Provide preventive health services
- Provide sick-care to assigned members
- Recommend/refer member to specialists and/or sub-specialists when needed
- Provide referrals if necessary to specialists or sub-specialists outside of the PPN or when a second opinion is desired
- Coordinate member visits to specialists and/or sub-specialists outside the PPN
- Provide prescriptions for medications and/or treatments needed by member
- Maintain accurate and updated medical records for members
- Consult with other health professions about member's diagnosis and treatment.

Section 7. Medical Management Program

Introduction

Molina Healthcare maintains a medical management program to ensure patient safety as well as detect and prevent fraud, waste and abuse in its programs. The Molina Healthcare medical management program also ensures that Molina Healthcare only reimburses for services identified as a covered benefit and medically necessary . Elements of the Molina Healthcare medical management program include medical necessity review, prior authorization, inpatient management and restrictions on the use of non-network providers.

Medical Necessity Review

In conjunction with regulatory guidance from federal and Commonwealth regulations and industry standards, Molina Healthcare only reimburses services provided to its members that are medically necessary. Molina Healthcare may conduct a medical necessity review of all requests for authorization and claims, within the specified time frame governed by Federal or Commonwealth law for all lines of business. This review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively, as long as the review complies with Federal or Commonwealth regulations and the Molina Healthcare Hospital or Provider Services Agreement.

Molina Healthcare employs appropriately licensed professionals to supervise all Prior Authorization decisions. Any decision to deny a Service Authorization Request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a Provider who possesses the appropriate clinical expertise for treating the Member's condition.

Molina Healthcare will utilize established criteria to determine medical necessity and will not deny or unreasonably delay Medically Necessary Services to Members.

Clinical Information

Molina Healthcare requires copies of clinical information be submitted for documentation in all medical necessity determination processes. Clinical information includes but is not limited to; physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina Healthcare does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless Commonwealth or federal regulations or the Molina Healthcare Hospital or Provider Services Agreement require such documentation to be acceptable.

Prior Authorization

Referrals are made when medically necessary services are beyond the scope of the PCPs practice. Most referrals to in-network specialists do not require an authorization from Molina Healthcare. Prior Authorization is a request for prospective review. It is designed to:

- Assist in benefit determination
- Prevent unanticipated denials of coverage
- Create a collaborative approach to determining the appropriate level of care for Members receiving services
- Identify Case Management and Disease Management opportunities
- Improve Coordination of care.

Request for services listed on the Molina Healthcare of Puerto Rico Authorization Guide are evaluated by licensed nurses and trained staff that have authority to approve services.

Molina Healthcare requires prior authorization for specified services as long as the requirement complies with Federal or Commonwealth regulations and the Molina Healthcare Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina Healthcare prior authorization documents are updated annually and the current documents are posted on the Molina Healthcare website. Molina Healthcare has included at the end of this section of this manual a copy of the current Authorization Request form. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina Healthcare ID number, etc.)
- Provider demographic information (referring provider and referred to provider/facility)
- Requested service/procedure, including all appropriate CPT, HCPCS and Diagnosis codes
- Clinical information sufficient to document the medical necessity of the requested service

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and Commonwealth law) are excluded from the prior authorization requirements.

Molina Healthcare will process any non-urgent requests within seventy-two (72) hours of receipt of request. Urgent requests will be processed within twenty-four (24) hours.

Providers who request Prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting provider at (888) 558-5501.

Requesting Prior Authorization

Molina Healthcare's Prior Authorization Guide and request form on our website. Providers are encouraged to access this guide via our website to ensure they have the most current standards.

Web Portal: Providers are encouraged to use the Molina Healthcare Web Portal for prior authorization submission. Instructions for how to submit a Prior Authorization Request are available on the Portal.

Fax: The Prior Authorization form can be faxed to Molina Healthcare at: (855) 378-3641. If the request is not on the form provided in this manual, be sure to send to the attention of the Healthcare Services Department.

Phone: Prior Authorizations can be initiated by contacting Molina's Healthcare Services Department at (888) 558-5501. It may be necessary to submit additional documentation before the authorization can be processed.

Mail: Prior Authorization requests and supporting documentation can be submitted via Surface. Mail at the following address:

Molina Healthcare of Puerto Rico
Attn: Healthcare Services Dept.
654 Plaza, Suite 1600
654 Avenida Munoz Rivera
San Juan, PR 00918

Hospitals

Emergency Care

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent emergency care services rendered to the member do not require prior authorization from Molina Healthcare.

Members accessing the emergency department inappropriately will be contacted by Molina Healthcare Case Managers whenever possible to determine the reason for using emergency services. Case Managers will also contact the PCP to ensure that members are not accessing the emergency department because of an inability to be seen by the PCP.

Admissions

Hospitals are required to notify Molina Healthcare within (24) hours or the first working day of any inpatient admissions, including deliveries, in order for hospital services to be covered. Prior authorization is required for inpatient or outpatient surgeries. Retroactive authorization requests for services rendered will normally not be approved.

Inpatient Management

Elective Inpatient Admissions- Molina Healthcare requires prior authorization for all elective inpatient admissions to any facility. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent Inpatient Admissions-Molina Healthcare requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays. Molina Healthcare requires that notification includes member demographic information, facility information, date of admission and clinical information (see definition above) sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting notification and medical necessity requirements will result in a denial of authorization for the inpatient admission.

Concurrent Inpatient Review- Molina Healthcare performs concurrent inpatient review in order to ensure patient safety, medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina Healthcare will request updated original clinical records from inpatient facilities at regular intervals during a member's inpatient admission. Molina Healthcare requires that requested clinical information updates be received by Molina Healthcare from the inpatient facility within twenty-four (24) hours of the request. Failure to provide timely clinical information updates will result in denial of authorization for the remainder of the inpatient admission.

Inpatient Status Determinations Molina Healthcare follows payment guidelines for inpatient status determinations consistent with CMS guidelines and regulations. Molina Healthcare requires that members stay in an inpatient facility for at least two (2) midnights AND meet inpatient medical necessity criteria during their stay in order to qualify for inpatient status. Stays less than two (2) midnights will be processed as observation status. Rare exceptions include when the admitting physician has clearly documented the reasons for an expectation of an inpatient stay lasting less than two (2) midnights and the patient expires, is transferred or leaves the facility against medical advice (AMA) before the two (2) midnight stay is completed. Molina Healthcare applies this inpatient status determination methodology to all lines of business as long as the methodology complies with Federal or Commonwealth regulations and the Molina Healthcare Hospital or Provider Services Agreement. As of the effective date of this manual CMS has delayed financial enforcement of the two midnight rule. Until such time as CMS proceeds with that enforcement, Molina will be using a 24 hour timeframe in place of the two midnight rule as the basis for its short stay policy.

Readmission Policy Hospital readmissions within thirty (30) days potentially constitute a quality of care problem. Readmission review is an important part of Molina Healthcare's Quality Improvement Program to ensure that Molina Healthcare members are receiving hospital care that is compliant with nationally recognized guidelines as well as federal and Commonwealth regulations.

Molina Healthcare will review all hospital subsequent admissions that occur within the time frames allowed by federal and Commonwealth law of the previous discharge for all claims. Reimbursement for readmissions will be limited to the payment for the first admission and the second payment will be denied unless it meets one of the exceptions noted below, violates Commonwealth and/or Federal law or violates the terms of the Hospital or Provider Services Agreement between the Hospital and Molina. If the readmission occurs at a different facility the second admission will be reimbursed and the payment to the first facility will not be eligible for payment due to readmission unless the case meets one of the exception noted below, violates Commonwealth and/or Federal law or violates the terms of the Hospital or Provider Services Agreement between the Hospital and Molina.

Exceptions:

1. The readmission is determined to be due to an unrelated condition from the first inpatient admission AND there is no evidence that premature discharge or inadequate discharge planning in the first admission necessitated the second admission

2. The readmission is part of a medically necessary, prior authorized or staged treatment plan

3. There is clear medical record documentation that the patient left the hospital AMA during the first hospitalization prior to completion of treatment and discharge planning.

Definitions:

Readmission: A subsequent admission to an acute care hospital within a specified time frame of a prior admission for a related condition or as readmission is defined by Commonwealth laws or regulations.

Related Condition: A condition that has a same or similar diagnosis or is a preventable complication of a condition that required treatment in the original hospital admission.

Referrals and Non-Network Providers- Molina Healthcare maintains a contracted network of qualified healthcare professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Healthcare members. As part of our commitment to improved access for specialty care, Molina Healthcare maintains an "open access" Preferred Provider Network (PPN) for all providers contracted in the East and Southwest regions. (More information on this open access PPN is available in section 6.) Molina Healthcare encourages members to obtain care from within the Preferred Provider Network (PPN. A referral from the PCP or PMG is required to access services outside the PPN but within Molina Healthcare's general network. Molina Healthcare requires members to receive medical care within the participating, contracted general network of providers unless it is for emergency services as defined by federal law. If there is a need to go to a non-contracted provider, all care provided by non-contracted, non-network providers must be prior authorized by Molina Healthcare. 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 Commonwealth laws or regulations.

"Emergency services" for this section is defined as A) medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient

Avoiding Conflict of Interest

The HCS Department affirms its decision-making is based on appropriateness of care and service and the existence of benefit coverage.

Molina Healthcare does not reward providers or other individuals for issuing denials of coverage or care. Furthermore, Molina Healthcare never provides financial incentives to encourage authorization decision makers to make determinations that result in under-utilization. Molina Healthcare also requires our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Coordination of Care

Molina Healthcare's Integrated Care Management, which includes Utilization Management, Case Management and Health Management, will work with providers to assist with coordinating services and benefits for members with complex needs and issues. It is the responsibility of contracted providers to assess members and with the participation of the member and their representatives, create a treatment care plan. The treatment plan is to be documented in the medical record and is updated as conditions and needs change.

Molina Healthcare staff assists providers by identifying needs and issues that may not be verbalized by providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina Healthcare staff is done in partnership with providers and members to ensure efforts are efficient and non-duplicative.

Continuity of Care and Transition of Members

It is Molina Healthcare's policy to provide members with advance notice when a provider they are seeing will no longer be in network. Members and providers are encouraged to use this time to transition care to an in-network provider. The provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the provider(s) assuming care. Under certain circumstances, members may be able to continue treatment with the out of network provider for a given period of time. For additional information regarding continuity of care and transition of members, please contact Molina Healthcare at (888) 558-5501.

Continuity and Coordination of Provider Communication

Molina Healthcare stresses the importance of timely communication between providers involved in a member's care. This is especially critical between specialists, including behavioral health providers, and the member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

Case Management

Molina Healthcare provides a comprehensive Case Management (CM) program to all members who meet the criteria for services. The CM program focuses on procuring and coordinating the care, services, and resources needed by members with complex issues through a continuum of

care. Molina Healthcare adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina Healthcare case managers are licensed professionals and are educated, trained and experienced in the case management process. The CM program is based on a member advocacy philosophy, designed and administered to assure the member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes.

The CM program is individualized to accommodate a member's needs with collaboration and consultation from the member's PCP. The Molina Healthcare case manager will arrange individual services for members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina Healthcare case manager is responsible for assessing the member's appropriateness for the CM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

Referral to Case Management: Members with high-risk medical conditions may be referred by their PCP or specialty care provider to the CM program. The case manager works collaboratively with all members of the health care team, including the PCP, hospital UM staff, discharge planners, specialist providers, ancillary providers, the local Health Department and other community resources. The referral source provides the case manager with demographic, health care and social data about the member being referred.

Members with the following conditions may qualify for case management and should be referred to the Molina Healthcare CM Program for evaluation:

- High-risk pregnancy, including members with a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- High-risk and/ or Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
-
- Members who have accessed the emergency room seven (7) or more times within twelve (12) months.
- Members identified special health care needs;
- Members diagnosed with a Serious Mental Illness or a Serious Emotional Disability ("SMI/SED");
-

Referrals to the CM program may be made by contacting Molina Healthcare at (877) 335-3305.

PCP Responsibilities in Case Management Referrals

The member's PCP is the primary leader of the health team involved in the coordination and direction of services for the member. The case manager provides the PCP with reports, updates, and information regarding the member's progress through the case management plan. The PCP is responsible for the provision of preventive services and for the primary medical care of members.

Case Manager Responsibilities

The case manager collaborates with all resources involved and the member to develop a plan of care which includes a multidisciplinary action plan (team treatment plan), a link to the appropriate institutional and community resources, and a statement of expected outcomes. Jointly, the case manager, providers, and the member are responsible for implementing the plan of care. Additionally the case manager:

Monitors and communicates the progress of the implemented plan of care to all involved resources

Serves as a coordinator and resource to team members throughout the implementation of the plan, and makes revisions to the plan as suggested and needed

Coordinates appropriate education and encourages the member's role in self-help

Monitors progress toward the member's achievement of treatment plan goals in order to determine an appropriate time for the member's discharge from the CM program.

Health Management Level 1 and Health Management Programs

Molina Healthcare's Health Management Level 1 (previously Health Education) and Health Management (previously Disease Management) programs will be incorporated into the member's treatment plan to address the member's health care needs. Primary prevention programs may include smoking cessation and wellness. Additional information regarding these programs is available in Section 4 of this manual.

Emergency Services

Emergency services are covered on a (24) hour basis without the need for prior authorization for all members experiencing an emergency medical situation.

Molina Healthcare of Puerto Rico accomplishes this service by providing a (24) hour Nurse Triage option on the main telephone line for post business hours. In addition, the 911 information is given to all members at the onset of any call to the plan.

For members within our service area: Molina Healthcare of Puerto Rico. contracts with vendors that provide (24) hour emergency services for ambulance and hospitals.

Medical Record Standards

The provider is responsible for maintaining an electronic or paper medical record for each individual member. Records are expected to be current, legible, detailed and organized to allow for effective and confidential patient care by all providers.

Medical records are to be stored in a secure manner that permits easy retrieval. Only authorized personnel may have access to patient medical records.

Providers will develop and implement confidentiality procedures to guard member protected health information, in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy standards and all other applicable federal and Commonwealth regulations. The provider must ensure his/her staff receives periodic training regarding the confidentiality of member information.

The provider is responsible for documenting directly provided services. Such services must include, but not necessarily be limited to, family planning services, preventive services, services for the treatment of sexually transmitted diseases, ancillary services, diagnostic services and diagnostic and therapeutic services for which the member was referred to the provider.

At a minimum, each medical record must be legible and maintained in detail with the documentation outlined in section 8 (Quality Improvement) of this manual.

Medical Necessity Standards

Medically Necessary or Medical Necessity is defined as services that include medical or allied care, goods or services furnished or ordered that are:

- Necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain
- Individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs
- Consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational
- Reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available within the Commonwealth
- Furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider

The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/Benefit.

Section 8. Quality Improvement

Quality Improvement

Molina Healthcare of Puerto Rico maintains a Quality Improvement (QI) Department to work with members and practitioners/providers in administering the Molina Quality Improvement Program. You can contact the Molina QI Department at(787) 200-3300

The address for mail requests is:

Molina Healthcare of Puerto Rico, Inc.
Quality Improvement Department
654 Plaza, Suite 1600
654 Avenida Munoz Rivera
San Juan, PR 00918

This Provider Manual contains excerpts from the Molina Healthcare of Puerto Rico Quality Improvement Program (QIP). For a complete copy of Molina Healthcare of Puerto Rico's QIP you can contact your Provider Services Representative or call the telephone number above to receive a written copy.

Molina has established a Quality Improvement (QI) Program that complies with regulatory and accreditation guidelines. The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service and health of our members.

Molina does not delegate Quality Improvement activities to Medical Groups/IPAs. However, Molina requires contracted Medical Groups/IPAs to comply with the following core elements and standards of care and to:

- Have a quality improvement program in place;
- Comply with and participate in Molina Quality Improvement Program including reporting of Access and Availability and provision of medical records as part of the HEDIS® review process and quality studies; and
- Allow access to Molina QI personnel for site and medical record review processes.

Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the member's record. Molina conducts a medical record review of all Primary Care Practitioner (PCPs) that includes the following components:

- Medical record confidentiality and release of medical records including behavioral health care records;

- Medical record content and documentation standards, including preventive health care;
- Storage maintenance and disposal; and
- Process for archiving medical records and implementing improvement activities.

Practitioners/providers must demonstrate compliance with Molina Healthcare of Puerto Rico's medical record documentation guidelines. Medical records are assessed based on the following standards:

Content

- Patient name or ID is on all pages;
- Current biographical data is maintained in the medical record or database;
- All entries contain author identification;
- All entries are dated and are indelibly documented;
- Medication allergies and adverse reactions are prominently displayed. Absence of allergies is noted in easily recognizable location;
- Chronic conditions are listed or noted in easily recognizable location;
- Past medical history;
- There is appropriate notation concerning use of substances, and for patients, there is evidence of substance abuse query;
- The history and physical examination identifies appropriate subjective and objective information pertinent to a patient's presenting complaints and provides a risk assessment of the members health status;
- Consistent charting of treatment care plan;
- Working diagnoses are consistent with findings;
- Treatment plans are consistent with diagnoses;
- Encounter notation includes follow up care, call, or return instructions;
- Preventive health measures (i.e., immunizations, mammograms, etc.) are noted;
- A system is in place to document telephone contacts;
- Lab and other studies are ordered as appropriate;
- Lab and other studies are initialed by ordering practitioner/provider upon review with lab results and other studies are filed in chart;
- If patient was referred for consult, therapy, or ancillary service, a report or notation of result is noted at subsequent visit, or filed in medical record; and
- If the practitioner/provider admitted a patient to the hospital in the past twelve (12) months, the discharge summary must be filed in the medical record;
- Advanced Directives are documented for those 18 years and older.
- A release document for each member authorizing Molina Healthcare to release medical information for facilitation of medical care.
- Developmental screenings as conducted through a standardized screening tool.
- Documentation of the age-appropriate screening that was provided in accordance with the periodicity schedule and all EPSDT related services.
- Documentation of a pregnant member's refusal to consent to testing for HIV infection and any recommended treatment.

Organization

- The medical record is legible to someone other than the writer;
- Each patient has an individual record;
- Chart pages are bound, clipped, or attached to the file; and
- Chart sections are easily recognized for retrieval of information.

Retrieval

- The medical record is available to practitioner/provider at each encounter;
- The medical record is available to Molina Healthcare for purposes of quality improvement;
- The medical record is available to ASES and the External Quality Review Organization upon request;
- The medical record is available to the member upon their request;
- Medical record retention process is consistent with Commonwealth and federal requirements; and
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

- Medical Records are protected from unauthorized access;
- Access to computerized confidential information is restricted; and
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.

Additional information on medical records is available from your local Molina Quality Improvement Department at (787) 200-3300. See also Section 10 (Compliance) for additional information regarding the Health Insurance Portability and Accountability Act (HIPAA).

Access to Care

Molina is committed to timely access to care for all members in a safe and healthy environment. Practitioners/providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 95% availability for emergency services and 80% or greater for all other services. The PCP or his/her designee must be available 24 hours a day, 7 days a week to members.

Appointment Access

All practitioners/providers who oversee the member's health care are responsible for providing the following appointments to Molina members in the timeframes noted:

Primary Care Practitioner (PCP)	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Adult Routine Physical Exams	Routine physical exams shall be provided for Enrollees age twenty-one (21) and over within thirty (30) Calendar Days of the Enrollee's request for the service, taking into account both the medical and Behavioral Health need and condition
Primary Care	Routine evaluations for Primary Care shall be provided within thirty (30) Calendar Days, unless the Enrollee

	requests a later time;
Covered Services	Covered Services shall be provided within fourteen (14) Calendar Days following the request for service
Pediatric Routine Care	Periodic screens ("EPSDT Checkups") in accordance with the Puerto Rico Medicaid Program's periodicity schedule and the American Academy of Pediatrics EPSDT periodicity schedule.
Newly Enrolled / Newborn	Initial health and screening visits to all newly enrolled CHIP Eligible children within ninety (90) Calendar Days and within twenty-four (24) hours of birth to all newborns; and, after the initial Checkup, annually.
After Hours Care	After-Hours Instruction/Standards
After hours emergency instruction	"If this is an emergency, please hang up and dial 911"
After-Hours Care	Available by phone twenty-four (24) hours/seven (7) days
Behavioral Health	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Non-life Threatening Emergency Care (Crisis)	Behavioral Health crisis services, face-to-face appointments shall be available within two (2) hours; and Detoxification services shall be provided Immediately according to clinical necessity
Urgent Care	Behavioral Health Care outpatient appointments for urgent conditions shall be available within twenty-four (24) hours
Routine Care	Within ≤ ten (10) calendar days
Other Providers	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Specialist	Specialist Services shall be provided within thirty (30) Calendar Days of the Enrollee's original request for

	service
Dental Providers	Dental services shall be provided within sixty (60) Calendar Days following the request, unless the Enrollee requests a later date
Diagnostic Laboratory, Diagnostic Imaging and Other Testing	Diagnostic laboratory, diagnostic imaging and other testing appointments shall be provided consistent with the clinical urgency, but no more than fourteen (14) Calendar Days, unless the Enrollee requests a later time. Diagnostic laboratory, diagnostic imaging and other testing, if a "walk-in" rather than an appointment system is used, the Enrollee wait time shall be consistent with severity of the clinical need
Prescription Fill Time	The in-person prescription fill time (ready for pickup) shall be no longer than forty (40) minutes. A prescription phoned in by a practitioner shall be filled within ninety (90) minutes
Follow-up Visits	The timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need
Urgent Diagnostic Laboratory, Diagnostic Imaging and Other Testing	Urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than forty-eight (48) hours
Urgent Care Providers - Primary Medical, Dental	Primary medical, dental, and Behavioral Health Care outpatient appointments for urgent conditions shall be available within twenty-four (24) hours
Emergency Providers	Emergency Services shall be provided, including Access to an appropriate level of care, within twenty-four (24) hours of the service request

Additional information on appointment access standards is available from your local Molina QI Department at (787) 200-3300.

After Hours

All practitioners must have back-up (on call) coverage after hours or during the practitioner's absence or unavailability. Molina requires practitioners to maintain a twenty-four (24) hour phone service, seven (7) days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct

members with an emergency to hang-up and call 911 or go immediately to the nearest emergency room.

Women's Health Access

Molina allows members the option to seek obstetrical and gynecological care from an obstetrician or gynecologist or directly from a participating PCP designated by Molina Healthcare of Puerto Rico as providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure members have direct access to participating providers for obstetrical and gynecological services.

Additional information on access to care is available on the Molinahealthcare.com/puertorico website or from your local Molina QI Department at (787) 200-3300.

Monitoring Access Standards

Molina monitors compliance with the established access standards above. At least annually, Molina conducts an access audit of randomly selected contracted practitioner/provider offices to determine if appointment access standards are met. One or all of the following appointment scenarios may be addressed: routine care; acute care; preventive care; and after-hours information. Results of the audit are distributed to the practitioners after its completion. A corrective action plan may be required if standards are not met.

In addition, Molina's Member Services Department reviews member inquiry logs and grievances related to delays in access to care. These are reported quarterly to committees. Delays in access that may create a potential quality issue are sent to the QI Department for review.

Additional information on access to care is available at Molinahealthcare.com/puertorico or is available from your local Molina QI Department at (787) 200-3300.

Advance Directives (Patient Self-Determination Act)

Advance Directives

Practitioners/providers must inform adult Molina members (18 years old and up) of their right to make health care decisions and execute Advance Directives. It is important that members are informed about Advance Directives. During routine Medical Record review, Molina Healthcare auditors will look for documented evidence of discussion between the practitioner/provider and the member. Molina will notify the provider via fax of an individual member's Advance Directives identified through care management, Care Coordination or Case Management. Providers are instructed to document the presence of an Advance Directive in a prominent location of the Medical Record. Auditors will also look for copies of the Advance Directive form. Advance Directives forms are Commonwealth specific to meet Commonwealth regulations.

Each Molina practitioner/provider must honor Advance Directives to the fullest extent permitted under law. Members may select a new PCP if the assigned provider has an objection to the beneficiary's desired decision. Molina Healthcare will facilitate finding a new PCP or specialist as needed**.**

PCPs must discuss Advance Directives with a member and provide appropriate medical advice if the member desires guidance or assistance. Molina's network practitioners and facilities are

expected to communicate any objections they may have to a member directive prior to service whenever possible. In no event may any practitioner/provider refuse to treat a member or otherwise discriminate against a member because the member has completed an Advance Directive. CMS law gives members the right to file a complaint with Molina Healthcare or the Commonwealth survey and certification agency if the member is dissatisfied with Molina Healthcare's handling of Advance Directives and/or if a practitioner/provider fails to comply with Advance Directives instructions.

Advance Directives are a written choice for health care. There are three types of advance directives:

- Durable Power of Attorney for Health Care: allows an agent to be appointed to carry out health care decisions
- Living Will: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration
- Guardian Appointment: allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary

When There Is No Advance Directive: The member's family and practitioner will work together to decide on the best care for the member based on information they may know about the member's end-of-life plans.

EPSDT Services to Enrollees Under Twenty-One (21) Years

Molina Healthcare maintains systematic and robust monitoring mechanisms to ensure all required EPSDT Services to Enrollees under twenty-one (21) Years are timely according to required preventive guidelines. All Enrollees under twenty-one (21) years of age should receive screening examinations including appropriate childhood immunizations at intervals as specified by the EPSDT Program as set forth in §§1902(a)(43)and 1905(a)(4)(B) of the Social Security Act and 89 Ill. Adm. Code 140.485. Molina's Quality Improvement Department is available to perform provider training and offer EPSDT forms/tools to ensure that best practice guidelines are followed in relation to well child services and care for acute and chronic health care needs.

Well child / adolescent visits

Visits consist of age appropriate components including but not limited to:

- A comprehensive health and developmental history;
- Developmental assessment, including mental, emotional, and behavioral health development (includes the use of the Ages and Stages Questionnaire and the Modified Checklist for Autism in Toddlers screening tool);
- Measurement (including head circumference for infants);
- An assessment of nutritional status;
- A comprehensive unclothed physical exam;
- Immunizations (according to the Advisory Committee on Immunization Practices)
- Laboratory procedures, including lead testing;
- Anticipatory guidance (including child development, healthy lifestyles, and accident and disease prevention) and health education;
- Vision screening;
- Tubercolosis testing;
- Hearing screening; and

- Dental and oral health assessment;

Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the member's Covered Benefit Services. Members should be referred to an appropriate source of care for any required services that are not Covered Services. If, as a result of EPSDT services, it is determined that the member is in need of services that are not Covered Services but are services otherwise provided for under the Health Management Program, Molina will ensure that the member is referred to an appropriate source of care. Molina shall have no obligation to pay for services that are not Covered Services.

Monitoring for Compliance with Standards

Molina monitors compliance with the established performance standards as outlined above at least annually. Within (30) calendar days of the review, a copy of the review report and a letter will be sent to the medical group or Provider notifying them of their results. Performance below Molina Healthcare's standards may result in a corrective action plan (CAP) with a request to the Provider to submit a written corrective action plan to Molina Healthcare within (30) calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Providers permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new members.

Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement Program (QIP). The QIP provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Clinical Practice Guidelines

Molina Healthcare adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-practitioner/provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established Authority. Clinical Practice Guidelines are reviewed annually and are updated as new recommendations are published.

Molina Clinical Practice Guidelines include the following:

Asthma	Cholesterol
Chronic Obstructive Pulmonary Disease (COPD)	Coronary Heart Disease
Depression	Diabetes
Hypertension	Substance Abuse Treatment
ADHD	

The adopted Clinical Practice Guidelines are distributed to the appropriate practitioners, providers, provider groups, staff model facilities, delegates and members by the Quality Improvement, Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through provider newsletters, Just the Fax electronic bulletins and other media and are available on the Molina Healthcare Website. Individual practitioners or members may request copies from your local Molina Healthcare QI Department at (787) 200-3300.

Preventive Health Guidelines

Molina Healthcare provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF) and in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include but are not limited to:

- Mammography screening;
- Cholesterol screening;
- Influenza, pneumococcal and hepatitis vaccines.
- Childhood and adolescent immunizations;
- Cervical cancer screening;
- Chlamydia screening;
- Prenatal visits.

All guidelines are updated with each release by USPSTF and are approved by the Quality Improvement Committee. On annual basis, Preventive Health Guidelines are distributed to practitioners/providers via www.MolinaHealthcare.com/PuertoRico and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Services

Molina serves a diverse population of members with specific cultural needs and preferences. Practitioners/providers are responsible to ensure that interpreter services are made available at no cost for members with sensory impairment and/or who are Limited English Proficient (LEP). The following cultural and linguistic services are offered by Molina Healthcare to assist both members and practitioners/providers.

24 Hour Access to Interpreter

Practitioners/providers may request interpreters for members by calling **Molina's Provider Services Department toll free at (888) 558-5501.** If Service Representatives are unable to provide the interpretation services internally, the member and practitioner/provider are immediately connected to Language Line telephonic interpreter service.

Measurement of Clinical and Service Quality

Molina Healthcare monitors and evaluates the quality of care and services provided to members through the following mechanisms:

- Healthcare Effectiveness Data and Information Set (HEDIS®);
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®);

- Provider Satisfaction Survey; and
- Effectiveness of Quality Improvement Initiatives.

Contracted Providers and Facilities must allow Molina Healthcare to use its performance data collected in accordance with the provider's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of quality improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced member cost sharing.

Molina Healthcare's most recent results can be obtained from the Molina Healthcare of Puerto Rico QI Department toll free at (787) 200-3300 or fax (787) 200-3251 or by visiting our website at www.MolinaHealthcare.com/PuertoRico.

HEDIS®

Molina utilizes the NCQA© HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including well visits, immunizations, women's health screening, pre-natal visits, diabetes care, behavioral health, asthma, and cardiovascular disease.

HEDIS® results are used in a variety of ways. They are the measurement standard for many of Molina's clinical quality improvement activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

Selected HEDIS® results are provided to regulatory and accreditation agencies as part of our contracts with these agencies. The data are also used to compare to established health plan performance benchmarks.

CAHPS®

CAHPS® is the tool used by Molina to summarize member satisfaction with the health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Promotion and Education, Coordination of Care and Customer Service. The CAHPS® survey is administered annually in the spring to randomly selected members by a NCQA certified vendor.

CAHPS® results are used in much the same way as HEDIS® results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Molina's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® both focus on member experience with health care practitioners/providers and health plans, Molina Healthcare conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina, as this is one of the primary methods we use to identify improvement areas pertaining to the Molina Healthcare Provider Network. The survey results have helped establish improvement activities relating to

Molina's specialty network, inter-provider communications, and pharmacy authorizations. This survey is fielded to a random sample of practitioners/providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

Molina Healthcare monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating "best practices". The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods.

In addition to the methods described above, Molina also compiles complaint and appeals data as well as on requests for out-of-network services to determine opportunities for service improvements.

Section 9. Claims

As a contracted provider, it is important to understand how the claims process works to avoid delays in processing your claims. The following items are covered in this section for your reference:

- Claim Submission
- Corrected Claim
- Claims Disputes/Adjustments
- Overpayments/Refund Requests
- Coordination of Benefits (COB)
- Third Party Liability (TPL)
- Billing the member

Claim Submission

Claims may be submitted to Molina Healthcare with appropriate documentation by mail or filed electronically (EDI) for CMS-1500 and UB-04 claims. For members assigned to a delegated medical group/IPA that processes its own claims, please verify the "Remit To" address on the member's Molina Healthcare ID card (Refer to Section 2). Providers billing Molina Healthcare directly should send claims to:

Molina Healthcare of Puerto Rico, Inc.
PO Box 364828
San Juan, PR 00936-4828

Providers billing Molina Healthcare electronically should use current HIPAA compliant ANSI X12N format (e.g., 837I for institutional claims, 837P for professional claims, and 837D for dental claims)**.**

Providers must use good faith effort to bill Molina Healthcare for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility claims, the date of discharge. The following information must be included on every claim:

- Institutional Providers:
    - The completed UB 04 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC. Entries stated as mandatory by NUBC and required by federal statue and regulations and any Commonwealth designated data requirements included in statues or regulation.

- Physicians and Other Professional Providers:
    - The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format. Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD) codes. Entries states as mandatory by NUCC and required by federal statute and regulation and any Commonwealth designated data requirements included in statutes or regulations.

National Provider Identifier (NPI)

Providers must report any changes in their NPI or subparts to Molina Healthcare within thirty (30) calendar days of the change.

Documents that do not meet the criteria described above may result in the claim being denied or returned to the provider. Claims must be submitted on the proper claim form, either a CMS-1500 or UB-04. Molina Healthcare will only process legible claims received on the proper claim form containing the essential data requirements. Incomplete, inaccurate, or untimely re-submissions may result in denial of the claim.

Electronic Claim Submissions and Claims Payment

Providers are encouraged to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow providers to reduce paperwork, provides searchable ERAs, and providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the provider for EFT enrollment, and providers are not required to be in-network to enroll. Molina Healthcare uses a vendor to facilitate the HIPPA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at www.MolinaHealthcare.com/PuertoRico or by contacting our Provider Services Department.

Electronic Claims Submission Options

Molina Healthcare offers the following electronic claims submission options:

- Submit claims directly to Molina Healthcare of Puerto Rico (MHPR) via the Provider Portal
- Submit claims to MHPR via your regular EDI clearinghouse using Payor ID 81794

Molina Healthcare of Puerto Rico uses Emdeon as its gateway clearinghouse. Emdeon has relationships with hundreds of other clearinghouses, including Immediata and Assertus. Providers can continue to submit claims to their usual clearinghouse. Emdeon will receive those claims on behalf of Molina Healthcare.

Molina Healthcare of Puerto Rico accepts EDI transactions for both claims and encounters via the 837P for Professional, 837I for Institutional, and 837D for dental. In addition, Molina also accepts pharmacy encounters via the NCPDP file format or proprietary if applicable. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure claims are received for processing in a timely manner.

When your claims are filed electronically:

- You should receive an acknowledgement from your current clearinghouse
- You should receive a 999 acknowledgement from the clearinghouse within two (2) business days of your transmission
- You should contact your local clearinghouse representative if you experience any problems with your transmission
- For any direct submissions to Molina you should receive a 999 acknowledgement of your transmission
- For encounter submission you will also receive a 277CA response file for each file transaction.

EDI Claims Submission Issues:

Providers who are experiencing EDI submission issues call the Molina Healthcare EDI Customer Service line at (866) 409-2935 or email us at EDI.Claims@molinahealthcare.com.

Timely Claim Filing

Provider shall promptly submit to Molina Healthcare claims for Covered Services rendered to members. All claims shall be submitted in a form acceptable to and approved by Molina Healthcare, and shall include any and all medical records pertaining to the claim if requested by Molina Healthcare or otherwise required by Molina Healthcare's policies and procedures. Claims must be submitted by provider to Molina Healthcare within ninety (90) calendar days after the following have occurred: discharge for inpatient services or the date of service for outpatient services; and provider has been furnished with the correct name and address of the member's health maintenance organization. If Molina Healthcare is not the primary payer under coordination of benefits or third party liability, provider must submit claims to Molina Healthcare within ninety (90) calendar days after final determination by the primary payer. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted to Molina Healthcare within these timelines shall not be eligible for payment, and provider hereby waives any right to payment therefore.

Fraud and Abuse

Failure to report instances of suspected Fraud and Abuse is a violation of the law and subject to the penalties provided by law. Please refer to the Compliance section of this manual for more information.

Timely Claim Processing

Claims payment will be made to contracted providers in accordance with the timeliness provisions set forth in the provider's contract. Unless the provider and Molina Healthcare or contracted medical group/IPA have agreed in writing to an alternate payment schedule, Molina Healthcare will pay the provider of service within thirty (30) calendar days after receipt of clean claims.

The receipt date of a claim is the date Molina Healthcare receives either written or electronic notice of the claim.

Claim Review

Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, current Uniform Billing ("UB") manual and editor, Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS"), federal, state and commonwealth billing and payment rules, National Correct Coding Initiative ("NCCI") Edits, and Federal Drug Administration ("FDA") definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Furthermore, Provider acknowledges Molina Healthcare's right to conduct medical necessity reviews and apply clinical practices to determine appropriate payment. Payment may exclude certain items not billed in accordance with industry standard billing and payment rules or certain items which do not meet certain medical necessity criteria.

Claim Auditing

Provider acknowledges Molina Healthcare's right to conduct post-payment billing audits. Provider shall cooperate with Molina Healthcare's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data. Molina Healthcare shall use established industry claims adjudication and/or clinical practices, state, commonwealth and federal guidelines, and/or Molina Healthcare's policies and data to determine the appropriateness of the billing, coding, and payment.

Coordination of Benefits and Third Party Liability

COB

Medicaid is the payor of last resort. Private and governmental carriers must be billed prior to billing Molina Healthcare or medical groups/IPAs. Provider shall make reasonable inquiry of members to learn whether member has health insurance, benefits or Covered Services other than from Molina Healthcare or is entitled to payment by a third party under any other insurance or plan of any type, and provider shall immediately notify Molina Healthcare of said entitlement. In the event that coordination of benefits occurs, provider shall be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to Molina Healthcare's contracted allowable rate. The provider must include a copy of the other insurance's EOB with the claim.

Third Party Liability

Molina Healthcare is the payor of last resort and will make every effort to determine the appropriate Third Party payer for services rendered. Molina Healthcare may deny claims when a Third Party has been established and will pay claims for covered services when probable Third Party Liability (TPL) has not been established or third party benefits are not available to pay a claim. Molina Healthcare will attempt to recover any third-party resources available to members and shall maintain records pertaining to TPL collections on behalf of members for audit and review.

Corrected Claims

Corrected claims are considered new claims. Corrected claims may be submitted electronically with the appropriate field on the 837 I or 837 P completed. Paper corrected claims need to be marked as corrected and should be submitted to the following address (subject to timely filing requirements):

Molina Healthcare of Puerto Rico, Inc.
PO Box 364828
San Juan, PR 00936-4828

Claims Disputes/Adjustments

Providers seeking a redetermination of a claim previously adjudicated must request such action within ninety (90) calendar days of Molina Healthcare's original remittance advice date. Additionally, any claim(s) dispute requests (including denials) should be submitted to Molina Healthcare using the standard Claims Reconsideration Review Form (CRRF). This form can be found on the provider website.

In addition to the CRRF, Providers should submit the following documentation:

- The previous claim and remittance advice, any other documentation to support the adjustment and a copy of the Referral/Authorization form (if applicable) must accompany the adjustment request.
- The claim number clearly marked on all supporting documents

These requests shall be classified as a Claims Disputes/Adjustment and may be faxed to 844-488-7050. Requests may also be sent to the following address:

Molina Healthcare of Puerto Rico, Inc.
Attention: Claims Disputes / Adjustments
654 Plaza, Suite 1600
654 Avenida Munoz Rivera
San Juan, PR 00918

Requests for adjustments of claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original claim.

The Provider will be notified of Molina Healthcare of Puerto Rico's decision in writing within thirty (30) calendar days of receipt of the Claims Dispute/Adjustment request. Providers may request a claim dispute/adjustment when the claim was incorrectly denied as a duplicate or due to claims examiner or data-entry error.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, Molina Healthcare determines that it has made an overpayment to a provider for services rendered to a member, it will request recovery for such overpayment. Molina Healthcare will not reduce payment to that provider for other services unless the provider agrees to the reduction or fails to respond to Molina Healthcare's claim as required in this subsection.

A provider shall pay a claim for an overpayment made by a Molina Healthcare which the provider does not contest or deny within the specified number of days on the refund request letter mailed to the provider.

Payment of a claim for overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to the organization, or the date that the provider receives a payment from the organization that reduces or deducts the overpayment.

Billing the Member

Molina Healthcare contracted providers may not bill the member for any covered benefit. The contract between the provider and Molina Healthcare places the responsibility for verifying eligibility and obtaining approval for those services that require prior authorization on the provider.

Encounter Data

Each capitated provider/organization delegated for Claims payment is required to submit encounter data to Molina Healthcare for all adjudicated Claims. The data is used for many purposes, such as reporting to HFS, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS reporting.

Encounter data must be submitted once per month, and must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D -- Dental. In addition, Molina Healthcare also accepts pharmacy encounters via the NCPDP file

format or proprietary if applicable. Data must be submitted with claims level detail for all non-institutional services provided. For institutional services, only those services covered by Molina Healthcare should be reported.

Molina Healthcare shall have a comprehensive automated and integrated encounter data system capable of meeting these requirements.

Molina Healthcare will create Molina's 837P, 837I, and 837D Companion Guides with the specific submission requirements available to providers.

Section 10. Compliance

Fraud, Waste & Abuse

Introduction

Molina Healthcare of Puerto Rico maintains a comprehensive Fraud, Waste, and Abuse program. The program is held accountable for the special investigative process in accordance with federal and commonwealth statutes and regulations. Molina Healthcare of Puerto Rico is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, the Compliance department maintains a comprehensive plan, which addresses how Molina Healthcare of Puerto Rico will uphold and follow federal and commonwealth statutes and regulations pertaining to fraud, waste, and abuse. Molina's Special Investigation Unit supports Compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations to identify and report findings to the appropriate regulatory and/or law enforcement agencies. The program also addresses fraud prevention and the education of appropriate employees, vendors, providers and associates doing business with Molina Healthcare of Puerto Rico.

Mission Statement

Molina Healthcare of Rico regards health care fraud, waste and abuse as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. Molina Healthcare of Puerto Rico has therefore implemented a program to prevent, investigate, and report suspected health care fraud, waste and abuse in order to reduce health care cost and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. Government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or Acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Deficit Reduction Act

On February 8, 2006, the Deficit Reduction Act ("DRA") was signed into law, which became effective on January 1, 2007. The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities like Molina Healthcare of Puerto Rico who receive or pay out at least $5 million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina Healthcare of Puerto Rico, providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and Commonwealth laws pertaining to submitting false claims;
- How providers will detect and prevent fraud, waste, and abuse;
- Employee protection rights as a whistleblowers.

The Federal False Claims Act has Qui Tam language commonly referred to as "whistleblower" provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in disclosing or reporting a false claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority;
- Two times the amount of back pay plus interest;
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare will take steps to monitor Molina Healthcare of Puerto Rico contracted providers to ensure compliance with the law.

Definitions

Fraud:

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or Commonwealth law. (42 CFR § 455.2)

Waste:

Health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program.

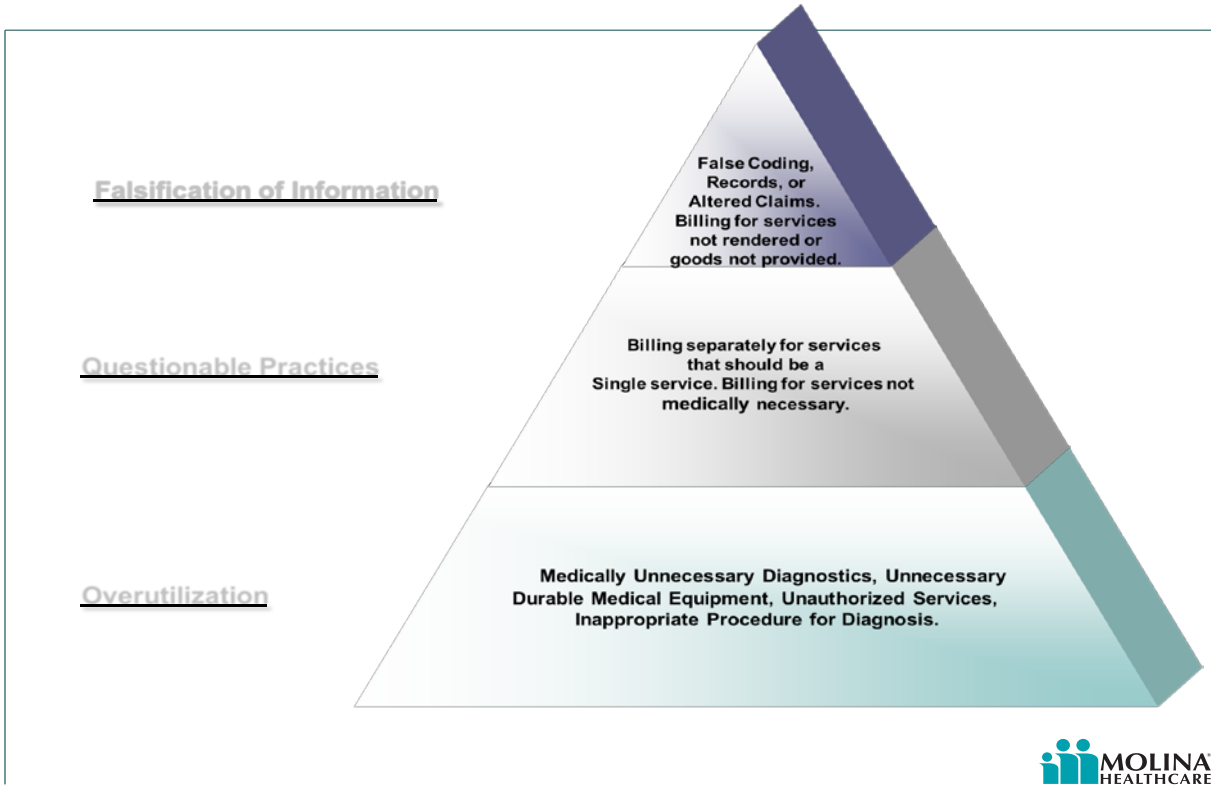
Abuse:

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized

standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid programs. (42 CFR § 455.2)

Examples of Fraud, Waste and Abuse by a Provider

- Billing for services, procedures and/or supplies that have not actually been rendered.
- Providing services to patients that are not medically necessary.
- Balance Billing a Medicaid member for Medicaid covered services. For example, asking the patient to pay the difference between the discounted fees, negotiated fees, and the provider's usual and customary fees.
- Intentional misrepresentation or manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of provider/practitioner or the recipient of services, "unbundling" of procedures, non-covered treatments to receive payment, "up-coding", and billing for services not provided.
- Concealing patients misuse of Molina Healthcare of Puerto Rico identification card.
- Failure to report a patient's forgery/alteration of a prescription.
- Knowingly and willfully soliciting/receiving payment of kickbacks or bribes in exchange for the referral of Medicaid patients.
- A physician knowingly and willfully referring Medicaid patients to health care facilities in which or with which the physician has a financial relationship. (The Stark Law)



Review of Provider

The Credentialing Department is responsible for monitoring practitioners through the various government reports, including:

- Federal and state/commonwealth Medicaid sanction reports.
- Federal and state/commonwealth lists of excluded individuals and entities.
- List of parties excluded from Federal Procurement and Non-procurement Programs.
- Medicaid suspended and ineligible provider list.
- Monthly review of state/commonwealth Medical Board sanctions list.
- Review of license reports from the appropriate specialty board.

If a match is found, the Credentialing Services staff will request copies of relevant information from the appropriate government entity. Upon receiving this information the documents are presented to the Credentialing Committee for review and potential action. The Credentialing staff will also present the list of physicians found on the Medicaid sanctions report to the Compliance Committee for review and potential oversight of action.

Provider Profiling

Molina Healthcare of Puerto Rico performs claims audits to detect potential external health care fraud, waste, or abuse. These audits of provider billings are based on objective and documented criteria. Molina Healthcare of Puerto Rico uses a fraud, waste, and abuse detection software application designed to score and profile provider and member billing behavior and patterns. The software utilizes a fraud finder engine to identify various billing behaviors, billing patterns, known schemes, as well as unknown patterns by taking into consideration a provider or member's prior billing history. The software statistically identifies what is expected based on prior history and specialty norms, including recognition of pattern changes from those identified in profiled historical paid claims data and ongoing daily claims batches. If a score reaches a certain parameter or threshold, the provider or member is placed on a list for further review.

Molina Healthcare of Puerto Rico will inform the provider of the billing irregularities and request an explanation of the billing practices. The Compliance department, with the aid of the Special Investigation Unit, may conduct further investigation and take action as needed.

Provider/Practitioner Education

When Molina Healthcare of Puerto Rico identifies through an audit or other means a situation with a provider (e.g. coding, billing) that is either inappropriate or deficient, Molina Healthcare of Puerto Rico may determine that a provider/practitioner education visit is appropriate.

The Molina Healthcare of Puerto Rico Provider Services Representative will inform the provider's office that an on-site meeting is required in order to educate the provider on certain issues identified as inappropriate or deficient.

Review of Provider Claims and Claims System

Molina Healthcare Claims Examiners are trained to recognize unusual billing practices and to detect fraud, waste and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the Compliance Department.

The claims payment system utilizes system edits and flags to validate those elements of claims are billed in accordance with standardized billing practices; ensure that claims are processed accurately and ensure that payments reflect the service preformed as authorized.

Molina Healthcare of Puerto Rico performs auditing to ensure the accuracy of data input into the claims system. The claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected and a thorough review of system edits is conducted to detect and locate the source of the errors.

Cooperating with Special Investigation Unit Activities

Molina Healthcare's Special Investigation Unit may conduct prepayment, concurrent, or post-payment review. Providers will cooperate with Special Investigation Unit activities, and will provide requested documentation to the unit following the timelines indicated in such requests. Failure to cooperate may result in further action, up to and including termination of the Provider contract.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina Healthcare AlertLine. AlertLine is an external telephone and web based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. AlertLine telephone and web based reporting is available 24 hours a day, 7 days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Healthcare Compliance Department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina Healthcare AlertLine can be reached toll free at 1-866-606-3889 or you may use the service's website to make a report at any time at **https://molinahealthcare.alertline.com**

You may also report cases of fraud, waste or abuse to Molina Healthcare of Puerto Rico's Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of Puerto Rico
Attn: Compliance
654 Plaza, Suite 1600
654 Avenida Munoz Rivera
San Juan, PR 00918

You can report potential fraud, waste and abuse without giving us your name.

To report suspected Medicaid fraud, waste or abuse, contact Molina Healthcare AlertLine at:

Toll free, 866-606-3889

or

Complete a report form online at:

https://www.molinahealthcare.alertline.com

Remember to include the following information when reporting:

- Nature of complaint.
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Medicaid ID number and any other identifying information.

Suspected fraud and abuse may also be reported directly to the commonwealth at:

The Health Insurance Administration (ASES)

Toll Free Phone: (800) 981-2737

or download the incident referral document which you can use to report fraud, waste, or abuse at:

www.ases.pr.org

HIPAA Requirements and Information

HIPAA (The Health Insurance Portability and Accountability Act)

Molina Healthcare's Commitment to Patient Privacy

Protecting the privacy of members' personal health information is a core responsibility that Molina Healthcare takes very seriously. Molina Healthcare is committed to complying with all federal and Commonwealth laws regarding the privacy and security of members' protected health information (PHI).

Provider/Practitioner Responsibilities

Molina Healthcare expects that its contracted providers/practitioners will respect the privacy of Molina Healthcare members and comply with all applicable laws and regulations regarding the privacy of patient and member PHI.

Applicable Laws

Providers/practitioners must understand all Commonwealth and federal healthcare privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of laws that providers/practitioners must comply with. In general, most healthcare providers/practitioners are subject to various laws and regulations pertaining to privacy of health information, which may include, but are not limited to, the following:

1. Federal Laws and Regulations
    - HIPAA
    - The Health Information Technology for Economic and Clinical Health Act (HITECH)
    - Medicaid Laws

- The Affordable Care Act

2. Applicable Laws and Regulations of the Commonwealth of Puerto Rico

Providers/practitioners should be aware that HIPAA provides a floor for patient privacy but that more stringent laws should be followed in certain situations. Providers/practitioners should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a provider/practitioner may use and disclose PHI for their own treatment, payment, and healthcare operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the provider/practitioner's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity, or healthcare provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a healthcare provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[2]."

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

- Quality improvement;
- Disease management;
- Case management and care coordination;
- Training Programs;
- Accreditation, licensing, and credentialing

[1]See, Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.

[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

Importantly, this allows providers/practitioners to share PHI with Molina Healthcare for our healthcare operations activities, such as HEDIS and quality improvement.

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable Commonwealth law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Patient Rights

Patients are afforded various rights under HIPAA. Molina Healthcare providers/practitioners must allow patients to exercise any of the below-listed rights that apply to the provider/practitioner's practice:

1. Notice of Privacy Practices

Providers/practitioners that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The provider/practitioner should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. Requests for Restrictions on Uses and Disclosures of PHI

Patients may request that a healthcare provider/practitioner restrict its uses and disclosures of PHI. The provider/practitioner is not required to agree to any such request for restrictions.

3. Requests for Confidential Communications

Patients may request that a healthcare provider/practitioner communicate PHI by alternative means or at alternative locations. Providers/practitioners must accommodate reasonable requests by the patient.

4. Requests for Patient Access to PHI

Patients have a right to access their own PHI within a provider/practitioner's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a provider/practitioner includes the patient's medical record, as well as billing and other records used to make decisions about the member's care or payment for care.

5. Request to Amend PHI

Patients have a right to request that the provider/practitioner amend information in their designated record set.

6. Request Accounting of PHI Disclosures

Patients may request an accounting of disclosures of PHI made by the provider/practitioner during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or healthcare operations or made prior to April 14, 2003.

HIPAA Security

Providers/practitioners should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. As more providers implement electronic health records, providers need to ensure that they have implemented and maintain appropriate cyber security measures. Providers/practitioners should recognize that identity theft – both financial and medical -- is a rapidly growing problem and that their patients trust their health care providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the healthcare industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity –such as health insurance information—without the person's knowledge or consent to obtain healthcare services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina Healthcare.

HIPAA Transactions and Code Sets

Molina Healthcare strongly supports the use of electronic transactions to streamline healthcare administrative activities. Molina Healthcare providers/practitioners are encouraged to submit claims and other transactions to Molina Healthcare using electronic formats. Certain electronic transactions are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advices

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/practitioners who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to Molina Healthcare's website at www.MolinaHealthcare.com/PuertoRico for additional information. Click on the area titled "For Health Care Professionals" click the tab titled "HIPAA" and then click on the tab titled "HIPAA Transaction Readiness."

National Provider Identifier

Provider/practitioners must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The provider/practitioners must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the provider/practitioner. The provider/practitioner must report its NPI and any subparts to Molina Healthcare and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to Molina Healthcare within 30 days of the change. Provider/practitioners must use its NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters (both electronic and paper formats) submitted to Molina Healthcare.

Additional Requirements for Delegated Providers/Practitioners

Providers/practitioners that are delegated for claims and utilization management activities are the "business associates" of Molina Healthcare. Under HIPAA, Molina Healthcare must obtain contractual assurances from all business associates that they will safeguard member PHI. Delegated providers/practitioners must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION

Member Name:_____ Member ID #:_____

Member Address:_____ Date of Birth:_____

City/State/Zip:_____ Telephone #:_____

I hereby authorize the use or disclosure of my protected health information as described below.

1. Name of persons/organizations authorized to make the requested use or disclosure of protected health information:

_____

_____

_____

2. Name of persons/organizations authorized to receive the protected health information:

_____

_____

_____

3. Specific description of protected health information that may be used/disclosed:

_____

_____

_____

4. The protected health information will be used/disclosed for the following purpose(s):

_____

_____

_____

5. The person/organization authorized to use/disclose the protected health information will receive compensation for doing so. Yes____ No____

6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.

7. Molina Healthcare may condition the provision of research related treatment on my provision of an authorization for the use or disclosure of PHI for such research.

8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Molina Healthcare reserves the right to deny that health care.

9. I understand that I have a right to receive a copy of this authorization, if requested by me.

10. I understand that I may revoke this authorization at any time by notifying Molina Healthcare in writing, except to the extent that:
    a) action has been taken in reliance on this authorization; or
    b) if this authorization is obtained as a condition of obtaining health care coverage, other law provides the health plan with the right to contest a claim under the benefits or coverage under the plan.

11. I understand that the information I authorize a person or entity to receive may be no longer protected by federal law and regulations.

12. This authorization expires on the following date or event* :

_____

*If no expiration date or event is specified above, this authorization will expire 12 months from the date signed below.

Signature of Member or Member's Personal Representative	Date
Printed Name of Member or Member's Personal Representative, if applicable	Relationship to Member or Personal Representative's Authority to act for the Member, if applicable

A copy of this signed form will be provided to the Member, if the authorization was sought by Molina Healthcare

Section 11. Credentialing and Recredentialing

The purpose of the Credentialing Program is to strive to assure that the Molina Healthcare network consists of quality practitioners/providers who meet clearly defined criteria and standards. It is the objective of Molina Healthcare to provide superior health care to the community.

The decision to accept or deny a credentialing applicant is based upon primary source verification, recommendation of peer practitioners/providers and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under commonwealth and federal law.

The Credentialing Program has been developed in accordance with commonwealth and federal requirements and accreditation guidelines. In accordance with those standards, Molina Healthcare members will not be referred and/or assigned to you until the credentialing process has been completed.

Criteria for Participation in the Molina Healthcare Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of practitioners for participation in the Molina network. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network.

To remain eligible for participation practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina Healthcare.

Molina reserves the right to exercise discretion in applying any criteria and to exclude practitioners who do not meet the criteria. Molina may, after considering the recommendations of the Credentialing Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined that such waiver is necessary to meet the needs of Molina and the community it serves. The refusal of Molina to waive any requirement shall not entitle any practitioner to a hearing or any other rights of review.

Practitioners must meet the following criteria to be eligible to participate in the Molina Healthcare network. If the practitioner fails to provide proof of meeting these criteria, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina Healthcare network. Practitioners who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

Practitioner must practice, or plan to practice within 90 calendar days, within the area served by Molina.

1. All providers, including ancillary providers, (i.e. vision, pharmacy, etc.), will apply for enrollment in the Medicaid program. Providers are required to have an NPI or an Administrative Provider Identification Number (APIN).
2. Practitioner must complete and submit to Molina a credentialing application. The application must be entirely complete. The practitioner must sign and date that application attesting that their application is complete and correct within 180 calendar days of the credentialing decision. If Molina or the Credentialing Committee requests any additional information or clarification the practitioner must supply that information in the time-frame requested.
3. Practitioner must have a current, valid license to practice in their specialty in every state/commonwealth in which they will provide care for Molina members.If applicable to the specialty, practitioner must hold a current and unrestricted federal Drug Enforcement Agency (DEA) certificate and Controlled Substance Certification or Registration. If a practitioner has never had any disciplinary action taken related to his/her DEA or CDS and chooses not to have a DEA or CDS, the practitioner may be considered for network participation if they submit a written prescription plan describing the process for allowing another practitioner with a valid DEA or CDS certificate to write all prescriptions. If a practitioner does not have a DEA because of disciplinary action including but not limited to being revoked or relinquished, the practitioner is not eligible to participate in the Molina network.
4. Providers providing opiate addiction treatment must be trained and certified by the Substance Abuse and Mental Health Services Administration ("SAMHSA") to provide opiate addiction treatment.
5. Practitioners will be required to be enrolled with the GHP as a managed care Provider.
6. Practitioners will only be credentialed in an area of practice in which they have adequate education and training as outlined below. Therefore practitioners must confine their practice to their credentialed area of practice when providing services to Molina members.
7. Practitioners must have graduated from an accredited school with a degree required to practice in their specialty.
8. Oral Surgeons and Physicians (MDs, DOs) must have satisfactorily completed a training program from an accredited training program in the specialty in which they are practicing. Molina only recognizes training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must have completed a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA).Board certification in the specialty in which the practitioner is practicing is preferred but not required. Initial applicants who are not Board Certified may be considered for participation only if they have satisfactorily completed a training program from an accredited training program in the specialty in which they are practicing. Molina recognizes Board Certification only from the following Boards:
    a. American Board of Medical Specialties (ABMS)
    b. American Osteopathic Association (AOA)
    c. American Board of Podiatric Surgery (ABPS)
    d. American Board of Podiatric Medicine (ABPM)
9. American Board of Oral and Maxillofacial Surgery
10. Practitioners who are not Board Certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a General Practitioner in the Molina network. To be eligible, the practitioner must have

maintained a Primary Care practice in good standing for a minimum of the most recent five years without any gaps in work history.

11. Practitioner must supply a minimum of 5-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If the practitioner has practiced fewer than 5-years from the date of Credentialing, the work history starts at the time of initial licensure. Experience practicing as a non-physician health professional (e.g. registered nurse, nurse practitioner, clinical social worker) within the 5-years should be included. If Molina determines there is a gap in work history exceeding six-months, the practitioner must clarify the gap either verbally or in writing. Verbal communication must be appropriately documented in the credentialing file. If Molina determines there is a gap in work history that exceeds one-year, the practitioner must clarify the gap in writing.
12. Practitioner must supply a full history of malpractice and professional liability claims and settlement history. Documentation of malpractice and professional liability claims and settlement history is requested from the practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
13. Practitioner must disclose a full history of all license actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Practitioner must also disclose any history of voluntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
14. At the time of initial application, the practitioner must not have any pending or open investigations from any state/commonwealth or governmental professional disciplinary body.[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.
15. Practitioner must disclose all Medicare and Medicaid sanctions. Practitioner must disclose all debarrements, suspensions, proposals for debarments, exclusions or disqualifications under the nonprocurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
16. Practitioner must not be currently sanctioned, excluded, expelled or suspended from any state/commonwealth or federally funded program including but not limited to the Medicare or Medicaid programs.
17. Practitioner must have current professional malpractice liability coverage with limits that meet Molina criteria. This coverage shall extend to Molina members and the practitioners activities on Molina's behalf.

[3] If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

18. Practitioner must disclose any inability to perform essential functions of a practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
19. Practitioner must disclose if they are currently using any illegal drugs/substances. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner. If a practitioner discloses any issues with substance abuse (e.g. drugs, alcohol) the practitioner must provide evidence of either actively and successfully participating in a substance abuse monitoring program or successfully completing a program.
20. Practitioner must disclose if they have ever had any criminal convictions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
21. Practitioner must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including but not limited to healthcare fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.
22. Practitioner must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
23. Physicians (MD, DO), Primary Care Practitioners, Nurse Midwives, Oral Surgeons, Podiatrists and/or those practitioners dictated by state/commonwealth law, must have admitting privileges in their specialty. If a practitioner chooses not to have admitting privileges, the practitioner may be considered for network participation if they have a plan for hospital admission by using a Hospital Inpatient Team or having an arrangement with a credentialed Molina participating practitioner that has the ability to admit Molina patients to a hospital. Practitioners practicing exclusively on a consultative basis are not required to have admitting hospital privileges. Physicians practicing in Dermatology, Occupational Medicine, Pain Medicine, Physical Medicine and Rehabilitation, Psychiatry, Sleep Medicine, Sports Medicine, Telemedicine, Urgent Care and Wound Management do not require admitting privileges.
24. Practitioners not able to practice independently according to commonwealth law must have a practice plan with a supervising physician approved by the state/commonwealth licensing agency. The supervising physician must be contracted and credentialed with Molina.
25. Practitioner's currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare line of business.
26. If applicable to the specialty, practitioner must have a plan for shared call coverage that includes 24-hours a day, seven days per week and 365 days per year. The covering practitioner(s) must be qualified to assess over the phone if a patient should immediately seek medical attention or if the patient can wait to be seen on the next business day. All Primary Care Practitioners must have 24-hour coverage. Physicians practicing in Dermatology, Occupational Medicine, Pain Medicine, Physical Medicine and Rehabilitation, Sleep Medicine, Telemedicine, Sports Medicine, Urgent Care and Wound Management are not required to have 24-hour coverage.
27. Molina may determine, in its sole discretion, that a practitioner is not eligible to apply for network participation if the practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by Molina, who is currently in the Fair Hearing Process, or who is under investigation by Molina. Molina also may determine, in its sole discretion that a practitioner cannot continue network participation if the practitioner is an

employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by Molina. For purposes of this criteria, a company is "owned" by a practitioner when the practitioner has at least 5% financial interest in the company, through shares or other means.

28. Practitioners denied by the Credentialing Committee are not eligible to reapply until one year after the date of denial by the Credentialing Committee. At the time of reapplication, practitioner must meet all criteria for participation outlined above.
29. Practitioners terminated by the Credentialing Committee or terminated from the network for cause are not eligible to reapply until five years after the date of termination. At the time of reapplication, practitioner must meet all criteria for participation as outlined above.
30. Practitioners denied or terminated administratively are eligible to reapply for participation anytime as long as the practitioner meets all criteria for participation above.

Burden of Proof

The practitioner shall have the burden of producing adequate information to prove he/she meets all criteria for initial participation and continued participation in the Molina Healthcare network. This includes but is not limited to proper evaluation of their experience, background, training, demonstrated ability and ability to perform as a practitioner without limitation, including physical and mental health status as allowed by law, and the burden of resolving any doubts about these or any other qualifications to participate in the Molina Healthcare network. If the practitioner fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina Healthcare network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

Practitioner termination and reinstatement

If a practitioner's contract is terminated and later it is determined to reinstate the practitioner, the practitioner must be initially credentialed prior to reinstatement if there is a break in service more than 30 calendar days. The credentialing factors that are no longer within the credentialing time limits and those that will not be effective at the time of the Credentialing Committee's review must be re-verified. The Credentialing Committee or medical director, as appropriate, must review all credentials and make a final determination prior to the practitioner's reentry into the network.

If a practitioner is given administrative termination for reasons beyond Molina's control (e.g., the practitioner failed to provide complete credentialing information), and is then reinstated within 30 calendar days, Molina may recredential the practitioner as long as there is clear documentation that the practitioner was terminated for reasons beyond Molina Healthcare's control and was recredentialed and reinstated within 30 calendar days of termination. Molina Healthcare must initially credential the practitioner if reinstatement is more than 30 calendar days after termination.

If Molina Healthcare is unable to recredential a practitioner within 36-months because the practitioner is on active military assignment, maternity leave or sabbatical but the contract between Molina and the practitioner remains in place, Molina Healthcare will recredential the practitioner upon his or her return. Molina Healthcare will document the reason for the delay in the practitioner's file. At a minimum, Molina Healthcare will verify that a practitioner who returns

has a valid license to practice before he or she can resume seeing patients. Within 60 calendar days of notice when the practitioner resumes practice, Molina Healthcare will complete the recredentialing cycle. If either party terminates the contract and there is a break in service of more than 30 calendar days, Molina Healthcare will initially credential the practitioner before the practitioner rejoins the network.

Practitioners terminating with a delegate and contracting with Molina directly

Practitioners credentialed by a delegate who terminate their contract with the delegate and want to contract with Molina Healthcare directly must be credentialed by Molina Healthcare within six-months of the practitioner's termination with the delegate. If the practitioner has a break in service more than 30 calendar days, the practitioner must be initially credentialed prior to reinstatement.

Credentialing Application

At the time of initial credentialing and recredentialing, the practitioner must complete a credentialing application designed to provide Molina Healthcare with information necessary to perform a comprehensive review of the practitioner's credentials. The application must be completed in its entirety. The practitioner must attest that their application is complete and correct within 180 calendar days of the credentialing decision. The application must be completed in typewritten text, in pen or electronically through applications such as the Counsel for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source. Pencils or erasable ink will not be an acceptable writing instrument for completing credentialing applications. Molina Healthcare may use another organization's application as long as it meets all the factors. Molina Healthcare will accept faxed, digital, electronic, scanned or photocopied signatures. A signature stamp is not acceptable on the attestation. The application must include:

Reason for any inability to perform the essential functions of the position, with or without accommodation

- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice insurance coverage and
- The correctness and completeness of the application

<u>Inability to perform essential functions and illegal drug use</u>

An inquiry regarding illegal drug use and inability to perform essential functions may vary. Practitioners may use language other than "drug" to attest they are not presently using illegal substances. Molina Healthcare may accept more general or extensive language to query practitioners about impairments; language does not have to refer exclusively to the present, or only to illegal substances.

<u>History of actions against applicant</u>

An application must contain the following information:

- History of loss of license
- History of felony convictions

- History of all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which a practitioner has had privileges

Current malpractice coverage

The application form must include specific questions regarding the dates and amount of a practitioner's current malpractice insurance. Molina may obtain a copy of the insurance face sheet from the malpractice carrier in lieu of collecting the information in the application.

For practitioners with federal tort coverage, the application need not contain the current amount of malpractice insurance coverage. Practitioner files that include a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage are acceptable.

Correctness and completeness of the application

Practitioners must attest that their application is complete and correct when they apply for credentialing and recredentialing. If a copy of an application from an entity external to Molina is used, it must include an attestation to the correctness and completeness of the application. Molina Healthcare does not consider the associated attestation elements as present if the practitioner did not attest to the application within the required time frame of 180 days. If state/commonwealth regulations require Molina Healthcare to use a credentialing application that does not contain an attestation, Molina Healthcare must attach an addendum to the application for attestation.

Meeting Application time limits

If the practitioner attestation exceeds 180 days before the credentialing decision, the practitioner must attest that the information on the application remains correct and complete, but does not need to complete another application. It is preferred to send a copy of the completed application with the new attestation form when requesting the practitioner to update the attestation.

The Process for Making Credentialing Decisions

All practitioners requesting initial participation with Molina must complete a credentialing application. To be eligible to submit an application, practitioners must meet all the criteria outlined above in the section titled “Criteria for Participation in the Molina Healthcare Network”. Practitioners may not provide care to Molina members until the final decision is rendered by the Credentialing Committee or the Molina Medical Director.

Molina recredentials its practitioners at least every thirty-six (36) months. Approximately six months prior to the recredentialing due date, the practitioners application will be downloaded from CAQH (or a similar NCQA accepted online applications source), or a request will be sent to the practitioner requesting completion of a recredentialing application.

During the initial and recredentialing application process, the practitioner must:

- Submit a completed application within the requested timeframe
- Attest to the application within the last 180 calendar days

- Provide Molina Healthcare adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina Healthcare network.

Once the application is received, Molina Healthcare will complete all the verifications as outlined in the Molina Credentialing Program Policy. In order for the application to be deemed complete, the practitioner must produce adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina Healthcare network. All fields within the application must be completed, all required attachments must be included, detailed explanations must be provided to all affirmative answers on the attestation questions and any additional information requested by Molina Healthcare must be provided.

If the practitioner does not provide the information necessary to complete the application process in the time period requested, the application will be deemed incomplete and Molina will discontinue processing of the application. This will result in an administrative denial or administrative termination from the Molina network. Practitioners who fail to provide proof of meeting the criteria or fail to provide a complete credentialing application do not have the right to submit an appeal.

At the completion of the application and primary source verification process, each credentialing file is quality reviewed to ensure completeness. During this quality review process each credentialing file is assigned a level based on established guidelines. Credentialing files assigned a level 1 are considered clean credentialing files and the Medical Director(s) responsible for credentialing has the authority to review and approve them. Credentialing files assigned a level 2 are reviewed by the Molina Credentialing Committee.

At each Credentialing Committee meeting, practitioner credentialing files assigned a Level 2 are reviewed by the Credentialing Committee; all of the issues are presented to the Credentialing Committee members and then open discussion of the issues commences. After the discussion, the Credentialing Committee votes for a final decision. The Credentialing Committee can approve, deny, terminate, approve on watch status, place on corrective action or defer their decision pending additional information.

Process for Delegating Credentialing and Recredentialing

Molina will delegate credentialing and recredentialing activities to Independent Practice Associations (IPA) and Provider Groups that meet Molina's requirements for delegation. Molina's Delegation Oversight Committee (DOC) must approve all delegation and subdelegation arrangements, and retains the right to limit or revoke any and all delegated credentialing activities when a delegate fails to meet Molina's requirements.

Molina's Credentialing Committee retains the right to approve new providers and provider sites and terminate practitioners, providers and sites of care based on requirements in the Molina Credentialing Policy.

To be delegated for credentialing, IPAs and Provider Groups must:

- Be National Committee for Quality Assurance (NCQA) accredited or certified for credentialing or pass Molina Healthcare's credentialing delegation pre-assessment,

which is based on NCQA credentialing standards and requirements for the Medicaid and Medicare programs, with a score of at least 90%.
- Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by Molina Healthcare at pre-assessment
- Agree to Molina Healthcare's contract terms and conditions for credentialing delegates
- Submit timely and complete reports to Molina Healthcare as described in policy and procedure
- Comply with all applicable federal and state/commonwealth laws
- If the IPA or Provider Group subdelegates primary source verification to a Credentialing Verification Organization (CVO), the CVO must be NCQA certified in all ten areas of accreditation.
-

Non-Discriminatory Credentialing and Recredentialing

Molina Healthcare does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g. abortions) or patients (e.g. Medicaid or Medicare) in which the practitioner specializes. This does not preclude Molina Healthcare from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of members.

Notification of Discrepancies in Credentialing Information

Molina will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples include but are not limited to actions on a license, malpractice claims history or sanctions. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law. Please also refer to the section below titled Practitioners Right to Correct Erroneous Information.

Notification of Credentialing Decisions

A letter is sent to every practitioner with notification of the Credentialing Committee or Medical Director decision regarding their participation in the Molina network. This notification is sent within two weeks of the decision. Copies of the letters are filed in the practitioner's credentials files. Under no circumstance will notification letters be sent to the practitioners later than 60 calendar days from the decision.

Confidentiality and Immunity

Information regarding any practitioner or provider submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care shall, to the fullest extent permitted by law, be confidential and shall only be disseminated to a

Representative in order to carry out appropriate activities under these Policies and Procedures. Confidentiality shall also extend to such information that is provided by third parties.

For purposes of this section a “Representative” shall mean any individual authorized to preform specific information gathering or disseminating functions for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care.

For purposes of this section “information” may be any written or oral disclosures including, but not limited to, a practitioner’s or provider’s professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care or practitioner’s or provider’s provision of patient care services.

By providing patient care services at Molina, a practitioner or provider:

1. Authorizes representatives of Molina to solicit, provide, and act upon information bearing on the practitioner’s or provider’s qualifications.
2. Agrees to be bound by the provisions of this policy and procedure and to waive all legal claims against any representative who acts in accordance with the provisions of this policy and procedure.
3. Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, Molina membership and the continuation of such membership, and to the exercise of clinical privileges or provision of patient care.

The confidentiality and immunity provisions of this policy and procedure shall apply to all information so protected by State/commonwealth or Federal law. To the fullest extent permitted by State/commonwealth or Federal law, the confidentiality and immunity provisions of this policy and procedure shall include, but is not limited to:

1. Any type of application or reapplication received by the Provider or Practitioner;
2. Actions reducing, suspending, terminating or revoking a practitioner’s and provider’s status, including requests for corrective actions, investigation reports and documents and all other information related to such action;
3. Hearing and appellate review;
4. Peer review and utilization and quality management activities;
5. Risk management activities and claims review;
6. Potential or actual liability exposure issues;
7. Incident and/or investigative reports;
8. Claims review;
9. Minutes of all meetings by any committees otherwise appropriately appointed by the Board;
10. Any activities related to monitoring the quality, appropriateness or safety of health care services;
11. Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services;
12. Any Molina operations and actions relating to practitioner and provider conduct.

Immunity from Liability for Action Taken: No representative shall be liable to a practitioner or provider or any third party for damages or other relief for any decision, opinion, action, statement, or recommendations made within the scope of their duties as representative, if such representative acts in good faith and without malice.

Immunity from Liability for Providing Information: No representative or third parties shall be liable to a practitioner or provider for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any third party pursuant to authorization by the practitioner or provider, or if permitted or required by law, or these Policies and Procedures, provided that such representative or third parties acts in good faith and without malice.

Cumulative Effect: The provisions in this Policy and Procedure and any forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to other protections provided by relevant state/commonwealth and federal law, and are not a limitation thereof.

All members (voting and non-voting) and guests of the Credentialing Committee, or any other committee performing any peer review functions or other individuals who participate in peer review functions will sign a Statement of Confidentiality annually. Members and guests of the Credentialing Committee will not discuss, share or use any information for any purpose other than peer review at Molina.

The Director in charge of Credentialing grants access to electronic credentials files only as necessary to complete credentialing work or as required by law. Access to these documents are restricted to authorized staff, Credentialing Committee members, peer reviewers and reporting bodies as authorized by the Credentialing Committee or the Governing Board of Molina. Each person is given a unique user ID and password. It is the strict policy of Molina that employees keep their passwords confidential and never share their passwords with anyone. All Credentialing employees are prompted to change their passwords into the system every three-months.

Minutes, reports and files of Credentialing Committee meetings are stored in secure electronic folders or in locked cabinets in the Credentialing Department and will be protected from discovery under all applicable laws.

Copies of minutes and any other related Credentialing Committee meeting materials will not be allowed to be removed from meetings of peer review committees and Credentialing staff will

shred extra sets of information from such meetings. Electronic data and/or information are password protected and Molina Staff is instructed not to divulge passwords to their co-workers.

Practitioners Rights during the Credentialing Process

Practitioners have the right to review their credentials file at any time. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

The practitioner must notify the Credentialing Department and request an appointed time to review their file and allow up to seven calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The practitioner has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied by the practitioner are documents which the practitioner sent to Molina (e.g., the application, the license and a copy of the DEA certificate). Practitioners may not copy documents that include pieces of information that are confidential in nature, such as the practitioner credentialing checklist, the responses from monitoring organizations (i.e. National Practitioner Data Bank, State/commonwealth Licensing Board), and verification of hospital privileges letters.

Practitioners Right to Correct Erroneous Information

Practitioners have the right to correct erroneous information in their credentials file. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

Molina will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples include but are not limited to actions on a license or malpractice claims history. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

- The notification sent to the practitioner will detail the information in question and will include instructions to the practitioner indicating:
- Their requirement to submit a written response within 10 calendar days of receiving notification from Molina.
- In their response, the practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The practitioner's response must be sent to Molina Healthcare, Inc. Attention Kari Horseman, CPCS, Credentialing Director at PO Box 2470 Spokane WA 99210

Upon receipt of notification from the practitioner, Molina will document receipt of the information in the practitioners credentials file. Molina will then re-verify the primary source information in

dispute. If the primary source information has changed, correction will be made immediately to the practitioners credentials file. The practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with practitioners' notification, the Credentialing Department will notify the practitioner. The practitioner may then provide proof of correction by the primary source body to Molina's Credentialing Department. The Credentialing Department will re-verify primary source information if such documentation is provided.

If the practitioner does not respond within 10 calendar days, their application processing will be discontinued and network participation will be denied.

Practitioners Right to be Informed of Application Status

Practitioners have a right, upon request, to be informed of the status of their application. Practitioners applying for initial participation are sent a letter when their application is received by Molina and are notified of their right to be informed of the status of their application in this letter.

The practitioner can request to be informed of the status of their application by telephone, email or mail. Molina will respond to the request within two working days. Molina may share with the practitioner where the application is in the credentialing process to include any missing information or information not yet verified. Molina does not share with or allow a practitioner to review references or recommendations, or other information that is peer-review protected.

Credentialing Committee

Molina designates a Credentialing Committee to make recommendations regarding credentialing decisions using a peer review process. Molina works with the Credentialing Committee to strive to assure that network practitioners are competent and qualified to provide continuous quality care to Molina members. A practitioner may not provide care to Molina members until the final decision from the Credentialing Committee or in situations of "clean files" the final decision from the Molina Medical Director.

The Credentialing Committee is responsible for reviewing and evaluating the qualifications of applicant practitioners and for approving or denying applicants for participation. In addition, the Credentialing Committee reviews Credentialing Policies and Procedures annually and recommends revisions, additions and/or deletions to the policies and procedures. Composed of network practitioners, the committee is responsible for performing peer review of medical information when requested by the Medical Director, and recommending actions based on peer review findings, if needed. The committees report to the Quality Improvement Committee (QIC).

Each Credentialing Committee member shall be immune, to the fullest extent provided by law, from liability to an applicant or practitioner for damages or other relief for any action taken or statements or recommendations made within the scope of the committee duties exercised.

Committee Composition

The Medical Director chairs the Credentialing Committee and appoints all Credentialing Committee members. Each member is required to meet all of Molina's credentialing criteria. Credentialing Committee members must be current representatives of Molina's practitioner network. The Credentialing Committee representation includes at least five practitioners. These may include practitioners from the following specialties:

- Family Medicine
- Internal Medicine
- Pediatrics
- OB/GYN
- Surgery

Additionally, surgical specialists and Internal Medicine specialists may participate on the committee as appropriate. Other ad hoc practitioners may be invited to participate when representation of their discipline is needed. Ad hoc committees representing a specific profession (e.g., Behavioral Health Practitioner, Nurse Practitioners, Chiropractors) may be appointed by the chairs to screen applicants from their respective profession and make credentialing recommendations to the Credentialing Committee.

Committee Members Roles and Responsibilities

Committee members participate in and support the functions of the Credentialing Committee by attending meetings, providing input and feedback and overall guidance of the Credentialing Program.

Review/approve credentialing program policy and related policies established by Molina Healthcare on an annual basis, or more often as deemed necessary.

Review and consider each applicant’s information based on criteria and compliance requirements. The Credentialing Committee votes to make final decisions regarding credentialing determinations and disciplinary actions.

Conduct ongoing monitoring of those practitioners approved to be monitored on a “watch status”

Access clinical peer input when discussing standards of care for a particular type of practitioner when there is no committee member of that specialty.

Ensure credentialing activities are conducted in accordance with Molina's Credentialing Program.

Review quality improvement findings as part of the recredentialing and the ongoing monitoring process.

Excluded Practitioners

Excluded practitioner means an individual practitioner, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been

convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, Molina Healthcare and its subcontractors may not subcontract with an Excluded Practitioner/Person. Molina Healthcare and its subcontractors shall terminate subcontracts immediately when Molina Healthcare and its subcontractors become aware of such excluded practitioner/person or when Molina Healthcare and its subcontractors receive notice. Molina Healthcare and its subcontractors certify that neither it nor its member/practitioner is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina Healthcare and its subcontractors are unable to certify any of the statements in this certification, Molina Healthcare and its subcontractors shall attach a written explanation to this Agreement.

Practitioners/Providers opting out of Medicare

If a practitioner/provider opts out of Medicare, that practitioner/provider may not accept Federal reimbursement for a period of two (2) years. Practitioners/providers who are currently opted out of Medicare are not eligible to contract with Molina Healthcare for the Medicare line of business.

Ongoing Monitoring of Sanctions

Molina monitors practitioner sanctions between recredentialing cycles for all practitioner types and takes appropriate action against practitioners when occurrences of poor quality is identified.

Medicare and Medicaid sanctions

The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program releases a report every month of individuals and entities that have been excluded from Medicare and Medicaid programs. Within 30 calendar days of its release, Molina reviews the report and if a Molina network provider is found with a sanction, the practitioner's contract is terminated effective the same date the sanction was implemented.

Molina also monitors every month for state/commonwealth Medicaid sanctions/exclusions/terminations through each state/commonwealth's specific Program Integrity Unit (or equivalent). If a practitioner is found to be sanctioned/excluded/terminated from any state/commonwealth's Medicaid program, the practitioner will be terminated in every state/commonwealth where they are contracted with Molina and for every line of business.

Sanctions or limitations on licensure

Molina monitors for sanctions or limitations against licensure between credentialing cycles for all network practitioners. All practitioners with identified sanctions or limitations on license in the ongoing monitoring process will be immediately placed into the full credentialing process and will be recredentialed early. The practitioner must provide all necessary information to complete the recredentialing process within the requested time-frames or the practitioner will be

administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a determination.

Continuous Query (Proactive Disclosure Service)

Molina registers all network practitioners with the NPDB Continuous Query program.

Molina receives instant notification of all new NPDB reports against the enrolled providers. When a new report is received between recredentialing cycles, the practitioner will be immediately placed into the full credentialing process and will be recredentialed early. The practitioner must provide all necessary information to complete the recredentialing process within the requested time-frames or the practitioner will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a determination.

Member Complaints/Grievances

Each Molina health plan has a process in place to investigate practitioner-specific complaints from members upon their receipt. Molina evaluates both the specific complaint and the practitioner's history of issues, if applicable. The history of complaints is evaluation for all practitioners at least every six months.

Adverse Events

Each Molina health plan has a process in place for monitoring practitioner adverse events at least every six months. An adverse event is an injury that occurs while a member is receiving health care services from a practitioner. Molina monitors for adverse events at least every six months.

System for Award Management (SAM)

Molina monitors the SAM once per month to ensure practitioners have not been sanctioned. If a Molina network provider is found with a sanction, the practitioner's contract is terminated effective the same date the sanction was implemented.

Medicare Opt-Out

Practitioner's participating in Medicare must not be listed on the Medicare Opt-Out report. Molina Healthcare reviews the quarterly opt out reports released from the appropriate Medicare financial intermediary showing all of the practitioners who have chosen to Opt-Out of Medicare. These reports are reviewed within 30 calendar days of their release. If a physician or other practitioner opts out of Medicare, that physician or other practitioner may not accept Federal reimbursement for a period of 2 years. These provider contracts will be immediately terminated for the Molina Medicare line of business.

Program Integrity (Disclosure of Ownership/Controlling Interest)

Medicaid Managed Care Health Plans are required to collect specific information from network providers prior to contracting and during credentialing to ensure that it complies with federal regulations that require monitoring of federal and state sanctions and exclusions databases. This monitoring ensures that any network providers and the following details of any individual/entity being contracted and those individuals/entities affiliated with the contractor are

appropriately screened against these sources, ensuring compliance with 42 CFR §455. The categorical details required and collected at all initial and recredentialing must be current and are as follows:

1. Detailed identifying information for any individual who has ownership or controlling interest in the individual/entity being contracted if that individual has a history of criminal activity related to Medicaid, Medicare, or Title XX services (see 42 CFR §455.106).
2. Detailed identifying information for all individuals who exercise operational or managerial control either directly or indirectly over daily operations and activities (see 42 CFR §455.101).
3. Detailed identifying information for all individuals or entities that have a 5% or more ownership or controlling interest in the individual/entity being contracted (see 42 CFR §455.104).

Office Site and Medical Record Keeping Practices Review

A review of office sites where you see Molina Members may be required. This review may be scheduled as soon as the Credentialing Department receives your application. This may also include a review of your medical record keeping practices. A passing score is required to complete the application process. Your cooperation in working with the site review staff and implementing any corrective action plans will expedite a credentialing decision.

Office site and medical record keeping reviews may also be initiated if any member complaints are received regarding the physical accessibility, physical appearance or adequacy of waiting room and examining room space.

Range of Actions, Notification to Authorities and Practitioner Appeal Rights

Molina uses established criteria in the review of practitioners' performance. All adverse actions taken by the Credentialing Committee are conducted in compliance with the Fair Hearing Plan and the Healthcare Quality Improvement Act of 1986.

<u>Range of actions available</u>

The Molina Credentialing Committee can take one of the following actions against practitioners who fail to meet credentialing standards or who fail to meet performance expectations pertaining to quality of patient care:

- Monitor on a Watch Status
- Require formal corrective action
- Denial of network participation
- Termination from network participation
- In cases where the Medical Director determines the circumstances pose an immediate risk to patients, a practitioner may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

This applies to all practitioners who are contracted by Molina. These actions do not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. If at any point a practitioner fails to meet the minimum standards and criteria for credentialing or fails to meet performance expectations with regard to quality of patient care the Credentialing Committee may act to implement one of these actions. Termination may be taken after reasonable effort has been made to obtain all the facts of the matter and the practitioner may be given the opportunity to appeal this decision.

Criteria for Denial or Termination Decisions by the Credentialing Committee

The criteria used by the Credentialing Committee to make a decision to deny or terminate a practitioner from the Molina network include, but are not limited to, the following:

1. The practitioner's professional license in any state/commonwealth has or has ever had any informal or formal disciplinary orders, decisions, agreements, disciplinary actions or other actions including but not limited to, restrictions, probations, limitations, conditions suspensions and revocations.
2. Practitioner has or has ever surrendered, voluntarily or involuntarily, his or her professional license in any State/commonwealth while under investigation by the State/commonwealth or due to findings by the State/commonwealth resulting from the practitioner's acts, omissions or conduct.
3. Practitioner has any pending statement of charges, notice of proposed disciplinary actions, notice of agency action or the equivalent from any state/commonwealth or governmental professional disciplinary body which based on the judgment of the Credentialing Committee establishes an immediate potential risk to the quality of care or service delivered by the practitioner to Molina members.
4. Practitioner has or has ever had any restrictions, probations, limitations, conditions, suspensions or revocations on their federal Drug Enforcement Agency (DEA) certificate or Controlled Substance Certification or Registration.
5. Practitioner has a condition, restriction or limitation on their license, certification or registration related to an alcohol, chemical dependency, or health condition or if other evidence indicates that the practitioner has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the practitioner has complied with all such conditions, limitations, or restrictions and is receiving treatment adequate to ensure that the alcohol, chemical dependency problem or health condition will not affect the quality of the practitioner's practice.
6. Practitioner has or has ever had sanctions of any nature taken by any governmental program or professional body including but not limited to, Medicare, Medicaid, Federal Employee Program or any other State/commonwealth or Federal program or agency
7. Practitioner has or has ever had any denials, limitations, suspensions or terminations of participation of privileges by any health care institution, plan, facility or clinic.
8. Practitioner's history of medical malpractice claims or professional liability claims or settlements reflect what constitutes a pattern of questionable or inadequate treatment or contain what constitutes any gross or flagrant incident or incidents of malpractice.
9. Practitioner has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.

10. Practitioner has or has ever had involvement in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the practitioner's professional conduct or the health, safety or welfare of Molina members
11. Practitioner has or has ever engaged in acts which Molina, in its sole discretion, deems inappropriate.
12. Practitioner has or has ever had a pattern of member complaints or grievances in which there appears to be a concern regarding the quality of service provided to Molina members.
13. Practitioner has not complied with Molina's quality assurance program.
14. Practitioner is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
15. Practitioner has or has ever displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
16. Practitioner makes or has ever made any material misstatements in or omissions from their credentialing application and attachments.
17. Practitioner has ever rendered services outside the scope of their license.
18. Practitioner has or has ever had a physical or mental health condition that may impair their ability to practice with the full scope of licensure and qualifications, or might pose a risk of harm on patients.
19. Practitioner has or has ever failed to comply with the Molina Medical Record Review Guidelines.
20. Practitioner has or has ever failed to comply with the Molina Site Review or Medical Record Keeping Practice Review Guidelines.

Monitoring on a Committee Watch Status

Molina uses the credentialing category "watch status" for practitioners whose initial or continued participation is approved by the Credentialing Committee with follow-up to occur. The Credentialing Committee may approve a practitioner to be monitored on watch status when there are unresolved issues or when the Credentialing Committee determines that the practitioner needs to be monitored for any reason.

When a practitioner is approved on watch status, the Credentialing Department conducts the follow-up according to the Credentialing Committee direction. Any unusual findings are reported immediately to the Molina Medical Director to determine if immediate action is necessary. Every unusual finding is reviewed in detail at the next Credentialing Committee meeting for review and recommendation.

Corrective Action

In cases where altering the conditions of participation is based on issues related to quality of care and/or service, Molina may work with the practitioner to establish a formal corrective action plan to improve performance, prior to, or in lieu of suspending or terminating his or her participation status.

A corrective action plan is a written improvement plan, which may include, but is not limited to the following:

- Identifying the performance issues that do not meet expectations
- What actions/processes will be implemented for correction
- Who is responsible for the corrective action
- What improvement/resolution is expected

- How improvements will be assessed
- Scheduled follow-up, monitoring (compliance review, normally not to exceed six months)

Within ten (10) calendar days of the Credentialing Committee's decision to place practitioner on a corrective action plan, the practitioner will be notified via a certified letter from the Medical Director. Such notification will outline:

- The reason for the corrective action
- The corrective action plan

If the corrective actions are resolved, the practitioner's performance may or may not be monitored, as deemed appropriate. If the corrective action(s) are not adequately resolved within the designated time, depending on the circumstances of the case, the Credentialing Committee may recommend that the practitioner continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate practitioner response to corrective action will be brought to the Credentialing Committee for review and decision.

Summary Suspension

In cases where the Credentialing Committee or the Medical Director becomes aware of circumstances that pose an immediate risk to patients, the practitioner may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

Such summary suspension shall become effective immediately upon imposition, and the Medical Director shall promptly notify the practitioner of the suspension by written notification sent via certified letter. Notification will include the following:

- A description of the action being taken
- Effective date of the action
- The reason(s) for the action and/or information being investigated
- Information (if any) required from the practitioner
- The length of the suspension
- The estimated timeline for determining whether or not to reinstate or terminate the practitioner
- Details regarding the practitioners right to request a fair hearing within 30 calendar days of receipt of the notice and their right to be represented by an attorney or another person of their choice (see Fair Hearing Plan policy)
- If the practitioner does not request a fair hearing within the 30 calendar days, they have waived their rights to a hearing
- The action will be reported to the NPDB if the suspension is in place longer than 30 calendar days

Upon initiation of the suspension, the Medical Director and credentialing staff will commence investigation of the issues. Findings of the investigation will be presented to the Credentialing Committee. The Credentialing Committee has the authority to implement corrective action, place conditions on the practitioner's continued participation, discontinue the suspension or terminate the practitioner.

Denial

After review of appropriate information, the Credentialing Committee may determine that the practitioner should not be approved for participation in the Molina network. The Credentialing Committee may then vote to deny the practitioner.

The practitioner will not be reported to the NPDB and will not be given the right to a fair hearing. Within ten (10) calendar days of the Committee's decision, the practitioner is sent a written notice of denial via certified mail, from the Medical Director, which includes the reason for the denial.

Termination

After review of appropriate information, the Credentialing Committee may determine that the practitioner does not meet performance expectations pertaining to quality of care, services or established performance/professional standards. The Credentialing Committee may then vote to terminate the practitioner.

Terminations for reasons other than unprofessional conduct or quality of care

If the termination is based on reasons other than unprofessional conduct or quality of care, the practitioner will not be reported to the NPDB and will not be given the right to a fair hearing. Within ten (10) calendar days of the Committee's decision, the practitioner is sent a written notice of termination via certified mail, from the Medical Director, which includes the following:

1. A Description of the action being taken
2. Reason for termination

Terminations based on unprofessional conduct or quality of care

If the termination is based on unprofessional conduct or quality of care, the practitioner will be given the right to a fair hearing.

Within ten (10) calendar days of the Committee's decision, the practitioner is sent a written notice of Molina's intent to terminate them from the network, via certified mail from the Medical Director, which includes the following:

- A Description of the action being taken
- Reason for termination
- Details regarding the practitioner's right to request a fair hearing within 30 calendar days of receipt of notice (see Fair Hearing Plan policy). The Fair Hearing Policy explains that Molina will appoint a hearing officer and a panel of individuals to review the appeal.
- The practitioner does not request a fair hearing within the 30 calendar days, they have waived their rights to a hearing.
- The notice will include a copy of the Fair Hearing Plan Policy describing the process in detail.
- Practitioner's right to be represented by an attorney or another person of their choice.
- Obligations of the practitioner regarding further care of Molina patients/members
- The action will be reported to the NPDB and the State/commonwealth Licensing Board.

Molina will wait 30 calendar days from the date the terminated practitioner received the notice of termination. If the practitioner requests a fair hearing within that required timeframe, Molina will follow the Fair Hearing Plan Policy. Once the hearing process is completed, the practitioner will receive written notification of the appeal decision which will contain specific reasons for the decision (see Fair Hearing Plan Policy). If the hearing committee's decision is to uphold the termination, the action will be reported to the State/commonwealth Licensing Board and the NPDB as defined in reporting to appropriate authorities section below. If the hearing committee overturns the termination decision and the practitioner remains in the Molina network, the action will not be reportable to the State/commonwealth Licensing Board or to the NPDB.

If the practitioner does not request a hearing within the 30 calendar days, they have waived their rights to a hearing and the termination will become the final decision. A written notification of the final termination will be sent to the practitioner and the termination will be reported to the State/commonwealth Licensing Board and the NPDB as defined in reporting to appropriate authorities section below.

Reporting to Appropriate Authorities

Molina will make reports to appropriate authorities as specified in the Molina Fair Hearing Plan Policy when the Credentialing Committee takes or recommends certain Adverse Actions for a practitioner based upon Unprofessional Conduct or quality of care. Adverse Actions include:

- Revocation, termination of, or expulsion from Molina Provider status.
- Summary Suspension in effect or imposed for more than thirty (30) calendar days.
- Any other final action by Molina that by its nature is reportable to the State/commonwealth Licensing Board and the NPDB.

Within 15 calendar days of the effective date of the final action, the Manager responsible for credentialing reports the action to the following authorities:

- All appropriate state/commonwealth licensing agencies
- National Practitioner Data Bank (NPDB)

A letter is then written to the appropriate state/commonwealth licensing boards describing the adverse action taken, the practitioner it was taken against and a copy of the NPDB report is attached to the letter. This letter is sent certified to the appropriate state/commonwealth licensing boards within 24-hours of receiving the final NPDB report. A copy of this letter is filed into the Practitioner's credentials file. The action is also reported to other applicable State/commonwealth entities as required.

Fair Hearing Plan Policy

Under State/commonwealth and Federal law, certain procedural rights shall be granted to a provider in the event that peer review recommendations and actions require a report be made to the State Licensing Board, the National Practitioner Data Bank ("NPDB").

Molina Healthcare, Inc., and its affiliates ("Molina"), will maintain and communicate the process providing procedural rights to providers when a final action by Molina will result in a report to the State/commonwealth Licensing Board and/or NPDB..

A. Definitions

1. Adverse Action shall mean an action that entitles a provider to a hearing, as set forth in Section B (l)-(3) below.
2. Chief Medical Officer shall mean the Chief Medical Officer for the respective Molina affiliate state plan wherein the provider is contracted.
3. Days shall mean calendar days. In computing any period of time prescribed or allowed by this Policy, the day of the act or event from which the designated period of time begins shall not be included.
4. Medical Director shall mean the Medical Director for the respective Molina affiliate state plan wherein the provider is contracted.
5. Molina Plan shall mean the respective Molina affiliate state plan wherein the provider is contracted.
6. Notice shall mean written notification sent by certified mail, return receipt requested, or personal delivery.
7. Peer Review Committee or Credentialing Committee shall mean a Molina Plan committee or the designee of such a committee.
8. Plan President shall mean the Plan President for the respective Molina affiliate state plan wherein the provider is contracted.
9. Provider shall mean physicians, dentists, and other health care practitioners as defined by 42 USC 11151 and Social Security Act § 1861(u).
10. State shall mean the licensing board in the state/commonwealth in which the provider practices.
11. State Licensing Board shall mean the state/commonwealth agency responsible for the licensure of provider.
12. Unprofessional Conduct refers to a basis for corrective action or termination involving an aspect of a provider's competence or professional conduct which is reasonably likely to be detrimental to patient safety or the delivery of quality care. Unprofessional conduct does not refer to instances where a provider violates a material term of the provider's contract with a Molina Plan.

B. Grounds for a Hearing

Grounds for a hearing exist whenever the Peer Review Committee or Credentialing Committee takes or recommends any of the following Adverse Actions for a provider based upon Unprofessional Conduct:

1. Revocation, termination of, or expulsion from Molina Provider status when such revocation, termination, or expulsion is reportable to the State/commonwealth Licensing Board and NPDB..
2. Suspension, reduction, limitation, or revocation of authority to provide care to Molina members when such suspension, reduction, limitation, or revocation is reportable to the State/commonwealth Licensing Board and NPDB
3. Any other final action by Molina that by its nature is reportable to the State/commonwealth Licensing Board and NPDB.

C. Notice of Action

If the Peer Review Committee and/or Credentialing Committee have recommended an Adverse Action, the Committee shall give written notice to the provider by certified mail with return receipt requested. The notice shall:

1. State the reasons for the action;
2. State any Credentialing Policy provisions that have been violated;
3. Advise the provider that he/she has the right to request a hearing on the proposed Adverse Action;
4. Advise the provider that any request for hearing must be made in writing within thirty (30) days following receipt of the Notice of Action, and must be sent to the respective Molina Plan Medical Director by certified mail, return receipt requested, or personal delivery;
5. Advise the provider that he/she has the right to be represented by an attorney or another person of their choice.
6. Advise the provider that the request for a hearing ***must*** be accompanied by a check in the amount of $1,000.00 as a deposit for the administrative expenses of the hearing and specify that this amount will be refunded if the Adverse Action is overturned;
7. State that the proposed action or recommendation, if adopted, must be reported pursuant to State/commonwealth and Federal law; and
8. Provide a summary of the provider's hearing rights or attach a copy of this Policy.

D. Request for a Hearing - Waiver

If the provider does not request a hearing in writing to the Chief Medical Officer within thirty (30) days following receipt of the Notice of Action, the provider shall be deemed to have accepted the action or recommendation of the Peer Review Committee and/or Credentialing Committee, and such action or recommendation shall be submitted to the Chief Medical Officer for final decision. In the event that a timely written Request for Hearing is received, a Hearing Officer and/or hearing panel shall be appointed as set forth below and the Peer Review Committee and/or Credentialing Committee shall provide the provider with a Notice of Hearing and Statement of Charges consistent with this Policy.

A provider who fails to request a hearing within the time and in the manner specified above waives his or her right to any hearing to which he or she might otherwise have been entitled. If the provider waives his or her right to any hearing by failing to request a hearing within the time and in the manner specified above, the recommendation of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action shall be forwarded to the Chief Medical Officer for final approval. In the event of a submittal to the Chief Medical Officer upon the provider's waiver as set forth herein, the Peer Review Committee and/or Credentialing Committee may submit to the Chief Medical Officer additional information relevant to its recommended Adverse Action to be considered by the Chief Medical Officer in accepting or rejecting the recommended Adverse Action.

E. Appointment of a Hearing Committee

1. Composition of Hearing Committee

The Chief Medical Officer/Plan President shall select the individuals to serve on the Hearing Committee. The Hearing Committee shall consist of individuals who are not in direct economic competition with the subject provider; who shall gain no direct financial benefit from the outcome of the hearing; and, who shall have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. General knowledge of the matter involved shall not preclude a physician from serving as a member of the panel.

The panel shall consist of three or more providers and shall include, whenever feasible, at least one individual practicing the same specialty as the affected provider. In the event providers are not available to sit as Hearing Committee members, physicians from the community may be substituted by the Medical Director.

2. Scope of Authority

The Hearing Committee shall have the authority to interpret and apply this Policy insofar as it relates to its powers and duties.

3. Responsibilities

The Hearing Committee shall:

a. Evaluate evidence and testimony presented.
b. Issue a decision accepting, rejecting, or modifying the decision of the Peer Review Committee and/or Credentialing Committee.
c. Maintain the privacy of the hearing unless the law provides to the contrary.

4. Vacancies

In the event of a vacancy in a hearing panel after a hearing has commenced, the remaining panel members may continue with the hearing and determination of the controversy, unless the parties agree otherwise.

5. Disclosure and Challenge Procedures

Any person appointed to the Hearing Committee shall disclose to the Chief Medical Officer/Plan President any circumstance likely to affect impartiality, including any bias or a financial or personal interest in the result of the hearing or any past or present relationship with the parties or their representatives. The Hearing Officer may remove any person appointed to the Hearing Committee if the Hearing Officer believes that the person is unable to render an impartial decision.

F. Hearing Officer

1. Selection

The Chief Medical Officer and/or Plan President shall appoint a Hearing Officer, who may be an attorney. The Hearing Officer shall gain no direct financial benefit from the

outcome of the hearing, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.

2. Scope of Authority

The Hearing Officer shall have the sole discretion and authority to:

a. Exclude any witness, other than a party or other essential person.
b. Determine the attendance of any person other than the parties and their counsel and representatives.
c. For good cause shown to postpone any hearing upon the request of a party or upon a Hearing Committee's own initiative, and shall also grant such postponement when all of the parties agree thereto.

3. Responsibilities

The Hearing Officer shall:

a. Guide the hearing process, including endeavoring to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner;
b. Ensure that proper decorum is maintained;
c. Be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing;
d. Issue rulings pertaining to matters of law, procedure and the admissibility of evidence;
e. Issue rulings on any objections or evidentiary matters;
f. Discretion to limit the amount of time;
g. Assure that each witness is sworn in by the court reporter;
h. May ask questions of the witnesses (but must remain neutral/impartial);
i. May meet in private with the panel members to discuss the conduct of the hearing;
j. Remind all witnesses at the conclusion of their testimony of the confidentiality of the hearing;
k. Participate in the deliberations of the Hearing Committee as a legal advisor, but shall not be entitled to vote; and
l. Prepare the written report.

G. Time and Place of Hearing

Upon receipt of a Request for Hearing, the Chief Medical Officer and/or Plan President shall schedule and arrange for a hearing. The Chief Medical Officer and/or Plan President shall give notice to the affected provider of the time, place and date of the hearing, as set forth below. The date of commencement of the hearing shall be not less than thirty (30) days from the date of the Notice of the Hearing, and not more than sixty (60) days from the date of receipt of the Request for Hearing. Notwithstanding the above timeframes, the parties may agree to extensions, or the Hearing Officer may grant an extension on a showing of good cause. If more than one meeting is required for a hearing, the Hearing Officer shall set the date, time, and location for additional meetings.

H. Notice of Hearing

The Notice of Hearing shall contain and provide the affected provider with the following:

1. The date, time and location of the hearing.
2. The name of the Hearing Officer.
3. The names of the Hearing Committee Members.
4. A concise statement of the affected provider's alleged acts or omissions giving rise to the Adverse Action or recommendation, and any other reasons or subject matter forming the basis for the Adverse Action or recommendation which is the subject of the hearing.
5. The names of witnesses, so far as they are then reasonably known or anticipated, who are expected to testify on behalf of the Peer Review Committee and/or Credentialing Committee, provided the list may be updated as necessary and appropriate, but not later than ten (10) days prior to the commencement of the hearing.
6. A list of all documentary evidence forming the bases of the charges reasonably necessary to enable the provider to prepare a defense, including all documentary evidence which was considered by the Peer Review Committee and/or Credentialing Committee in recommending the Adverse Action.

Except with regard to the disclosure of witnesses, as set forth above, the Notice of Hearing may be amended from time to time, but not later than the close of the case at the conclusion of the hearing by the Hearing Committee. Such amendments may delete, modify, clarify or add to the acts, omissions, or reasons specified in the original Notice of Hearing.

I. Pre-Hearing Procedures

1. The provider shall have the following pre-hearing rights:
   a. To inspect and copy, at the provider's expense, documents upon which the charges are based which the Peer Review Committee and/or Credentialing Committee have in its possession or under its control; and
   b. To receive, at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the provider to prepare a defense, including all evidence that was considered by the Peer Review Committee and/or Credentialing Committee in recommending Adverse Action.
2. The Hearing Committee shall have the following pre-hearing right:

   To inspect and copy, at Molina's expense, any documents or other evidence relevant to the charges which the provider has in his or her possession or control as soon as practicable after receiving the hearing request.

3. The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards required to protect the peer review process, privileges and ensure justice. In so doing, the Hearing Officer shall consider:

a. Whether the information sought may be introduced to support or defend the charges;
b. The exculpatory or inculpatory nature of the information sought, if any;
c. The burden attendant upon the party in possession of the information sought if access is granted; and
d. Any previous requests for access to information submitted or resisted by the parties.

4. The provider shall be entitled to a reasonable opportunity to question and object to or challenge the impartiality of members of the Hearing Committee and the Hearing Officer. Challenges to the impartiality of any Hearing Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.
5. It shall be the duty of the provider, the Peer Review Committee and/or Credentialing Committee to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.
6. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance or limitation of the evidence or the testimony if deemed appropriate by the Hearing Officer.
7. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable physicians or patients, other than the provider under review, or to information, interviews, reports, statements, findings and conclusions resulting from studies or other data prepared specifically to be submitted for review purposes made privileged by operation of State.

J. Conduct of Hearing

1. Rights of the Parties

Within reasonable limitations, and as long as these rights are exercised in an efficient and expeditious manner, both sides at the hearing may:

a. Call and examine witnesses for relevant testimony.
b. Introduce relevant exhibits or other documents.
c. Cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues.
d. Otherwise rebut evidence.
e. Have a record made of the proceedings.
f. Submit a written statement at the close of the hearing.
g. Receive the written recommendation of the Hearing Officer or Hearing Committee, including a statement of the basis for the recommendations, upon completion of the hearing.

The provider may be called by the Peer Review Committee and/or Credentialing Committee and examined as if under cross-examination.

2. Course of the Hearing

   a. Each party may make an oral opening statement.
   b. The Peer Review Committee and/or Credentialing Committee shall call any witnesses and present relevant documentary evidence to support its recommendation.
   c. The affected provider may then call any witnesses and present relevant documentary evidence supporting his/her defense.
   d. The Hearing Committee or Officer has the discretion to vary the course of the hearing, but shall afford a full and equal opportunity to all parties for the presentation of material and relevant evidence and for the calling of witnesses.
   e. The Hearing Committee shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence shall not be necessary. All evidence shall be taken in the presence of the entire Hearing Committee and all of the parties, except when agreed to by the parties, or determined by the Hearing Officer.

3. Use of Exhibits

   a. Exhibits, when offered by either party, may be received into evidence by the Hearing Committee as ruled upon by the Hearing Officer.
   b. A description of the exhibits in the order received shall be made a part of the record.

4. Witnesses

   a. Witnesses for each party shall submit to questions or other examination.
   b. The Hearing Officer shall have the power to sequester witnesses (exclude any witness, other than a party or other essential person, during the testimony of any other witness). The names and addresses of all witnesses and a description of their testimony in the order received shall be made a part of the record.
   c. The Hearing Committee may receive and consider the evidence of witnesses by affidavit, but shall give it only such weight as the Hearing Committee deems it is entitled to after consideration of any objection made to its admission.
   d. The party producing such witnesses shall pay the expenses of their witnesses.

5. Rules for Hearing:

   a. Attendance at Hearings

Only those persons having a direct interest in the hearing are entitled to attend the hearing. This means that the hearing will be closed except for the parties and their representatives. The only exception is when good cause is shown satisfactory to the Hearing Officer that it is necessary in the interest and fairness of the hearing to have others present.

b. Communication with Hearing Committee

There shall be no direct communication between the parties and the Hearing Committee other than at the hearing, unless the parties and the Hearing Committee agree otherwise. Any other oral or written communication from the parties to the Hearing Committee shall be directed to the Hearing Officer for transmittal to the Hearing Committee.

c. Interpreter

Any party wishing to utilize an interpreter shall make all arrangements directly with the interpreter and shall assume the costs of the services.

K. Close of the Hearing

At the conclusion of the hearing, the Hearing Officer shall dismiss all parties and participate in the deliberations of the Hearing Committee. The Hearing Committee shall render its final decision by a majority vote, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached to the Hearing Officer.

Within thirty (30) days of the conclusion of the deliberations, the Hearing Officer shall issue a written report including the following:

1. A summary of facts and circumstances giving rise to the hearing.
2. A description of the hearing, including:
   a. The panel members' names and specialties;
   b. The Hearing officer's name;
   c. The date of the hearing;
   d. The charges at issue; and
   e. An overview of witnesses heard and evidence.
3. The findings and recommendations of the Hearing Committee.
4. Any dissenting opinions desired to be expressed by the hearing panel members.

Final adjournment of the Hearing Committee shall occur when the Hearing Officer has mailed or otherwise delivered the written report.

L. Burden of Proof

In all hearings it shall be incumbent on the Peer Review Committee and/or Credentialing Committee taking or recommending an Adverse Action to come forward initially with evidence in support of its action or decision. Thereafter, the provider who requested the hearing shall come forward with evidence in his/her support.

The burden of proof during a hearing shall be as follows:

The Peer Review Committee or Credentialing Committee taking or recommending the Adverse Action shall bear the burden of persuading the Hearing Committee that its action or recommendation is reasonable and warranted. The term "reasonable and warranted" means within the range of alternatives reasonably available to the Peer Review Committee and/or Credentialing Committee taking or recommending Adverse Action under the circumstances and not necessarily that the action or recommendation is the only measure or the best measure that could have been taken or formulated.

M. Provider Failure to Appear or Proceed

Failure, without good cause, of the provider to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

N. Record of the Hearing/Oath

A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings, if deemed appropriate by the Hearing Officer. The cost of attendance of the reporter shall be borne by Molina, but the cost of the transcript, if any, shall be borne by the party requesting it. The Hearing Officer shall be required to order that all oral evidence be taken by oath administered by a person lawfully authorized to administer such oath.

O. Representation

Each party shall be entitled to representation by an attorney at law, or other representative at the hearing, at their own expense, to represent their interests, present their case, offer materials in support thereof, examine witnesses, and/or respond to appropriate questions.

P. Postponements

The Hearing Officer, for good cause shown, may postpone any hearing upon the request of a party or the Hearing Committee.

Q. Notification of Finding

The Hearing Office shall serve a copy of the written report outlining the basis of the Hearing Committee's decision to the Medical Director, the Peer Review Committee and/or Credentialing Committee imposing the Adverse Action, and the affected provider.

R. Final Decision

Upon receipt of the Hearing Committee's decision, the Chief Medical Officer/Plan President shall either adopt or reject the Hearing Committee's decision. The Chief Medical Officer/Plan President's action constitutes the final decision.

S. Reporting

In the event the Chief Medical Officer/Plan President adopts the proposed decision of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action, Molina will submit a report to the State/commonwealth Licensing Board and NPDB, as required. Reports shall be made in accordance with the Credentialing Program Policy.

Reports to the State/commonwealth Licensing Board and NPDB for adverse actions must be submitted within 15 days from the date the adverse action was taken.

T. Exhaustion of Internal Remedies

If any of the above Adverse Actions are taken or recommended, the provider must exhaust the remedies afforded by this Policy before resorting to legal action.

U. Confidentiality and Immunity

Information regarding any practitioner or provider submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care shall, to the fullest extent permitted by law, be confidential and shall only be disseminated to a Representative in order to carry out appropriate activities under these Policies and Procedures. Confidentiality shall also extend to such information that is provided by third parties.

For purposes of this section a "Representative" shall mean any individual authorized to preform specific information gathering or disseminating functions for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care.

For purposes of this section "information" may be any written or oral disclosures including, but not limited to, a practitioner's or provider's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care or practitioner's or provider's provision of patient care services.

By providing patient care services at Molina, a practitioner or provider:

1. Authorizes representatives of Molina to solicit, provide, and act upon information bearing on the practitioner's or provider's qualifications.

2. Agrees to be bound by the provisions of this policy and procedure and to waive all legal claims against any representative who acts in accordance with the provisions of this policy and procedure.
3. Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, Molina membership and the continuation of such membership, and to the exercise of clinical privileges or provision of patient care.

The confidentiality and immunity provisions of this policy and procedure shall apply to all information so protected by State/commonwealth or Federal law. To the fullest extent permitted by State/commonwealth or Federal law, the confidentiality and immunity provisions of this policy and procedure shall include, but is not limited to:

1. Any type of application or reapplication received by the Provider or Practitioner;
2. Actions reducing, suspending, terminating or revoking a practitioner's and provider's status, including requests for corrective actions, investigation reports and documents and all other information related to such action;
3. Hearing and appellate review;
4. Peer review and utilization and quality management activities;
5. Risk management activities and claims review;
6. Potential or actual liability exposure issues;
7. Incident and/or investigative reports;
8. Claims review;
9. Minutes of all meetings by any committees otherwise appropriately appointed by the Board;
10. Any activities related to monitoring the quality, appropriateness or safety of health care services;
11. Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services;
12. Any Molina operations and actions relating to practitioner and provider conduct.

Immunity from Liability for Action Taken: No representative shall be liable to a practitioner or provider or any third party for damages or other relief for any decision, opinion, action, statement, or recommendations made within the scope of their duties as representative, if such representative acts in good faith and without malice.

Immunity from Liability for Providing Information: No representative or third parties shall be liable to a practitioner or provider for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any third party pursuant to authorization by the practitioner or provider, or if permitted or required by law, or these Policies

and Procedures, provided that such representative or third parties acts in good faith and without malice.

Cumulative Effect: The provisions in this Policy and Procedure and any forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to other protections provided by relevant state/commonwealth and federal law, and are not a limitation thereof.

Section 12. Complaints, Grievance and Appeals Process

Member Complaints, Grievances and Appeals:

Molina Healthcare is committed to protecting members' rights and ensuring that their concerns are addressed. Molina Healthcare has an organized and thorough process for members to request an Appeal of an Action or to file a complaint or grievance. Molina Healthcare ensures timely, fair, unbiased, and appropriate resolution in the event of dissatisfaction with any aspect of Molina's operation, provision of health care services, activities, or behaviors.

What is a Complaint?

A Complaint is an expression of dissatisfaction about any matter other than an Action that is resolved at the point of contact rather than through filing a formal Grievance (see below for the definition of a Grievance).

For example, a Member can make a Complaint for incidents related to, but not limited to:

- Problems getting an appointment, or having to wait a long time for an appointment; or
- Disrespectful or rude behavior by doctors, nurses or other Molina Healthcare clinic or hospital staff.

How does a Member File a Complaint?

Members can file a Complaint by calling or writing Molina Healthcare. They can also visit one of Molina Healthcare's Service Centers to make their Complaint. The Member may authorize another person (such as a physician, relative or friend) to file a Complaint on their behalf. However, the authorization must be in *writing.* Molina Healthcare staff can assist Members who wish to file a Complaint.

The Member, or their authorized representative, must file a Complaint within fifteen (15) calendar days after the date of occurrence that initiated the Complaint. Molina Healthcare will resolve the Complaint within seventy-two (72) hours of receiving the initial Complaint, orally or in writing. If the Complaint is not resolved within this timeframe, the Complaint shall be treated as a Grievance.

What is a Grievance?

A Grievance is a formal expression of dissatisfaction about any matter, other than an Action, that is documented and investigated by the plan.

The Grievance can be presented in writing, by telephone or by visiting any of Molina Healthcare's Service Centers or the Patient Advocate Office. For example, the Member can file a Grievance for incidents related to, but not limited to:

- The quality of care or services provided
- Access to care or services

- Aspects of interpersonal relationships such as rudeness of a provider or employee
- Misinformation provided by Molina Healthcare or its providers
- Failure to respect your member rights
- Preauthorization requests
- Network provider changes
- Referrals
- Hazardous environment conditions

How can a Member file a Grievance?

A Member can call, write or visit Molina Healthcare's Service Centers to file a Grievance. The Member may authorize another person (such as a physician, relative or friend) to file a Grievance on their behalf. However, the authorization must be in writing. Molina Healthcare staff can assist Members who wish to file a Grievance.

Members have up to ninety (90) calendar days from the date of the occurrence to file a Grievance with Molina Healthcare. Molina Healthcare will acknowledge receipt of their Grievance in writing (and the authorized representative if applicable) within ten (10) business days of receipt.

Molina Healthcare will provide a written notice of how the Grievance was resolved as promptly as the Member's health condition requires, but in any event, within ninety (90) calendar days from the day we received the Grievance.

Members can call Molina Healthcare's Member Services Department toll free to file a Complaint or Grievance. Member Services is available from 7:00am to 7:00pm Monday through Friday to assist you. Please call 1-877-335-3305/TTY 1-787-522-8281.

What is an Action?

An Action is a decision that Molina Healthcare makes that may affect the services the Member receives. Specifically, an Action is:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service; or
- The failure to provide services in a timely manner.

What is a Notice of Action?

A Notice of Action is a written notice provided by the Molina Healthcare to the Member notifying the Member of an Action (as defined above). The Notice of Action must contain the following information:

- The Action Molina Healthcare has taken or intends to take;
- The reason(s) for the Action;
- The Member's right to file an Appeal through Molina Heatlhcare's internal Grievance System and the procedure for filing an Appeal;
- The Member's right to request an Administrative Law Hearing after exhaustion of Molina Healthcare's Grievance System;
- The Member's right to allow a provider to file an Appeal or an Administrative Law Hearing on their behalf, upon written consent;
- The circumstances under which expedited review is available and how to request it;
- The Member's right to continue receiving benefits and covered services pending resolution of the Appeal with Molina Healthcare or during the Administrative Law Hearing; and
- How the Member can request that benefits be continued and the circumstances under which the Member may be required to pay the costs of these services.

Molina Healthcare shall mail the Notice of Action within the following timeframes:

- For termination, suspension, or reduction of previously authorized covered services, at least ten (10) calendar days before the date of Action or no later than the date of Action except in the event of one of the following exceptions:
    1. Molina Healthcare has factual information confirming the death of an enrollee.
    2. Molina Healthcare receives a clear written statement signed by the enrollee that he or she no longer wishes to receive services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information.
    3. The enrollee's whereabouts are unknown and the post office returns Molina Healthcare's mail directed to the enrollee indicating no forwarding address.
    4. The enrollee's provider prescribes a change in the level of medical care.
    5. Molina Healthcare may shorten the period of advance notice to five (5) calendar days before the date of Action if it has facts indicating that Action should be taken because of probable enrollee fraud and the facts have been verified, if possible, through secondary sources.
- For denial of payment, at the time of any Action affecting the claim.
- If Molina Healthcare extends the timeframe for the Authorization decision and issuance of Notice of Action it shall give you written notice of the reasons for the decision to extend if you did not request the extension. Molina Healthcare shall issue and carry out its determination as expeditiously as the Member's health requires and no later than the date the extension expires.

What if the Member does not agree with the Notice of Action?

If the Member does not agree with Molina Healthcare's determination included in the Notice of Action, the Member has the right to appeal the determination before Molina Healthcare or the Patient Advocate Office within sixty (60) calendar days from the date of the Notice of Action.

What is an Appeal?

An Appeal is a formal request that the Member files with Molina Healthcare or the Patient Advocate Office when the Member does not agree with Molina Healthcare's determination (Notice of Action) to deny, in whole or in part, a service, procedure, study, collection or payment. Members have a period of sixty (60) calendar days to file a standard Appeal with Molina Healthcare after receipt of the Notice of Action from Molina Healthcare. Molina Healthcare will review and make a decision on all standard Appeals as expeditiously as possible, but no later than forty-five (45) calendar days from receipt.

Members can call, write or visit Molina Healthcare's Service Centers to file an Appeal. However, if an Appeal is requested orally, it must be confirmed by the Member in writing within ten (10) calendar days of the oral filing.

The member's physician, a relative, or a person authorized by the Member can file the Appeal on their behalf; however, the Member's written consent is required*. If written confirmation of the Appeal request and/or written consent (when applicable) is not received, the Appeal will be closed and a decision will not be made.*

Members have the right to request an expedited review process for an Appeal if taking the time for a standard Appeal resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. The expedited Appeal request will be reviewed to determine if it meets the expedited appeal criteria. If the Member's condition does not meet the expedited review criteria, the Member will be promptly notified and the request will be treated as a standard appeal.

Expedited Appeal requests received orally do not require additional follow up in writing. However, written consent is required if the expedited Appeal was requested by a third party on the Member's behalf.

Members can call Molina Healthcare's Member Services Department toll free to request an Appeal. Member Services is available from 9:00am to 5:00pm Monday through Friday to assist you. Please call 1-877-335-3305/TTY 1-787-522-8281. The Member may also fill out the Member Appeal Request Form and send via fax or mail directly to Molina Healthcare's Member Appeals and Grievance Department:

Fax: (844) 488-7053

Mail: Molina Healthcare of Puerto Rico, Inc.
ATTN: Member A&G Dept.
PO Box 365068
San Juan, PR 00936-5068

Who will hear the Appeal?

The Appeal will be evaluated by a team of experts (specific for the health condition) that did not take part in the determination or in the Notice of Action. This is to ensure the appeal process is fair, transparent and dependable.

How much time will it take to make a determination on an Appeal?

If the Appeal does not adversely affect the Member's health and/or does not put the Member's life at risk, the Member must receive the determination of the appeal within a period that does not exceed forty-five (45) calendar days. However, if the Member's health condition requires an expedited determination; the Member will receive an answer within a period of three (3) business days or less.

Molina Healthcare can request a 14-day extension to send its determination, as long as this extension request benefits the Member or because the Member needs more time to find evidence or data that may benefit their case.

If during the appeal process the Member request a continuation of services, the Member may be required to pay the cost of services furnished while the Appeal is still pending. This would be the case if the final decision is adverse to the Member.

What is an Administrative Law Hearing?

An Administrative Law Hearing is an appeal process, administered by the Commonwealth and as required by Federal law that is available to the Member after Molina Healthcare's internal Appeals process has been exhausted.

How is an Administrative Law Hearing requested?

If the Member is not satisfied with the outcome of the appeal after the Member has gone through Molina Healthcare's internal Appeal process for an Action; the Member can request an Administrative Law Hearing through ASES or the Health Advocate Office, or both, in a period not to exceed thirty (30) calendar days from the date of Molina Healthcare's *notice of disposition of the Appeal.*

The Administrative Law Hearing resolution will be within ninety (90) calendar days of the date the Member filed an Appeal with Molina Healthcare for standard resolutions (not including the days it took you to file for an Administrative Law Hearing). For expedited resolution, the Administrative Law Hearing resolution will be within three (3) business days from ASES's receipt of a request for a hearing for a denial of service.

Before the Administrative Law Hearing, the Member and/or their authorized representative (or a representative of a deceased enrollee, if applicable) can request to look at and copy the documents and records Molina Healthcare will use at the Administrative Law Hearing or that the Member may otherwise need to prepare the case for the hearing. Molina Healthcare shall provide such documents and records at no charge to the Member.

Timeframes to solve Complaints, Grievances and Appeals

Below are timeframes Molina Healthcare uses to address and resolve Complaints, Grievances, Appeals and ASES uses to resolve issues brought before an Administrative Law Hearing:

- Molina Healthcare must resolve Complaints within 72 hours of receipt whether orally or in writing. If it is not resolved in 72 hours, it becomes a Grievance.

- Molina Healthcare must send a written notice to enrollees within ten (10) business days of receiving a Grievance.
- Molina Healthcare must provide a written notice on the resolution of the Grievance as quickly as the Member's health requires but no later than ninety (90) calendar days from the day Molina Healthcare receives the Grievance.
- If Molina Healthcare denies a service Authorization request, it must provide a written Notice of Action to the Member and the Member's provider.
- The Member, their provider, or another person authorized (with written consent) can appeal the Notice of Action no later than sixty (60) calendar days after receiving the Notice of Action.
- The determination on standard Appeals must be sent to the affected parties within a period that does not exceed 45 days. Molina Healthcare may request a 14-day extension, as long as it is for the Member's benefit.
- Determination on expedited Appeals will always depend on the Member's health condition and may not exceed three (3) business days. Molina Healthcare may request a 14-day extension as long as it is for the Member's benefit.
- The Member may request an Administrative Law Hearing before ASES thirty (30) days from the date you received notification from Molina Healthcare of the determination on the appeal.
- The Administrative Law Hearing resolution will be ninety (90) calendar days from the date an Appeal was filed with Molina Healthcare (not including the days it took to file for an Administrative Law Hearing) for standard resolutions. For expedited resolution, the Administrative Law Hearing resolution will be within three (3) business days from ASES's receipt of a request for a hearing for a denial of service.

Provider Claims Dispute

Molina Healthcare strives to provide a prompt, fair dispute resolution mechanism to process and resolve contracted and non-contracted provider claim disputes.

Discrimination, intimidation, or retaliation against a provider who has filed a claim dispute shall not be tolerated

Providers seeking a redetermination of a claim previously adjudicated must request such action within ninety (90) calendar days of Molina Healthcare's original remittance advice date. Additionally, any claim(s) dispute requests (including denials) should be submitted to Molina Healthcare using the standard Claims Reconsideration Review Form (CRRF). This form can be found on the provider website (www.MolinaHealthcare.com/PuertoRico).

In addition to the CRRF, Providers should submit the following documentation:

- The previous claim and remittance advice, any other documentation to support the adjustment and a copy of the Referral/Authorization form (if applicable) must accompany the adjustment request.
- The claim number clearly marked on all supporting documents

These requests shall be classified as a Claims Disputes/Adjustment and may be faxed to 844-488-7050. Requests may also be sent to the following address:

Molina Healthcare of Puerto Rico, Inc.
Attention: Claims Disputes / Adjustments
654 Plaza, Suite 1600
654 Avenida Munoz Rivera
San Juan, PR 00918

Requests for adjustments of claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original claim.

The Provider will be notified of Molina Healthcare of Puerto Rico's decision in writing within thirty (30) calendar days of receipt of the Claims Dispute/Adjustment request. Providers may request a claim dispute/adjustment when the claim was incorrectly denied as a duplicate or due to claims examiner or data-entry error.

Reporting

All Member Grievance/Appeal data, including practitioner specific data, is reported quarterly to Member/Provider Satisfaction Committee by the Department Managers for review and recommendation. A Summary of the results is reported to the Executive Quality Improvement Committee (EQIC) quarterly. Annually, a quantitative/qualitative report will be compiled and presented to the Member/Provider Satisfaction Committee (MPSC) and EQIC by the chairman of MPSC to be included in the organization's Grand Analysis of customer satisfaction and assess opportunities for improvement.

Member Appeals and Grievances will be reported to the Commonwealth quarterly. Grievance and Appeals reports will be reviewed regularly by Molina Healthcare for inclusion in the trending of ongoing provider sanctions, complaints and quality issues.

Record Retention

Molina Healthcare will maintain all grievance and related appeal documentation on file for a minimum of ten (10) years. In addition to the information documented electronically via Call Tracking in QNXT or maintained in other electronic files, Molina Healthcare will retain copies of any written documentation submitted by the provider pertaining to the grievance/appeal process. Provider shall maintain records for a period not less than ten (10) years from the termination of the Model Contract and retained further if the records are under review or audit until the review or audit is complete. (Provider shall request and obtain Health Plan's prior approval for the disposition of records if Agreement is continuous.)

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
- Case Management
- Non Emergent Transportation
- Utilization Management

Credentialing functions may be delegated to capitated or non-capitated entities, which meet NCQA criteria for credentialing functions. Claims Payment, Case Management, or Utilization Management (UM) responsibilities are generally only delegated to capitated entities.

Note: The member's Molina Healthcare ID card will identify which group the member is assigned. If 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 UM functions.

Medical Group/IPA Full Name	ID card Acronym	Claims Remit to Address	UM Referral/ Authorization Phone #
Delta Dental			(888) 558-5501
First Healthcare (FHC)			(888) 558-5501

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.

Care Management

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

- Be certified by the National Committee for Quality Assurance (NCQA) for complex case management and disease management programs
- Have a current complex case management and disease management program descriptions in place
- Pass a care management pre assessment audit, based on NCQA and Molina Healthcare requirements
- 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 care management delegates
- Submit timely and complete care management reports to Molina Healthcare
- Comply with all applicable federal and commonwealth laws.

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

A medical group/IPA may request Complex Case Management or Disease Management 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 Complex Case Management and/or Disease Management process is based on the medical group/IPAs ability to meet Molina Healthcare's standards and criteria for delegation.

Claims Payment

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

- Have a capitation contract with Molina Healthcare and be in compliance with the financial reserves requirements of the contract
- Be delegated for UM by Molina Healthcare
- Have a Claims delegation pre-assessment completed by Molina Healthcare to determine compliance with all regulatory requirements for Claims payment
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare
- 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 commonwealth 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

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.

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
- 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 commonwealth 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 Commonwealth 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.

Non-emergent Medical Transportation

To be delegated for non-emergent functions medical transportation functions, vendors must:

- Own, or sub contract for, a fleet of vehicles and a driver network that ensures timely transportation for Molina Healthcare members for covered services
- Pass a transportation pre assessment audit based on Molina Healthcare requirements
- 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 non-emergent medical transportation delegates
- Submit timely and complete non-emergent medical transportation reports to Molina Healthcare
- Comply with all applicable federal and commonwealth laws

Note: If the vendor sub-delegates non-emergent medical transportation functions, the vendor must complete oversight of the sub-delegate against all Molina Healthcare, Commonwealth and Federal requirements identified above. The vendor may not execute sub delegation arrangements without notifying Molina Healthcare of the intent to sub-delegate with at least 30 days advanced notice. Notification must include results of the vendor's pre assessment audit and a process to implement corrective action if issues of non-compliance are identified.

A vendor may request non-emergent medical 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 the non-emergent medical transportation process is based on the vendor's 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
- 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/commonwealth 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.

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.

Section 14. Cultural Competency

Background

The Cultural Competency Plan promotes the delivery of culturally competent services to ensure the provision of Linguistic Access and Disability-related Access to all members, including those with Limited English Proficiency. The plan reflects the guidelines outlined in National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH). The Cultural Competency Plan describes how the individuals and systems within the Organization will effectively provide services to people of all cultures, races, ethnic backgrounds and religions, as well as those with disabilities, in a manner that recognizes values, affirms and respects the worth of the individuals, and protects and preserves the dignity of each.

Training employees and providers, followed by quality monitoring are the cornerstones of successful culturally competent service delivery. For that reason, Molina Healthcare integrates the cultural competency program into the overall provider training and quality monitoring programs. An integrated quality approach intends to enhance the way people think about our members, service delivery, and program development, so that cultural competency becomes part of everyday thinking.

Provider and Community Training

Molina Healthcare offers educational opportunities in cultural competency concepts for providers on a regular basis. Molina offers Cultural Competency trainings to providers, supporting staff and Community Based Organizations.

Molina conducts provider training during provider orientation as well as annual reinforcement training. Additional training reinforcement is provided through continuing medical education (CME) monographs developed by the health plan, and periodically accompanying provider communications. Molina delivers training modules through a variety of methods including:

1. Written materials – Provider Manual;
2. Reference materials available through health plan representatives and the Molina Healthcare website;
3. Integration of cultural competency concepts into provider communications; and
4. Continuing Medical Education.

Integrated Quality Improvement – Ensuring Access

Molina Healthcare ensures member access to language services such as written translation and interpreting services. Interpretation services will be available so that all members and potential enrollees may receive information in their primary language. Molina provides all written member materials in Spanish and alternative formats such as Braille, audio or large print. Members may also request English versions of materials. Materials will be available in any other language when Molina receives notification that more 5% of the population of Puerto Rico speaks this language. Such congruency with member populations leads to better communication, understanding and member satisfaction. Molina often provides access to programs and services that are congruent with cultural norms to provide quality care.

Molina delivers key member information, including Appeals and Grievance forms, in Spanish and any other threshold language on the Molina member website.

Program and Policy Review Guidelines

Molina Healthcare conducts assessments at regular intervals of the following information to ensure its programs are most effectively meeting the needs of its members and providers:

- Annual review of membership and practitioner demographics (preferred language, ethnicity, race)
- Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment)
- Network Assessment
- Applicable national demographics and trends derived from publicly available sources
- Health status measures such as those measured by HEDIS, as available
- Comparison with selected measures such as those in Healthy People 2010.

The Cultural Competency Plan will be posted on the provider website. Providers may also requested printed copies.

Section 15. Glossary of Terms

Action – The denial or limited Authorization of a requested service, including the type, level or provider of service; reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.

Acute Inpatient Care – Care provided to persons sufficiently ill or disabled requiring:

I Constant availability of medical supervision by attending provider or other medical staff
II Constant availability of licensed nursing personnel
III Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to ensure proper medical management by the provider

Ambulatory Care – Health services provided on an outpatient basis. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient has come to a location other than his/her home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility – A facility licensed by the commonwealth where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries, and allows patients to leave the facility the same day surgery or delivery occurs.

Ancillary Services – Health services ordered by a provider, including but not limited to laboratory services, radiology services, and physical therapy.

Appeal – A written request by a member or member's personal representative received at Molina Healthcare for review of an action.

ASES - Administracion de Seguros de Salud de Puerto Rico. The Puerto Rico Health Insurance Administration, the entity in the Commonwealth responsible for oversight and administration of the Government Health Program (GHP), or its Agent**.**

Authorization – Approval obtained by providers from Molina Healthcare for designated service before the service is rendered. Used interchangeably with preauthorization or prior Authorization.

Average Length of Stay (ALOS) – Measure of hospital utilization calculated by dividing total patient days incurred by the number of admissions/discharges during the period.

Capitation – A prospective payment based on a certain rate per person paid on a monthly basis for a specific range of health care service.

Centers for Medicare & Medicaid Services (CMS) – A federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and SCHIP programs.

Children's Health Insurance Plan (CHIP) – A federal/commonwealth funded health insurance program authorized by Title XXI of the SSA and administered by ASES.

Claim – A request for payment for the provision of Covered Services prepared on a CMS-1500 form, UB-04, or successor, submitted electronically or by mail.

Coordination of Benefits (COB) – Applies when a person is covered under more than one group medical plan. The plans coordinate with each other to avoid duplicate payments for the same medical services.

Complaint – Any written or oral expression of dissatisfaction.

Covered Services – Medically necessary services included in the commonwealth contract. Covered services change periodically as mandated by federal or commonwealth legislation.

Credentialing – The verification of applicable licenses, certifications, and experience to assure that provider status be extended only to professional, competent providers who continually meet the qualifications, standards, and requirements established by Molina Healthcare.

Current Procedural Terminology (CPT) Codes – American Medical Association (AMA) approved standard coding for billing of procedural services performed.

Delivery System – The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, hospitals, providers' offices and home health care.

Denied Claims Review – The process for providers to request a review of a denied claim.

Discharge Planning – Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

Durable Medical Equipment (DME) – Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. It is also equipment that is appropriate for use in the home and prescribed by a provider.

Electronic Data Interchange (EDI) – The electronic exchange of information between two or more organizations.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT) – A package of services in a preventive (well child) exam covered by Medicaid as defined in the SSA section 1905 (R). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance abuse, mental health and hearing, as well as any medically necessary services found during the EPSDT exam.

Emergency Care – The provision of medically necessary services required for the immediate attention to evaluate or stabilize a Medical Emergency (See definition below).

Encounter Data – Molina Healthcare shall collect, and submit to HFS, enrollee service level encounter data for all covered services.

Excluded Providers – Excluded provider means an individual provider, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been: convicted of crimes as specified in section 1128 of the SSA, excluded from

participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Expedited Appeal – An oral or written request by a member or member's personal representative received by Molina Healthcare requesting an expedited reconsideration of an action when taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Expedited Grievance – A grievance where delay in resolution would jeopardize the member's life or materially jeopardize the member's health.

Federally Qualified Health Center (FQHC) – A facility which:

- receive a grant under Section 329, 330 or 340 of the Public Health Service Act; or
- based on the recommendation of the Health Resources and Services Administration within the Public Health Service, are determined to meet the requirements for receiving such a grant.

Fee-For-Service (FFS) – FFS is a term Molina Healthcare uses to describe a method of reimbursement based upon billing for a specific number of units of services rendered to a member.

GHP (Government Health Plan): The government health services program (formerly referred to as "La Reforma" or "MI Salud") offered by the Commonwealth of Puerto Rico, and administered by ASES, which serves a mixed population of Medicaid Eligible, CHIP Eligible, and Other Eligible Persons, and emphasizes integrated delivery of physical and Behavioral Health Services.

Grievance – An oral or written expression of dissatisfaction by a member, or representative on behalf of a member, about any matter other than an action received at Molina Healthcare.

Health Plan Effectiveness Data and Information Set (HEDIS) – Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems, provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.

HIPAA – Health Insurance Portability and Accountability Act

Independent Practice Association (IPA) – A legal entity, the members of which are independent providers who contract with the IPA for the purpose of having the IPA contract with one or more health plans.

Independent Review Organization (IRO) – A review process by a state/commonwealth-contracted independent third party.

Medicaid – The state/commonwealth and federally funded medical program created under Title XIX of the SSA.

Medical Emergency – Circumstances which a reasonably prudent person would regard as the unexpected onset of sudden or acute illness or injury requiring immediate medical care such that the member's life or health would have been jeopardized had the care been delayed.

Medical Records – A confidential document containing written documentation related to the provision of physical, social and mental health services to a member.

Medically Necessary –a service, supply or medicine is appropriate and meets the standards of good medical practice in the medical community for the diagnosis or treatment of a covered illness or injury, the prevention of future disease, to assist in the Enrollee's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth, as determined by the provider in accordance with Molina's guidelines, policies and/or procedures.

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the SSA. Medicare has two parts:

- Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- Part B is the supplementary medical insurance benefit (SMIB) covering the Medicare provider's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Member – A current or previous member of Molina Healthcare.

NCQA – National Committee for Quality Assurance

Participating Provider – A provider that has a written agreement with Molina Healthcare to provide services to members under the terms of their agreement.

Preferred Provider Network (PPN): A group of Network Providers that (i) GHP Enrollees may access without any requirement of a referral or Prior Authorization; (ii) provides services to GHP Enrollees without imposing any co-payments; and (iii) meets the appropriate Network requirements.

Primary Medical Group (PMG): A grouping of associated Primary Care Physicians and other Providers for the delivery of services to GHP Enrollees using a coordinated care model. PMGs may be organized as Provider care organizations, or as another group of Providers who have contractually agreed to offer a coordinated care model to GHP Enrollees.

Provider Group – A partnership, association, corporation, or other group of providers.

Physician Incentive Plan – Any compensation arrangement between a health plan and a provider or provider group that may directly or indirectly have the effect of reducing or limiting services to members under the terms of the agreement.

Preventive Care – Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.

Primary Care Provider (PCP) – A participating provider responsible for supervising, coordinating, and providing primary health care to members, initiating referrals for specialist care, and maintaining the continuity of member care. PCPs include, but are not limited to; Pediatricians, Family Practice providers, General Medicine providers, Internists, Obstetrician/Gynecologists, Physician Assistants (under the supervision of a Physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by Molina Healthcare.

Quality Improvement Program (QIP) – A formal set of activities provided to assure the quality of clinical and non-clinical services. QIP includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

Remittance Advice (RA) – Written explanation of processed claims.

Referral – The practice of sending a patient to another provider for services or consultation which the referring provider is not prepared or qualified to provide.

Rural Health Clinic (RHC) – a provider that has been designed by the Public Health Service, the US Department of Health and Human Services, or the Governor of Puerto Rico as a RHC.

Service Area – A geographic area serviced by Molina Healthcare, designated and approved by ASES.

Specialist – Any licensed provider, who practices in a specialty field such as Cardiology, Dermatology, Oncology, Ophthalmology, Radiology, etc.

Supplemental Security Income (SSI) – A federal cash program for aged, blind, or disabled persons, administered by the SSA.

Sub-Contract – A written agreement between a health plan and a participating provider, or between a participating provider and another sub-contractor, to perform all or a portion of the duties and obligations a plan is required to perform pursuant to the agreement.

Tertiary Care – Care requiring high-level intensive, diagnostic and treatment capabilities for adults and/or children, typically administered at highly specialized medical centers.

Third Party Liability (TPL) – A company or entity other than Molina Healthcare liable for payment of health care services rendered to members. Molina Healthcare will pay claims for covered benefits and pursue a refund from the third party when liability is determined.

Title V – The portion of the federal SSA that authorizes grants to states/commonwealths for the care of CSHCN.

Title XIX – The portion of the federal SSA that authorizes grants to states/commonwealths for medical assistance programs. Title XIX is also called Medicaid.

Title XXI – The portion of the federal SSA that authorizes grants to states/commonwealths for CHIP.

Utilization Management (UM) – The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to ensure appropriate use of resources. UM includes

prior Authorization, concurrent review, retrospective review, discharge planning and case management.

¿Ayuda con su Plan de Salud del Gobierno?

ASES
Asegurando tu Salud
Administración de Seguros de Salud de Puerto Rico

Línea libre de cargos
1-800-981-2737