Vital
Salud en tus manos
GOBIERNO DE PUERTO RICO

ASES
ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO

PROVIDER GUIDELINES

MMM
multihealth

¿Ayuda con su Plan de Salud del Gobierno?
ASES
ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO
Línea libre de cargos
1-800-981-2737
TTY 787-474-3389

Table of Contents

1. Eligibility

1.1 Enrollee eligibility and MA-10

The Puerto Rico Medicaid Program's determined that a person is eligible for *MI Salud* if he/she is on Form MA-10, titled "Notification of Action Taken on Application and/or Recertification." A person who has received a MA-10 will be referred to hereinafter as a "Potential Enrollee." The Potential Enrollee may access covered services using the MA-10 as a temporary enrollee ID Card from the certification date, even if the person has not received an enrollee ID Card. Only Medicaid, Children's Health Insurance Program (CHIP), and Commonwealth enrollees receive an MA-10 and may access covered services using the MA-10 as a temporary enrollee ID Card.

1.2 Effective date

The Effective date of eligibility for Medicaid and CHIP Eligible is the effective date of eligibility specified on the Form MA-10, which is the first day of the month in which the potential enrollee submits his / her eligibility application to the Medicaid Program Office; they will be eligible to be enrolled as of that date. The date of effectiveness for Commonwealth population is the date in which they are certified in the medical assistance program (Medicaid). The Commonwealth population does not have the benefit of retroactivity of the cover.

The date specified on the MA-10 may be a retroactive date of eligibility which is up to ninety (90) calendar days before the first day of the month in which the potential enrollee submits the eligibility application to the Medicaid Program Office for Medicaid and CHIP populations only during which services can be retroactively covered. The effective date of eligibility is specified on the Form MA-10, and they will be eligible to be enrolled as of that date.

Public employees and pensioners will be eligible to enroll in MMM Multi Health according to policies determined by the Commonwealth, and their effective date of eligibility will be determined with said policies. The Puerto Rico Medicaid Program and

ASES do not play a role in determining the eligibility for public employees and pensioners.

1.3 Termination of Eligibility

A Medicaid, CHIP, Commonwealth, ELA Employee or Pensioner enrollee who is determined ineligible for MMM Multi Health after a redetermination conducted by the Puerto Rico Medicaid Program will remain eligible for services under MMM Multi Health until the date specified in a negative redetermination decision on the MA-10 issued by the Puerto Rico Medicaid Program. An enrollee who is a public employee or pensioner will remain eligible until disenrolled from MMM Multi Health by the applicable Commonwealth agency.

1.4 The duty to verify eligibility

All contracted providers under MMM Multi Health can validate a patient's eligibility with their enrollee ID. It also provides the patients coverage history and access to print the Certificate of Eligibility. The verification of eligibility warrants that all of its network providers will verify the eligibility of enrollees before the provider provides covered services. This verification of eligibility is a condition of receiving payment. It's required that the provider verify the enrollee's eligibility before providing services or making a referral. The systems that support the eligibility verification process are:

InnovaMD Access– (www.innovamd.com)

MSO Provider Call Center Telephones:

787-993-2317 (Metro Area)

1-866-676-6060 (toll free)

Monday through Friday, 7:00 a.m. to 7:00 p.m.

2. Enrollment and disenrollment

2.1 Effective date of enrollment

With the exception of the example provided below, enrollment, whether chosen or automatic, will be effective the same date as the effective date of eligibility. A newborn

will be auto-enrolled, with an effective date of enrollment as of the date of his or her birth. In the event that a female enrollee who is included in a family group for coverage under MMM Multi Health as a dependent child becomes pregnant, the enrollee will be referred to the Puerto Rico Medicaid Program. She will effectively establish a new family with the diagnosis of her pregnancy and will become the head of household of the new family. The effective date of enrollment of the new family will be the date of the first diagnosis of the pregnancy, and the enrollee will be auto-enrolled, effective as of this date. The mother will be auto assigned to the PMG and PCP to which she was assigned before the re-enrollment.

If an enrollee who is a Medicaid or CHIP eligible person or enrollee loses eligibility for MMM Multi Health for a period of less than two (2) months in duration, enrollment in MMM Multi Health Plan will be reinstated. Upon notification from ASES of the recertification, MMM Multi Health after will auto-enroll the person, with enrollment effective as of the effective date of eligibility.

2.2 Dual eligible enrollees

If it's a dual eligible enrollee, it's their responsibility to keep their certification to the Government Health Insurance Program (Medicaid) up to date. They have to attend to the annual recertification appointment and inform the health plan about any changes to their eligibility for Medicaid.

At the time of enrollment, the MMM Multi Health after will provide potential enrollees who are Medicaid-eligible and are also eligible for Medicare Part A or Part A and Part B ("Dual Eligible Enrollees") with the information about their covered services and copayments. Members of the Commonwealth Population who are Medicare-eligible will not be considered Dual Eligible Enrollees.

Dual eligible enrollees who receive Medicare Part A Only MMM Multi Health provide regular coverage, excluding services covered under Medicare Part A (hospitalization). However, MMM Multi Health will cover hospitalization services after the Medicare Part A coverage limit has been reached:

- MMM Multi Health will not cover the copayments or coinsurance of Medicare Part A.
- Once the dual beneficiary has spent the benefit of hospitalization under Medicare will pay copayments or coinsurance applicable to hospitalization under *MI Salud*.

2.3 Termination enrollment

The Term of enrollment will be a period of twelve (12) consecutive months for all MMM Multi Health enrollees, except that in cases in which the Puerto Rico Medicaid Program has designated an eligibility redetermination period shorter than twelve (12) months for an enrollee who is a Medicaid or CHIP Eligible; that same period will also be considered the enrollee's term of enrollment. Such a shortened eligibility redetermination period may apply, at the discretion of the Puerto Rico Medicaid Program, when an enrollee is pregnant, is homeless, or anticipates a change in status.

2.4 Auto-enrollment

The Auto-Enrollment process will include Auto-Assignment of a PMG and a PCP. A new Enrollee who is a Dependent of a current MMM Multi Health enrollee will be automatically assigned to the same PMG as his or her parent or spouse who is a current MMM Multi Health Enrollee.

2.5 Newborn enrollees

MMM Multi Health will promptly, upon learning that an enrollee is an expectant mother, mail a Newborn enrollment packet to the expectant mother instructing her to register the newborn with the Puerto Rico Medicaid Program within ninety (90) calendar days of birth by providing evidence of the newborn's birth and birth certificate; notifying her that the newborn will be auto-enrolled in MMM Multi Health; informing her that unless she visits MMM Multi Health office to select a PMG and PCP, the child will be auto-assigned to the mother's PMG and to a PCP who is a pediatrician; and informing her that she will have ninety (90) calendar days after the child's birth to disenrolls the child from the Plan or to change the child's PMG and PCP, without cause.

If the mother has not made a PCP and PMG selection at the time of the child's birth MMM Multi Health will, within one (1) Business Day of the birth, auto-assign the newborn to a PCP who is a pediatrician and to the mother's PMG.

2.6 Re-enrollment procedure

MMM Multi Health will inform enrollees who are Medicaid and CHIP Eligible and members of the Commonwealth Population of an impending redetermination through written notices. Such notices will be provided ninety (90) calendar days, sixty (60) calendar days, and thirty (30) calendar days before the scheduled date of the redetermination. The notice will inform the enrollee that, if he or she is recertified, his or her term of enrollment in the plan will automatically renew; but that, effective as of the date of recertification, he or she will have a ninety- (90) calendar day period in which he or she may disenrolls from the plan without cause or may change his or her PMG and/or PCP selection without cause. The notice will advise Enrollees that Disenrollment from the MCO only will terminate the enrollee's access to health services from the plan without cause or may change his or her PMG and/or PCP selection without cause.

2.7 Disenrollment

Disenrollment occurs only when ASES or the Medicaid Program determines that an enrollee is no longer eligible for MMM Multi Health; or when disenrollment is requested by MMM Multi Health or enrollee, and approved by ASES. Disenrollment will be effected by ASES, and ASES will issue notification to MMM Multi Health. Such notice will be delivered via file transfer to MMM Multi Health on a daily basis simultaneously with Information on potential enrollees within five (5) calendar days of making a final determination on disenrollment.

Disenrollment decisions are the responsibility of ASES; however, notice to enrollees of Disenrollment will be issued by MMM Multi Health. MMM Multi Health will issue such notice in person or via traditional mail to the enrollee within five (5) business days of a

final disenrollment decision. Each notice of disenrollment will include information concerning:

- The effective date of disenrollment;
- The reason for the disenrollment;
- The enrollee's appeal rights, including the availability of the Grievance System and of ASES's Administrative Law Hearing process, as provided by Act 72 of September 7, 1993.
- The right to re-enroll in MMM Multi Health upon receiving a recertification from the Puerto Rico Medicaid Program.

2.7.1 If applicable; disenrollment will occur according to the following timeframes:

- Disenrollment will take effect as of the effective date of disenrollment specified in ASES's notice to MMM Multi Health that an enrollee is no longer eligible.
- If ASES notifies MMM Multi Health of disenrollment on or before the last working day of the month in which eligibility ends, the disenrollment will be effective on the first day of the following month.
- When disenrollment is effected at the request of MMM Multi Health or of the enrollee's, disenrollment will take effect no later than the first day of the second month following the month that MMM Multi Health or enrollee requested the disenrollment.
- If ASES fails to make a decision on MMM Multi Health or enrollee's request before this date, the disenrollment will be deemed granted.

2.7.2 If the enrollee requests reconsideration of a disenrollment through MMM Multi Health Grievance System, the Grievance System process will be completed in time to permit the disenrollment (if approved) to take effect in accordance with this timeframe. Otherwise the effective date of disenrollment would be:

- When the enrollee is an inpatient at a hospital, ASES will postpone the effective date of disenrollment so that it occurs on the last day of the

month in which the enrollee is discharged from the hospital, or the last day of the month following the month in which disenrollment would otherwise be effective, whichever occurs earlier.

- During a month in which the enrollee is in the second or third trimester of pregnancy, ASES will postpone the effective date of disenrollment so that it occurs on the date of delivery.
- During a month in which an enrollee is diagnosed with a terminal condition, ASES will postpone the effective date of disenrollment so that it occurs on the last day of the following month.
- For the public employees and pensioners who are other eligible persons referred, disenrollment will occur according to the timeframes set forth in a Normative Letter issued by ASES annually.

2.8 Disenrollment initiated by the enrollee**:**

An enrollee may request disenrollment from the Health Plan without cause during the ninety (90) calendar days following the effective date of enrollment with the Health Plan or the date that the Health Plan sends a notice of the Enrollment, whichever is later. An enrollee may request disenrollment without cause every twelve (12) months thereafter. An enrollee may request disenrollment from the *MI Salud* for cause at any time. The following constitute cause for disenrollment by the Enrollee:

- The Enrollee moves to a Service Region not administered by the Health Plan, or outside of Puerto Rico;
- The Enrollee needs related services to be performed at the same time, and not all related services are available within the Network. The Enrollee's PCP or another Provider in the Preferred Provider Network has determined that receiving service separately would subject the Enrollee to unnecessary risk;
- Poor quality of care; or
- Lack of Access to Covered Services, or lack of Providers experienced in dealing with the Enrollee's health care needs.

ASES shall make the final decision on enrollee requests for disenrollment. An enrollee wishing to request disenrollment must submit an oral or written request to ASES or to the Health Plan. If the request is made to the Health Plan, the Health Plan shall forward the request to ASES, within ten (10) business days of receipt of the request, with a recommendation of the action to be taken.

2.8.1 The following are acceptable reasons for the Health Plan to request Disenrollment:

- The Enrollee's continued enrollment in the *MI Salud* seriously impairs the ability to provide services to either this particular Enrollee or other Enrollees;
- The Enrollee demonstrates a pattern of disruptive or abusive behavior that is not caused by a presenting illness;
- The Enrollee's use of services constitutes Fraud, Waste or Abuse (for example, the Enrollee has loaned his or her Enrollee ID Card to other persons to seek services);
- The Enrollee has moved out of Puerto Rico or out of the Health Plan's Service Regions;
- The Enrollee is placed in a long-term care nursing facility or intermediate care facility for the developmentally disabled;
- The Enrollee's Medicaid or CHIP eligibility category changes to a category ineligible for the *MI Salud*; or
- The Enrollee has died or has been incarcerated, thereby making him or her ineligible for Medicaid or CHIP or otherwise ineligible for the *MI Salud*.
- If you are disenrolled from your Health Plan, you will lose access to services under the *MI Salud*.

2.8.2 Disenrollment (cancellations) requested by *MI Salud* Beneficiaries:

1. Beneficiaries of the *MI Salud* can request the disenrollment in writing:
    a. visiting one of our regional offices

b. Sending the written request, along with a copy of a valid identification to the fax **1-844-330-9330**
c. By email, writing to Fullfilment-at-EnrollmentPSG@mmmhc.com
d. Surface mail to the following address:

PO BOX 72010,

San Juan, P.R. 00936-7710.

2. Request received at the Regional Offices or Member Services will be sent to the distribution list email.
3. Enrollment Department will send the requests to the central office of the Medical Assistance Program **(Medicaid)** for processing.
4. The official disenrollment will be received electronically for Medicaid in the ASES Files.

*** Policy ENR-16-004

1 2.9 Standard or expedited

The Enrollee, the Enrollee's Authorized Representative, or the Provider may file an Appeal either orally or in writing in the following ways: Contacting the *MI Salud* Call Center at 1-844-336-3331, available on Monday to Friday of 7:00 am at 7:00 pm. For Hearing impaired, the TTY telephone services are available by calling (787) 999-4411; visiting in person the nearest Service Center for an action to be taken or in writing through regular mail, email or facsimile. Unless the enrollee requests an expired appeal, the enrollee, the authorized representative of the enrollee or the provider acting on behalf of the enrollee must have the written consent of the enrollee. At the time of filing a verbal appeal, you must send the appeal request in writing and signed for enrollee within ten (10) calendar days after the verbal presentation, unless the expedited appeal does not require additional follow-up.

2.9.1 The requirements of the appeal process will:

- Handle all types of appeals, including expedited appeals, unless otherwise established.

- The appeals process shall provide the enrollee, the enrollee's authorized representative, or the provider acting on behalf of the enrollee with the enrollee's written consent, reasonable time to present evidence and allegations of fact or law, in person, as well as in written. MMM shall inform the enrollee of the time available to file an expedited appeal.
- The appeals process shall provide the enrollee, the enrollee's authorized representative, or the provider acting on behalf of the enrollee with the enrollee's written consent, opportunity, before and during the Appeals process, to review the enrollee's case file, including medical records, and any other documents and records considered during the appeals process and provide copies of documents contained therein without charge.
- The appeals process shall include as parties to the appeal the enrollee, the enrollee's authorized representative, the provider acting on behalf of the enrollee with the enrollee's written consent, or the legal representative of the estate of a deceased enrollee's estate.
- MMM shall resolve each standard appeal and provide written notice of the disposition, as expeditiously as the enrollee's health condition requires, but no more than thirty (30) calendar days from the date MMM receives the appeal.
- MMM shall establish and maintain an expedited review process for appeals, when the MMM determines (based on a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function. The enrollee, the enrollee's authorized representative, or the provider acting on behalf of the enrollee with the enrollee's written consent, may file an expedited appeal either orally or in writing.
- MMM shall resolve each expedited appeal and provide a written notice of disposition, as expeditiously as the enrollee's health condition requires, but

no longer than seventy-two (72) hours after the MMM receives the appeal and makes reasonable efforts to provide oral notice.

3. Enrollee Rights and Responsibilities

3.1 Advance Directives

Information on Advance Directives, including the rights of enrollees to file directly with ASES or with the Puerto Rico Office of the Patient Advocate. In compliance with 42 CFR 438.6 (i), Law No. 160 of November 17, 2001, and 42 CFR 489.100, MMM Multi Health, LLC., will maintain written policies and procedures for Advance Directives. Such Advance Directives will be included in each Enrollee's Medical Record. MMM Multi Health will provide policies and procedures to all its Enrollees with eighteen (18) years of age and older and will advise Enrollees of:

1. Their rights under Puerto Rico laws, including the right to accept or refuse medical or surgical treatment and the right to formulate an Advance Directive; MMM Multi Health written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience. The right to receive emergency services within twenty-four (24) hours, seven (7) days of week.
2. The Enrollee's right to file complaints concerning noncompliance with Advance Directive requirements directly with ASES or with the Puerto Rico Office of the Patient Advocate. The information must include a description of Puerto Rico law reflecting changes in laws as soon as possible and no later than ninety (90) calendar days after the effective change.
3. MMM Multi Health will educate its staff about its policies and procedures on Advance Directives, situations in which Advance Directives may be of benefit to Enrollees, and the staff's responsibility to educate Enrollees about this tool and assist them in making use of it.
4. MMM Multi Health will educate Enrollees about their ability to direct their care using Advance Directives and will specifically designate which staff members or Network Providers are responsible for providing this education.

5. MMM Multi Health will provide Enrollees with at least thirty (30) calendar days written notice of any significant change in policies concerning Enrollees' disenrollment rights, right to change PMG or PCP, or any significant change to any of the items listed in Enrollee Rights and Responsibilities, regardless of whether ASES or MMM Multi Health caused the change to take place.
6. Evidence of a current Advanced Directives should be noted in a prominent place in the patient's record.
7. Advance Directives pertaining to treatment preferences and the designation of a surrogate decision-maker in the event that a person should become unable to make medical decisions on their own behalf. Advanced directives generally may be a living will, power of attorney or healthcare proxy:

- Actionable Medical Orders:

Written instructions regarding initiation, continuation, withholding, withdrawal of a form of life-sustaining treatment.

- Living Wills:

Legal documents denoting preferences for life-sustaining treatment and end of life care.

- Surrogate Decision Maker:

A written document designating someone else to make future medical treatment choice.

- Oral Statements:

Conversations with relatives or friends about life-sustaining treatments and end of life care documented in the medical record.

Patient designation of an individual who can make decisions on their behalf. Evidence of oral statements must be noted in the medical record during the measurement year.

8. MMM Multi Health will have written policies and procedures regarding the rights of Enrollees and will comply with any applicable federal and Puerto Rico laws and regulations that pertain to Enrollee rights, including those set

forth in 42 CFR 438.100, and in the Puerto Rico Patient's Bill of Rights Act 194 of August 25, 2000 (as amended); the Puerto Rico Mental Health Law of October 2, 2000, as amended and implemented; and Law 77 of July 24, 2013 which was created the Office of the Patient Advocate. These rights will be included in the Enrollee Handbook. At a minimum, policies and procedures will specify Enrollee's right to:

a. Receive information pursuant to 42 CFR 438.10;
b. Be treated with respect and with due consideration for the Enrollee's dignity and privacy;
c. Have all medical records and personal information confidential;
d. Receive information on available treatment options and alternatives, presented appropriately to Enrollee's condition and ability to understand;
e. Participate in decisions regarding his or her healthcare, including the right to refuse treatment;
f. Be free from any form of restraint or reclusion as a means of coercion, discipline, convenience, or retaliation, as specified in 42 CFR 482.13(e) and other federal regulations on the use of restraints and reclusion;
g. Request and receive a copy of his or her medical records pursuant to 45 CFR Parts 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR 164.524 and 164.526;
h. Choose an Authorized Representative to be involved as appropriate in making care decisions;
i. Provide informed consent;
j. Be furnished with healthcare services in accordance with 42 CFR 438.206 through 438.210;

k. Exercise his or her rights, including those related to filing a grievance or appeal, and that exercising these rights will not adversely affect the way the Enrollee is treated;
l. Receive information about covered services and how to access covered services and network Providers.
m. Be free from harassment by MMM Multi Health or its network Providers with respect to contractual disputes between MMM Multi Health and its Providers;
n. Participate in the understanding of physical and behavioral health problems developing mutually agreed-upon treatment goals;
o. Not be held liable for MMM Multi Health debts in the event of insolvency; not be held liable for the covered services provided to the Enrollee for which ASES does not pay MMM Multi Health; not be held liable for covered services provided to the Enrollee for which ASES or MMM Multi Health Plan does not pay the Provider that furnishes the services; and not be held liable for payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are more than the amount the Enrollee would owe if MMM Multi Health provided the services directly. Only be responsible for cost-sharing in accordance with 42 CFR 447.50 through 42 CFR 447.60 and as permitted by the Puerto Rico Medicaid and CHIP State Plans and Puerto Rico law as applicable to the Enrollee.

3.2 The Right to change the Primary Medical Group (PMG) and Primary Care Physician (PCP).

During the ninety (90) calendar days period the Enrollee can change his/her auto assigned PMG and PCP. MMM Multi Health can offer counseling and assistance to the Enrollee in selecting a different PCP and PMG. MMM Multi Health will advise certain

Enrollees to choose a Physician other than, or in addition to, a general practice Physician as their PCP, as follows:

- Female Enrollees will be recommended to choose an Obstetrician / Gynecologist as a PCP;
- Enrollees under twenty-one (21) years of age will be recommended to choose a Pediatrician as a PCP; Enrollees with chronic conditions including heart, kidney failure, or diabetes will be recommended to choose an Internist as PCP.

MMM Multi Health will furnish to all new Enrollees an Enrollee ID card made of durable plastic material. The card will be mailed to the Enrollee via surface mail within five (5) calendar days of sending the Notice of Enrollment. The Enrollee ID card must, at a minimum, include the following information:

- ✓ The MMM Multi Health logo;
- ✓ Enrollee's name;
- ✓ Enrollee's date of birth;
- ✓ A designation of the Enrollee as a Medicaid Eligible, CHIP Eligible, or another eligible person;
- ✓ Enrollee's Medicaid or CHIP identification number, if applicable;
- ✓ Enrollee's Plan group number, when applicable;
- ✓ If the Enrollee is eligible for MMM Multi Health as a dependent;
- ✓ Enrollee's relationship with the principal Enrollee;
- ✓ Effective Date of Enrollment in MMM Multi Health;
- ✓ Master Patient Identifier (if applicable);
- ✓ Co-payment levels for various services outside the Enrollee's PPN and the assurance that no copayment will be charged for a Medicaid Eligible person and for CHIP children under twenty-one (21) years under any circumstances;
- ✓ PCP's and the PMG's names;
- ✓ The name and telephone number(s) of MMM Multi Health;

- ✓ The twenty-four (24) hour, seven (7) day a week toll-free MMM Multi Health service line of medical advice service phone number;
- ✓ A notice that the Enrollee ID card may under no circumstances be used by a person other than the identified Enrollee;
- ✓ Instructions to obtain emergency services.

2 3.3 Right to Enrollee Privacy Health Insurance Portability and Accountability Act (HIPAA)

The Beneficiary's health information is private. The law says that ASES and MMM Multi Health must protect your information. ASES and MMM Multi Health can share your information for your care, to pay your health claims, and run the program. But we can't share the Enrollee information with others people unless Enrollee authorizes it tell us we can. If you want to know more about what information we have, how we can share it, or what to do if you don't want your health information shared with certain people, call your MMM Multi Health:

Enrollee Services:
1-844-336-3331 (toll free)
787-999-4411 TTY (hearing impaired)
Monday through Friday
from 7:00 a.m. to 7:00 p.m.

3.4 Co-Payments

Do you have to pay copays for a PCP, Specialist, ER visit, hospital stay, or other type of service? Not sure? Check the chart below, look at your ID card or call:

MMM Multi Health at 1-844-336-3331 (toll free),

TTY 787-999-4411 (for the hearing impaired).

- No copayments can be charged to the Federal and CHIP population for the treatment of any Emergency Medical Condition or Psychiatric Emergency;
- No Co-Payments shall be charged for Medicaid and CHIP children under eighteen (18) years under any circumstances;

- By using *MI Salud* Medical Consultation Line the Enrollee may avoid a Co-Payment for such services.

The following chart shows a breakdown with the amounts you must pay, according to the services received and the type of coverage you have as a *MI Salud* enrollee.

SERVICES	Federal				CHIPS		Commonwealth				*ELA
	100	110	120	130	220	230	300	310	320	330	400
HOSPITAL											
Admissions	$0	$4	$5	$8	$0	$0	$15	$15	$15	$20	$50
Nursery	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EMERGENCY ROOM (ER)											
Emergency Room (ER) Visit	$0	$0	$0	$0	$0	$0	$2	$10	$15	$20	$20
Non-Emergency Services Provided in a Hospital Emergency Room, (per visit)	$0	$4	$5	$8	$0	$0	$20	$20	$25	$30	$20
Non-Emergency Services Provided in a Freestanding Emergency Room, (per visit)	$0	$2	$3	$4	$0	$0	$20	$20	$25	$30	$20
Trauma	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
AMBULATORY VISITS											
Primary Care Physician (PCP)	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$3
Specialist	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$7
Sub-specialist	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$10
Pre-Natal Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OTHER SERVICES											
High-Tech Laboratories**	$0	50¢	$1	$1.50	$0	$0	$2	$2	$5	$5	20%
Clinical Laboratories**	$0	50¢	$1	$1.50	$0	$0	$2	$2	$5	$5	20%
X Rays**	$0	50¢	$1	$1.50	$0	$0	$2	$2	$5	$5	20%
Specialized Diagnostic Tests**	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$6	40%
Therapy - Physical	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$5

Therapy – Respiratory	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$5
Therapy – Occupational	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$5
Vaccines	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Healthy Child Care	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Dental											
Preventive (Children)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Preventive (Adult)	$0	$1	$1.50	$2	$0	$0	$0	$2	$3	$5	$3
Restorative	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$6	$10
PHARMACY***											
Preferred (Children 0-21)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Preferred (Adult)	$0	$1	$2	$3	N/A	N/A	$3	$3	$5	$5	$5
Non-Preferred (Children 0-21)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$10
Non-Preferred (Adult)****	$0	$3	$4	$6	N/A	N/A	$8	$8	$10	$10	$10

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

** Apply to diagnostic test 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.

4. Covered Services by MMM Multi Health

4.1 Medical Necessity

Based on generally accepted medical practices specific to the medical or Behavioral Health condition of the Enrollee at the time of treatment, Medically Necessary Services are those that relate to the prevention, diagnosis, and treatment of health

impairments; the ability to achieve age-appropriate growth and development; or the ability to attain, maintain, or regain functional capacity. The scope of Medically Necessary Services must not be any more restrictive than that of Puerto Rico's Medicaid program. Additionally, Medically Necessary services must be:

- Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Enrollee is medical condition.
- Compatible with the standards of acceptable medical practice in the community.
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms.
- Not provided solely for the convenience of the Enrollee or the convenience of the Provider or hospital.
- Not primarily custodial care (for example, foster care).

In order for a service to be Medically Necessary, there must be no other effective and more conservative or substantially less costly treatment, service, or setting available.

4.2 Experimental or Cosmetic Procedures

In no instance will MMM Multi Health cover experimental or cosmetic procedures, except as required by the Puerto Rico Patient's Bill of Rights Act or any other Federal or Puerto Rico law or regulation. Breast reconstruction after a mastectomy and surgical procedures that are determined to be Medically Necessary to treat morbid obesity will not be regarded as cosmetic procedures.

4.3. Covered Services and Administrative Functions

Covered Services	
Preventive Services	1. Vaccines 2. Eye Exam 3. Hearing Exam 4. Evaluation and nutritional screening;

	5. Medically Necessary laboratory exams and diagnostic tests: ● Prostate and gynecological cancer screening ● Sigmoidoscopy and colonoscopy for colon cancer detection in adults 6. Provide the following Preventive Services as Covered Services under the Healthy Child Care Program: ● One (1) annual comprehensive evaluation by a certified Provider. 7. Other services, as needed, during the first two (2) years of the child's life.

Diagnostic Test Services	1. Diagnostic and testing services for Enrollees under age twenty-one (21) required by EPSDT, as defined in Section 1905(r) of the Social Security Act; 2. Clinical labs, including but not limited to, any laboratory order for disease diagnostic purposes, even if the final diagnosis is a condition or disease whose treatment is not a Covered Service. 3. Hi-tech Labs 4. X-Rays 5. Electrocardiograms 6. Radiation therapy (Prior Authorization required) 7. Pathology 8. Arterial gases and Pulmonary Function Test 9. Electroencephalograms 10. Diagnostic services for Enrollees who present learning disorder symptoms 11. Services related to a diagnostic code included in the Diagnostic and Statistical Manual of Mental Disorders ("DSM IV or DSM V"). The following will not be considered diagnostic test services covered under the *MI Salud*: 1. Polysomnography studies 2. Clinical labs processed outside of Puerto Rico
Outpatient Rehabilitation Services	1. Medically Necessary outpatient rehabilitation services for Enrollees under age twenty-one (21), as required by EPSDT, Section 1905(r) of the Social Security Act. 2. Physical therapy (limited to maximum of fifteen (15) treatments per Enrollee condition per year, unless Prior

	Authorization of an additional fifteen (15) treatments is indicated by an orthopedist or physician). 3. Occupational therapy, without limitations. 4. Speech therapy, without limitations.
Medical & Surgical Services	MMM Multi Health will provide the following medical and surgical services as Covered Services: 1. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, as defined in Section 1905(r) of the Social Security Act. 2. Primary Care Physician visits, including nursing services. 3. Specialist treatment, once referred by the selected PCP if outside of the Enrollee's PPN. 4. Sub-specialist treatment, once referred by the selected PCP if outside of the Enrollee's PPN. 5. Physician home visits when Medically Necessary. 6. Respiratory therapy, without limitations. 7. Anesthesia services (except for epidural anesthesia). 8. Radiology services 9. Pathology services 10. Surgery 11. Outpatient surgery facility services 12. Practical nurse services 13. Voluntary sterilization of men and women of legal age and sound mind, provided that they have been previously informed about the medical procedure's implications, and that there is evidence of Enrollee's written consent. 14. Prosthetics, including the supply of all extremities of the human body including therapeutic ocular prosthetics,

	segmental instrument tray, and spine fusion in scoliosis and vertebral surgery. 15. Ostomy equipment for outpatient-level ostomized patients. 16. Transfusion of blood and blood plasma services, without limitations, including the following: ● Authologal and irradiated blood. ● Monoclonal factor IX with the Referral of a certified hematologist. ● Intermediate purity concentrated antihemophilic factor (Factor VIII). ● Monoclonal type antihemophilic factor with a certified hematologist's authorization. ● Activated prothrombin complex (Auto flex and Feiba) with a certified hematologist's authorization. 17. Chronic renal disease Levels 1 and 2 are defined as follows: ● Level 1: GFR (Glomerular Filtration – ml/min. per 1.73m² per corporal area surface) over 90; slight damage when protein is present in the urine. ● Level 2: GFR between 60 and 89, a slight decrease in kidney function. ● When GFR decreases to less than 60 ml/min per 1.73 m², the Enrollee must be referred to a nephrologist for proper management. The Enrollee will be registered for Special Coverage. 18. While cosmetic procedures will be excluded from Covered Services, breast reconstruction after a mastectomy and surgical procedures Medically Necessary to treat morbid obesity will not be considered to be cosmetic procedures.

Emergency Transportation Services	1. MMM Multi Health will provide Emergency Transportation Services, including but not limited to, maritime and ground transportation, in emergency situations as Covered Services. 2. Emergency transportation services will be available twenty-four (24) hours a day, seven (7) days per Week throughout Puerto Rico. 3. Emergency transportation services do not require Prior Authorization. 4. Ensure that adequate emergency transportation is available to transport any Enrollees experiencing an Emergency Medical Conditions or a Psychiatric Emergency, or whose conditions require emergency transportation because of their geographical location. 5. Aerial emergency transportation services are provided and paid for by ASES under a separate contract. 6. In any case in which an Enrollee is transported by ambulance to a facility that is not a Network Provider, and, after being stabilized, is transported by ambulance to a facility that is a Network Provider, all emergency transportation costs, provided that they are justified by prudent layperson standards, will be borne by MMM Multi Health. 7. Emergency transportation services will be subject to periodic reviews and/or audits by applicable governmental agencies and ASES to ensure quality of services.
	Emergency Services will include the following without limitations: 1. Emergency room visits, including medical attention and routine and necessary services 2. Trauma services

Emergency Services	3. Operating room use 4. Respiratory therapy 5. Specialist and sub-specialist treatment when required by the emergency room physician 6. Anesthesia 7. Surgical material 8. Laboratory tests and X-Rays 9. Post-Stabilization Services. 10. Care as necessary in the case of a Psychiatric Emergency in an emergency room setting 11. Drugs, medicine and intravenous solutions used in the emergency room 12. Transfusion of blood and blood plasma services, without limitations, including: ● Authologal and irradiated blood; ● Monoclonal factor IX with a certified hematologist referral. ● Intermediate purity concentrated anti-hemophilic factor (Factor VIII); ● Monoclonal type anti-hemophilic factor with a certified hematologist's authorization. ● Activated prothrombin complex (Auto flex and Feiba) with a certified hematologist's authorization. Emergency Services Within and Outside Puerto Rico ● For all Enrollees, throughout Puerto Rico, including outside MMM Multi Health's Service Regions, and notwithstanding whether the emergency room is a Network Provider.

	● For Medicaid and CHIP Eligible, in Puerto Rico or in the US, when the services are Medically Necessary and could not be anticipated, notwithstanding that emergency rooms outside of Puerto Rico are not Network Providers.
Maternity & Pre Natal Services	The *MI Salud* will provide the following maternity and pre-natal services as Covered Services: 1. Pregnancy testing. 2. Medical services, during pregnancy and post-partum. 3. Physician and nurse obstetrical services during vaginal and caesarean section deliveries and services to address any complication that arises during the delivery. 4. Treatment of conditions attributable to the pregnancy or delivery, when medically recommended. 5. Hospitalization for a period of at least forty-eight (48) hours in cases of vaginal delivery, and at least ninety-six hours (96) in cases of caesarean section. 6. Anesthesia, excluding epidural. 7. Incubator use, without limitations. 8. Fetal monitoring services, during hospitalization only. 9. Nursery room/ routine care for newborns. 10. Circumcision and dilatation services for newborns. 11. Transportation of newborns to tertiary facilities when necessary. 12. Pediatrician assistance during delivery. 13. Delivery services provided in freestanding birth centers. 14. MMM Multi Health will implement a pre-natal and maternal program, aimed at preventing complications during and after pregnancy, and advancing the objective of lowering the

	incidence of low birth weight and premature deliveries. The program will include, at a minimum, the following components: ● A pre-natal care card, used to document services utilized ● Counseling regarding HIV testing ● Pregnancy testing ● A RhoGAM injection for all pregnant women who have a negative RH factor according to the established protocol. ● Alcohol screening of pregnant women with the 4P-Plus instrument or CAGE Test. ● Smoking cessation counseling and treatment. ● Post-partum depression screening using the Edinburgh post-natal depression scale. Post-partum counseling and Referral to the WIC program. ● Dental evaluation during the second trimester of gestation. ● Educational workshops regarding pre-natal care topics (importance of pre-natal medical visits and post-partum care), breast-feeding, stages of childbirth, oral and Behavioral Health, family planning, and newborn care, among others. 15. MMM Multi Health will ensure that eighty-five percent (85%) of pregnant Enrollees receive services under the Pre-Natal and Maternal Program. MMM Multi Health will submit its pre-natal and Maternal Program maternal wellness plan to

	ASES and will submit reports quarterly concerning the usage of services under this program. 16. MMM Multi Health will provide reproductive health and family planning counseling. Such services will be provided voluntarily and confidentially including circumstances where the Enrollee is under age eighteen (18). Family planning services will include, at a minimum, the following: ● Education and counseling necessary to make informed choices and understand contraceptive methods; ● Pregnancy testing; ● Diagnosis and treatment of sexually transmitted infections; Infertility assessment; ● Oral contraceptive medications, but only when prescribed for the purpose of treating menstrual dysfunction and other hormonal conditions; ● Information on the family planning services available through the Health Department.
Post-Stabilization Services	1. MMM Multi Health will cover Post-Stabilization Services obtained from any Provider, regardless of whether the Provider is in the General Network or PPN, that are administered to maintain the Enrollee's stabilized condition for one (1) hour while awaiting response on a Prior Authorization request. The attending Emergency Room physician or other treating Provider will be responsible for determining whether the Enrollee is sufficiently stabilized for transfer or discharge. That determination will be binding for MMM Multi Health with respect to its responsibility for coverage and payment.

Hospitalization Services	MMM Multi Health will provide hospitalization services, including the following: 1. Access to a nursery. 2. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year). 3. Access to an isolation room for physical or Behavioral Health reasons. 4. Food, including specialized nutrition services. 5. Regular nursing services. 6. Specialized room use, such as operation, surgical, recovery, treatment and maternity, without limitations; 7. Drugs, medicine, and contrast agents, without limitations. 8. Availability of materials such as bandages, gauze, plaster, or any other therapeutic or healing material. 9. Therapeutic and maintenance care services, including the use of the necessary equipment to offer the service. 10. Specialized diagnostic tests, such as electrocardiograms, electroencephalograms, arterial gases, and other specialized tests that are available at the hospital and necessary during the Enrollee's hospitalization. 11. Supply of oxygen, anesthetics, and other gases including administration. 12. Respiratory therapy, without limitations; 13. Rehabilitation services while Enrollee is hospitalized, including physical, occupational, and speech therapy. 14. Outpatient surgery facility use. 15. Transfusion of blood and blood plasma services, without limitations, including: ● Authologal and irradiated blood.

	● Monoclonal factor IX with the Referral of a certified hematologist. ● Intermediate purity concentrated anti-hemophilic factor (Factor VIII). ● Monoclonal type antihemophilic factor with a certified hematologist's authorization. ● Activated prothrombin complex (Auto flex and Feiba) with a certified hematologist's authorization.
Dental Services	MMM Multi Health will provide the following dental services as Covered Services: 1. All preventative and corrective services for children under age twenty-one (21) mandated by the EPSDT requirement. 2. Pediatric Pulp Therapy (Pulpotomy) for children under age twenty-one (21). 3. Stainless steel crowns for use in primary teeth following a Pediatric Pulpotomy. 4. Preventive dental services for Adults 5. Restorative dental services for Adults 6. One (1) comprehensive oral exam per year 7. One (1) periodical exam every six (6) months 8. One (1) defined problem-limited oral exam 9. One (1) full series of intra-oral radiographies, including bite, every three (3) years 10. One (1) initial periapical intra-oral radiography 11. Up to five (5) additional periapical/intra-oral 12. One (1) single film-bite radiography per year 13. One (1) two-film bite radiography per year 14. One (1) panoramic radiography every three (3) years

	15. One (1) Adult cleanse every six (6) months 16. One (1) child cleanse every six (6) months 17. One (1) topical fluoride application every six (6) months for Enrollees under nineteen (19) years old 18. Fissure sealants for life for Enrollees up to fourteen (14) years old (including decidual molars up to eight (8) years old when Medically Necessary because of cavity tendencies); 19. Amalgam restoration 20. Resin restorations 21. Root canal 22. Palliative treatment 23. Oral surgery.
Basic Behavioral Health Services	Coverage: Covered Behavioral Health Services include the following: 1. Evaluation, screening, and treatment of individuals, couples, families and groups. 2. Outpatient services with psychiatrists, psychologists, and social workers. 3. Hospital or outpatient services for substance and alcohol abuse disorders. 4. Behavioral Health hospitalization. 5. Intensive outpatient services. 6. Immediate access to Emergency or crisis intervention Services twenty-four (24) hours a day, seven (7) days a Week (services outside of Puerto Rico available only for Medicaid and CHIP Eligible). 7. Detoxification services for Enrollees intoxicated with illegal substances, whether as a result of substance abuse, a suicide attempt, or accidental poisoning.

	8. Long lasting injected medicine clinics. 9. Escort/professional assistance and ambulance services when needed. 10. Prevention and secondary-education services. 11. Pharmacy coverage and access to medicine for a maximum of twenty-four (24) hours, in compliance with Act No. 408; 12. Medically Necessary clinical laboratories. 13. Treatment for Enrollees diagnosed with Attention Deficit Disorder (with or without hyperactivity). This includes, but is not limited to, neurologist visits and tests related to this diagnosis's treatment. 14. Substance abuse treatment. The following services are <u>excluded</u> from all Basic Coverage: 1. Expenses for personal comfort materials or services, such as, telephone use, television, or toiletries; 2. Services rendered by close family relatives (parents, children, siblings, grandparents, grandchildren, or spouses); 3. Weight control treatment (obesity or weight gain) for a esthetic reasons. As noted, procedures determined to be Medically Necessary to address morbid obesity will not be excluded; 4. Sports medicine, music therapy, and natural medicine; 5. Services, diagnostic testing, or treatment ordered or rendered by naturopaths, naturists, chiropractors, iridologists, or osteopaths; 6. Health Certificates, except as provided in (Preventive Services); 7. Epidural anesthesia services;

	8. Chronic pain treatment, if it is determined that the pain has a psychological or psychosomatic origin by a medical professional; 9. Educational tests or services; 10. Peritoneal dialysis or hemodialysis services (covered under Special Coverage, not Basic Coverage); 11. Hospice care; 12. Services received outside the territorial limits of Puerto Rico, except as provided in (Emergency Transportation) and (Emergency Services); 13. Expenses incurred for the treatment of conditions resulting from services not covered under MMM Multi Health (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); 14. Judicially ordered evaluations for legal purposes; Psychological, psychometric, and psychiatric tests and evaluations to obtain employment or insurance, or for purposes of litigation; 15. Travel expenses, even when ordered by the Primary Care Physician; 16. Eyeglasses, contact lenses and hearing aids; 17. Acupuncture services; 18. Rent or purchase of Durable Medical Equipment, wheelchairs, or any other transportation method for the handicapped, either manual or electric, and any expense for the repair or alteration of said equipment, except when the patient's life depends on this service;

	19. Sex change procedures; 20. Organ transplants and 21. Tuboplasty and Vasovasectomy any other procedure to restore procreation. The following are excluded from maternity and pre-natal Covered Services: 1. Outpatient use of fetal monitor; 2. Treatment services for infertility and/or related to conception by artificial means; 3. Services, treatments, or hospitalizations as a result of a provoked non-therapeutic abortion or associated complications are not covered. The following are considered to be provoked abortions: ● Dilatation and curettage (CPT Code 59840); ● Dilatation and expulsion (CPT Code 59841); ● Intra-amniotic injection (CPT Codes 59850, 59851, 59852); ● One or more vaginal suppositories (e.g., Prostaglandin) with or without cervical dilatation (e.g., Laminar), including hospital admission and visits, fetus birth, and secundines (CPT Code 59855); ● One or more vaginal suppositories (e.g., Prostaglandin) with dilatation and curettage/or evacuation (CPT Code 59856); ● One or more vaginal suppositories (e.g., Prostaglandin) with hysterectomy (omitted medical expulsion) (CPT Code 59857).

	4. Differential diagnostic interventions up to the confirmation of pregnancy are not covered. Any procedure after the confirmation of pregnancy will be at the *MI Salud* own risk. 5. Hospitalization for services that would normally be considered outpatient services or for diagnostic purposes only is not a Covered Service under the *MI Salud* . 6. The following drugs are <u>excluded</u> from the pharmacy services Benefit: ● Rebetron or any other medication prescribed for the treatment of Hepatitis C treatment (to be provided by the Health Department, upon Referral to the Health Department by a Network Provider. This medication is not provided through the *MI Salud*). ● Medications delivered directly to Enrollees 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 injections. Psychiatric Emergencies 1. MMM Multi Health will not deny payment for treatment of an Emergency Medical Condition or a Psychiatric Emergency, including cases in which the absence of immediate medical attention would not have resulted in the outcomes specified in the definition of Emergency Medical Condition or a Psychiatric Emergency in this Contract and in 42 CFR 438.114(a). 2. MMM Multi Health will not refuse to cover an Emergency Medical Condition or a Psychiatric Emergency on the ground that the emergency room Provider, hospital, or fiscal Agent did not notify the Enrollee's PCP or MMM Multi Health of the

	Enrollee's screening or treatment following the Enrollee's arrival for Emergency. 3. Care as necessary in the case of a Psychiatric Emergency in an emergency room setting. Substance abuse treatment 1. MMM Multi Health will provide appropriate services for Enrollees in need of Buprenorphine treatment due to of a diagnosis of opiate addiction cover all services related to assessment, treatment, and monitoring of opiate addiction including: ● Prescriptions for Buprenorphine or any other medically A list of CPTET Centers and community-based organizations that administer these medications is included as Attachment [4] to this Contract appropriate medications included on the PDL ● Comprehensive medical examination (CPT Code 99205) ● Extended office visits (CPT Code 99215 ● Brief office visit (CPT Code 99211) ● Psychiatric Diagnostic Interview Exam – New Patient (CPT Code 90801) ● Individual Therapy with Medical Evaluation and Management (CPT Code 90807) ● Pharmacologic Management (CPT Code 90862) ● Drug Urine Toxicology (CPT Code 80100) ● Blood Test Basic Metabolic Panel (CPT Code 80048) ● Blood Test CBC (CPT Code 85025)

	● TB Test – Skin (CPT Code 86580), but only in conjunction with the prescription of Buprenorphine for the treatment of opiate addiction ● HIV Test (CPT Code 86703), but only in conjunction with the prescription of Buprenorphine for the treatment of opiate addiction ● Hepatitis Panel (CPT Code 80074), but only in conjunction with the prescription of Buprenorphine for the treatment of opiate addiction ● Individual Counseling (CPT Code 90806) ● Group Counseling (CPT Code 90853) ● Mental Health Assessment by Non-Physician Professional (CPT Code H0031) ● Alcohol and substance abuse Services, Treatment Plan Development and Modification (CPT Code T007) 2. MMM Multi Health will have Providers trained and certified by the Substance Abuse and Mental Health Services Administration ("SAMHSA") to provide opiate addiction treatment. The training and certification of the Providers by SAMHSA may be evidenced with either (1) a copy of the letter issued by SAMHSA to the Provider certifying his/her training and certification or (2) a copy of the Controlled Substance Registration Certification issued by the Drug Enforcement Administration with the identification number assigned to the Provider by SAMHSA. Evidence of SAMHSA certification will be included in the Provider's Credentialing file maintained by MMM Multi Health.

	3. MMM Multi Health will establish and strengthen relationships (if needed, through memoranda of understanding) with ASSMCA, ADFAN, the Office of the Women's Advocate, and other government or nonprofit entities, in order to improve the delivery of Behavioral Health Services.
Special Coverage	1. The Special Coverage Benefit is designed to provide services for Enrollees with special healthcare needs caused by serious illness. 2. The physical and Behavioral Health Services, that the autism population needs to access through specialists such as gastroenterologists, neurologists, allergists, and dentists, will be offered through Special Coverage. The Uniform Guide for Special Coverage 3. Services provided under Special Coverage will be subject to Prior Authorization by the *MI Salud*. 4. Special Coverage will include in its scope the following services, provided, however, that an Enrollee will be entitled only to those services Medically Necessary to treat the condition that qualified the Enrollee for Special Coverage: ● 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. A) The following procedures and diagnostic tests, when Medically Necessary (Prior Authorization required): 1. Computerized Tomography 2. Magnetic resonance test. 3. Cardiac catheters; 4. Holter test; 5. Doppler test; 6. Stress tests; 7. Lithotripsy; 8. Electromyography; 9. Single-photon Emission Computed Topography ("SPECT") test; 10. Orthopantogram ("OPG") test; 11. Impedance Plesthymography. 12. Other neurological, cerebrovascular, and cardiovascular procedures, invasive and noninvasive; 13. Nuclear imaging; 14. Diagnostic endoscopies; and 15. Genetic studies; B) 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 or physician after MMM Multi Health Prior Authorization. C) General anesthesia, including for dental treatment of special-needs children. D) Hyperbaric Chamber. E) 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. A) Treatment for the following conditions after confirmed laboratory results and established diagnosis: 1. 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). 2. Tuberculosis; 3. Leprosy; 4. Lupus; 5. Cystic Fibrosis; 6. Cancer; 7. Hemophilia 8. Special children conditions, including the prescribed conditions in the Special Needs Children Diagnostic Manual Codes (see Attachment 13), except: asthma and diabetes, which are included in the Disease

	Management program, Psychiatric Disorders, Intellectual disabilities. 9. Scleroderma 10. Multiple Sclerosis 11. Conditions resulting from self-inflicted damage or as a result of a felony or negligence by an Enrollee. 12. Chronic renal disease in levels three (3), four (4) and five (5) (Levels 1 and 2 are included in the Basic Coverage); these levels of renal disease are defined as follows; a. Level 3 – GFR (Glomerular Filtration – ml/min. per 1.73m² per corporal surface area) between 30 and 59, a moderate decrease in kidney function. b. Level 4 - GFR between 15 and 29, a severe decrease in kidney function. c. Level 5 – GFR under 15, renal failure that will probably require either dialysis or a kidney transplant. 5. Required medication for the outpatient treatment of Tuberculosis and Leprosy is included under Special Coverage. Medication for the outpatient treatment or hospitalization for AIDS-diagnosed Enrollees or HIV-positive Enrollees is also included, with the exception of Protease inhibitors, which will be provided by CPTET Centers.
Pharmacy Benefit	Pharmacy Services 1. Provide pharmacy services under MMM Multi Health, including the following: a) All costs related to prescribed medications for Enrollees, excluding the Enrollee's Co-Payment where applicable;

	b) Drugs on the Preferred Drug List (PDL). c) Drugs included on the Master Formulary, but not in the PDL. d) In some instances, through the exceptions process, drugs that are not included on either the PDL or the Master Formulary 2. MMM Multi Health may not impose restrictions on available prescription drugs beyond those stated in the PDL, Master Formulary, or any other drug formulary approved by ASES. Role of Pharmacy Benefit Manager 1. Pharmacy services are administered primarily by a Pharmacy Benefit Manager ("PBM") under contract with ASES. MMM Multi Health will work with the PBM as well as the Pharmacy Program Administrator ("PPA") selected by ASES in order to ensure the successful provision of pharmacy services. 2. Among other measures, to enhance cooperation with the PBM, the *MI Salud* will: a) Work with the PBM to improve Information flow and to develop protocols for Information-sharing. b) Establish, in consultation with the PBM, the procedures to transfer funds for the payment of Claims to the pharmacy network according to the payments cycle specified by the PBM. c) Coordinate with the PBM to establish customer service protocols concerning pharmacy services. d) Collaborate with ASES to facilitate a smooth transition, since the PBM, PPA, and rebate contracts will take effect after April 1, 2015, which is the Implementation Date of this Contract.

	Medication for Treatment of HIV / AIDS 1. The following HIV/AIDS medications are excluded from the ASES PDL: Viread®, Emtriva®, Truvada®, Fuzeon®, Atripla®, Epzicom®, Selzentry®, Intelence®, Isentress®, Edurant®, Complera®, and Stribild®. 2. Because of an agreement between the Health Department and ASES, Enrollees diagnosed with HIV/AIDS may access the medications listed above through Health Department clinics. MMM Multi Health is not At Risk for the coverage of these medications. 3. Inform Providers to refer Enrollees for whom these medications are Medically Necessary to CPTET (*Centros de Prevención y Tratamiento de Enfermedades Transmisibles*) Centers or community-based organizations, where the Enrollee may be screened to determine whether the Enrollee is eligible for the AIDS Drug Assistance Program (ADAP). 4. A list of CPTET Centers and community-based organizations that administer these medications is included as Attachment [4] to this Contract. Formulary Management Program 1. Select two (2) members of its staff to serve on a cross-functional committee, the Pharmacy Benefit Financial Committee, tasked with rebate maximization. The Committee will evaluate recommendations regarding the PDL, from the P&T Committee and the PPA, and will ultimately develop and review the PDL from time to time under the direction of ASES and the PPA.

	2. MMM Multi Health will select a member of its staff to serve on a cross-functional subcommittee tasked with rebate maximization. The subcommittee will take recommendations on the PDL from the P&T Committee and will ultimately create and manage the PDL.
	Administrative Functions
Care Management	The *MI Salud* will be responsible for the Care Management of Enrollees who demonstrates the greatest need, including those who have catastrophic, high-cost, or high-risk conditions and /or who require intensive assistance to ensure integration of physical and Behavioral Health needs. Enrollees who present with the following conditions will be offered Care Management and may elect to opt out of the program: a. Enrollees identified with special healthcare needs and who qualify for Special Coverage b. Enrollees diagnosed with a Serious Mental Illness or a Serious Emotional Disability ("SMI/SED"); c. Enrollees identified as high-cost and/or high-risk; d. Enrollees who have accessed the emergency room seven (7) or more times within twelve (12) months. The *MI Salud* Care Management system will emphasize prevention, continuity of care, and coordination of care. The system will advocate for, and link Enrollees to, services as necessary across Providers and settings. Care Management functions include: a. Assignment of a specific Care Manager to each enrollee qualified for Care Management; b. Management of Enrollee to Care Manager ratios that have been reviewed and approved by ASES.

	c. Identification of Enrollees who have or may have chronic or severe Behavioral Health needs, including through use of the screening tools M-CHAT for the detection of Autism, ASQ, ASQ-SE, Conner's Scale (ADHD screen), DAST-10, GAD, and PC-PTSD, and other tools available for diagnosis of Behavioral Health disorders. d. Assessment of an Enrollee's physical and Behavioral Health needs utilizing a standardized needs assessment within thirty (30) Calendar Days of Referral to Care Management that has been reviewed and given written approval by ASES. e. Development of a plan of care within sixty (60) Calendar Days of the needs assessment. f. Referrals and assistance to ensure timely Access to Providers. g. Coordination of care actively linking the Enrollee to Providers, medical services, residential, social, and other support services where deemed necessary. h. Monitoring of the Enrollees needs for assistance and additional services via face-to-face or telephonic contact at least quarterly (based on high- or low-risk). i. Continuity and transition of care. j. Follow-up and documentation. MMM Multi Health will develop policies and procedures for Care Management that include, at a minimum, the following elements: a. The provision of an individual needs assessment and diagnostic assessment. b. The development of an individual treatment plan, as necessary, based on the needs assessment.

	c. The establishment of treatment objectives. d. The monitoring of outcomes. e. A process to ensure that treatment plans are revised as necessary. f. A strategy to ensure that all Enrollees or Authorized Representatives, as well as any specialists caring for the Enrollee, are involved in a treatment planning process coordinated by the PCP. g. Procedures and criteria for making Referrals to specialists and subspecialists. h. Procedures and criteria for maintaining care plans and Referral services when the Enrollee changes Providers. i. Capacity to implement, when indicated, Care Management functions such as individual needs assessment, including establishing treatment objectives, treatment follow-up, monitoring of outcomes, or revision of the treatment plan; j. Process for referring Enrollees into Disease Management. k. These procedures must be designed to include consultation and coordination with Enrollee's PCP. l. MMM Multi Health will submit its Care Management policies and procedures to ASES for review and prior written approval.
Disease Management	1. MMM Multi Health will develop a Disease Management program for individuals with Chronic Conditions, including the following: a. Asthma; b. Depression; c. Diabetes Type 1 or 2; d. Congestive heart failure;

	e. Hypertension; f. Obesity; g. Chronic renal disease, levels 1 and 2 h. Other conditions as determined necessary by ASES. 2. MMM Multi Health will identify and categorize Enrollees using clinical protocols of the Health Department and ASSMCA, and the protocols developed by the Committee for Management of Conditions established by ASES. 3. MMM Multi Health will report quarterly on the number of Enrollees diagnosed with each of these conditions. 4. MMM Multi Health will develop Disease Management policies and procedures detailing its program, including how Enrollees are identified for and referred to Disease Management, Disease Management program descriptions, and monitoring and evaluation activities. 5. MMM Multi Health will submit its Disease Management policies and procedures to ASES for review and prior written approval according to the timeframe specified in Attachment [12] to this Contract. 6. MMM Multi Health will require in its policies and procedures that an individualized treatment plan be developed for each Enrollee who receives Disease Management services. The policies and procedures will include a strategy to ensure that all Enrollees or Authorized Representatives, as well as any specialists caring for the Enrollee, are involved in a treatment planning process coordinated by the PCP.
Wellness Plan	1. In order to advance the goals of strengthening Preventive Services, providing integrated physical, Behavioral Health, and dental services to all Eligible Persons, and educating

	Enrollees on health and wellness, MMM Multi Health will develop a Wellness Plan. 2. The Wellness Plan will include a strategy for coordination with government agencies of Puerto Rico integral to disease prevention efforts and education efforts, including the Health Department, the Department of the Family, and the Department of Education. The Wellness Plan will incorporate strategies to reach all Enrollees including those living in remote areas of MMM Multi Health's Service Regions. 3. The Wellness Plan will present strategies for encouraging Enrollees to: a. Seek an annual health checkup; b. Appropriately use the services of the *MI Salud*, including *MI Salud* Service Line. c. Seek women's health screenings including mammograms, pap smears, cervical screenings, and tests for sexually transmitted infections; d. Maintain a healthy body weight, through good nutrition and exercise; e. Seek an annual dental exam; f. Seek Behavioral Health screening; g. Attend to the medical and developmental needs of children and adolescents, including vaccinations. h. Receive education regarding the diagnosis and treatment of high-risk diagnoses including: 1. Depression; 2. Schizophrenia; 3. Bipolar disorders;

	4. Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder; 5. Substance abuse. 6. Anxiety disorders. i. MMM Multi Health will ensure that its Wellness Plan reaches, at a minimum, eighty-five percent (85%) of MMM Multi Health Enrollees. To achieve the eighty-five (85%) goal, MMM Multi Health will, in compliance with the requirements of HIPAA and the rules and regulations thereunder, utilize wellness advertisements, campaigns and/or seminars, including without limitation, health fairs, educational activities, visits to enrollees, and others.

5. Pharmacy

MMM Multi Health pharmacy department working in close coordination with the Pharmacy Benefit Manager (PBM) contracted by ASES to ensure that pharmacy services provided to their beneficiaries enrolled, based on standards highest quality, and that maintenance operations are in compliance with ASES requirements, CMS and any other applicable law or statute. To facilitate claims processing, MMM Multi Health sent to PBM daily eligibility data of beneficiaries.

The PBM is the entity contracted by ASES to handle the Pharmacy Benefit Program from MMM Multi Health, and is responsible for administering claims processing, facilitate the formulary management process, review and analyze the use of drugs, and manage the pharmacy network. MMM Multi Health works with the PBM as well, as with the Pharmacy Program Administrator (PPA). Both entities are selected by ASES, in order to ensure quality in providing pharmacy services. MMM Multi Health is obliged to accept the terms and conditions of the contract ASES granted the PBM and the PPA.

MMM Multi Health Clinical Pharmacy operations are carried out by a team of experienced professionals in the *MI Salud* composed of doctors in pharmacy and

certified pharmacy technicians highly trained to handle clinical interventions and to effectively establish communication with providers involved in charge of health care. The MMM Multi Health Pharmacy Operations team consists on the Clinical Unit and the Rejects Monitoring Unit

- Clinical Pharmacy Unit: responsible for the evaluation and resolution of received coverage determination requests.
- Rejects Monitoring Unit: performs the rejected claims monitoring process, to ensure that claims are not inappropriately rejected at the point of service, based on the *MI Salud* Formulary of Covered Medications (FMC by its Spanish acronym) and Protocols approved by ASES.

MMM Multi Health has a pharmacy drug utilization specialist dedicated to continuously review the Drug Utilization in order to coordinate with the PBM topics to be discussed with medical groups in educational activities through the PBM Academic Detailing program and MMM Multi Health visits to physician offices by its Clinical Practice Consultants (CPC). In these activities topics as polypharmacy and its implications and appropriate use of medicines are discussed. The drug utilization analysis also allow us to establish programs for the optimum treatment of patients conditions such as asthma, depression, diabetes and cholesterol among others, and to identify opportunities for establishing a discipline that allows us to offer our beneficiaries a Pharmacy Benefit Program that assures the quality and effectiveness of the drug therapy.

5.1. Pharmacy Covered Services

MMM Multi Health provides pharmacy services, including the following:

- All costs related to prescribed medications for Enrollees, excluding the enrollee's Copayment where applicable.
- Drugs on the Formulary of Covered Medications of the *MI Salud* (FMC, for its Spanish acronym) Drugs on the ASES Formulary that are not included in the FMC, but that have been evaluated and approved by ASES

Pharmacy and Therapeutic Committee (P&T) to be covered only through an exception process if certain clinical criteria are met.

- An exception request may be used for (i) Non-FMC drugs, or (ii) medications covered with utilization management edits under the FMC (such as step therapy, quantity or dose limits, or prior authorization requirements), when the prescriber wishes to bypass such restrictions. In those cases, MMM Multi Health must suggest that the prescriber first consider using drugs listed on the List of Medications by Exception (LME). If the prescriber demonstrates that none of the alternatives in the LME are clinically viable for the patient, then MMM Multi Health can consider approving coverage for drugs outside of the LME.
- If a drug outside of the FMC but inside the LME is prescribed, the drug will be managed as an exception request. All evaluations will have to evidence medical necessity and will have to be justified by the patients prescribing physician.
    - Prescribing physician will have to evidence contraindication for all for the alternatives within the FMC. The MCO will request a copy of the patient's medical history that validates the presented contraindication to all the FMC alternatives or physician should provide scientific evidence that substantiates that the utilization of one of the FMC alternatives would represent serious health repercussion to the patients' health.
    - Patient has experienced serious adverse reactions to all the alternatives of the FMC.
    - Patient has failed experienced therapeutic failure to all the alternatives in the FMC due to ineffectiveness of therapy or because it has severely worsen the patient's condition or illness.
- If a drug outside of the FMC and the LME is prescribed, the drug will be managed as an exception request. All evaluations will have to evidence

medical necessity and will have to be justified by the patients prescribing physician.

- Prescribing physician will have to evidence contraindication for all for the alternatives within the FMC and the LME. The MCO will request a copy of the patient's medical history that validates the presented contraindication to all the FMC and LME alternatives or physician should provide scientific evidence that substantiates that the utilization of one of the FMC and LME alternatives would represent serious health repercussion to the patients' health.
- Patient has experienced serious adverse reactions to all the alternatives of the FMC and the LME.
- Patient has failed experienced therapeutic failure to all the alternatives in the FMC and the LME due to ineffectiveness of therapy or because it has severely worsen the patient's condition or illness.

- MMM Multi Health should not impose restrictions on available prescription drugs beyond those stated in the FMC, LME or any other drug formulary approved by ASES.

5.2 Drugs excluded from pharmacy benefit services

- Drugs used to promote fertility, drugs used for cosmetic purposes or hair growth, Drugs used for symptomatic relief of cough and colds, most prescription vitamins and mineral products, non-prescription drugs or over the counter medications unless specifically included in the GHIP coverage
- Drugs which the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Drugs that are not prescribed for a medically accepted indication.

- Drugs for the treatment of Hepatitis C, these drugs are covered under non-Medicaid government health programs.
- Medications delivered directly to Enrollees 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 injections.

5.3 Relevant information to our providers

Prescriptions ordered under the Pharmacy Benefit services are subject to the following utilization controls:

- Some prescription drugs may be subject to prior authorization, which will be implemented and managed in its majority by MMM Multi Health the or by the PBM, according to policies and procedures established by the ASES Pharmacy and Therapeutic Committee (P&T) and decided upon in consultation with MMM Multi Health, when applicable.
- MMM Multi Health ensures that Prior Authorizations for pharmacy services are provided for the Enrollees in the following timeframes, including outside of normal business hours.
    - The decision whether to grant a Prior Authorization for a prescription must not exceed twenty four (24) hours from the time of the Enrollee's Service Authorization Request is received for any Covered Service. However, incomplete requests that do not include all of the standard information will be returned or pharmacy receiving the request to the prescribing physician or health care provider by fax or e-mail, for completion as soon as practicable, and within 24 hours.
    - The minimum standard information required for the evaluation of drug is the following:
        - Prescription
        - A supporting statement setting forth the clinical justification and medical necessity for the prescribed medication

- Expected duration, as required by the protocol for the medication.
- For controlled drugs the request (written prescription) must comply with, but not limited to, the following Pharmacy Law Requirements:
    - Prescription date
    - Patient's full name and address
    - Patient's age
    - Prescriber's full name, address, phone number, license number
    - Drug name, dosage form, strength and quantity
    - Drug's direction for use
    - Prescriber's DEA registration number if a controlled drug is prescribed

In an emergency situation, MMM Multi Health must authorize at least a 72 hour supply of the requested drug as long as the drug is not statutorily excluded. An emergency situation means that a lack of access to the requested drug may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. MMM Multi Health must evaluate the request to determine based on the information presented whether the patient is in an emergency situation. Such evaluations must be conducted using appropriate clinical judgment, and shall not be used to deny a 72 hour emergency supply of the requested drug if an emergency situation does in fact exist.

- Prescriptions written by a Provider who is outside the Preferred Provider Network (PPN) may be filled only upon a Countersignature from the Enrollee's PCP, or another assigned PCP from the Primary Medical Group (PMG) in case of absence or unavailability of the Enrollee's PCP. A Countersignature request made to the PCP will be acted upon within three (3) Calendar Days of the request of the prescribing Provider, if the Enrollee's health is in danger, within twenty-four (24) hours. MMM Multi Health does not require a PCP Countersignature on prescriptions written by a Provider within the PPN.
- MMM Multi Health uses bioequivalent drugs approved by the Food and Drug Administration ("FDA"), provided they are classified as "AB" and authorized by regulations, branded medications with a bioequivalent generic available will be covered through the exception process in compliance with conditions established by this process. Nonetheless, MMM Multi Health will not refuse to cover a drug solely because the bioequivalent drug is unavailable; nor will they impose an additional payment on the Enrollee because the bioequivalent is unavailable.

5.3.1 MMM Multi Health observe the following timeframe limits with respect to prescribed drugs:

- Medication for critical conditions will be covered for a maximum of thirty (30) Calendar Days and for additional time, where Medically Necessary.
- Medication for Chronic Conditions or severe Behavioral Health conditions will be covered for a maximum of thirty (30) Calendar Days, except at the beginning of therapy where, upon a Provider's recommendation, a minimum of fifteen (15) Calendar Days will be prescribed in order to reevaluate compliance and tolerance. Under a doctor's orders, a prescription may be refilled up to five (5) times.

- For maintenance drugs that require Prior Authorization, the Prior Authorization will be effective for the time specified by the physician or for six (6) months, unless there are contra-indications or side effects.
- The prescribing Provider will re-evaluate pharmacotherapy as to compliance, tolerance, and dosage within ninety (90) Calendar Days of having prescribed a maintenance drug. Dosage changes will not require Prior Authorization. Changes in the drug used may require Prior Authorization.

5.3.2 Special considerations, including cooperation with Puerto Rico governmental entities other than ASES, govern coverage of medications for the following conditions:

- Medications for Treatment of HIV/AIDS. The following HIV/AIDS medications are excluded from the ASES PDL: Viread®, Emtriva®, Truvada®, Fuzeon®, Atripla®, Epzicom®, Selzentry®, Intelence®, Isentress®, Edurant®, Complera®, and Stribild®. Because of an agreement between the Health Department and ASES, Enrollees diagnosed with HIV/AIDS may access the medications listed above through Health Department clinics.
- Providers must refer Enrollees for whom these medications are medically necessary to the *Centros para el Control de Enfermedades Trasmisibles* (CPTET by its Spanish acronym) or community-based organizations, where the Enrollee may be screened to determine whether the Enrollee is eligible for the AIDS Drug Assistance Program (ADAP).
- Some contraceptive medications are provided by MMM Multi Health, but only for the treatment of menstrual dysfunction and other hormonal conditions. Contraceptives prescribed for family planning purposes will be provided through PREVEN clinics.

- Medications prescribed for children with special health needs that have a chronic condition:
    - Will be covered for thirty (30) calendar days, and if necessary up to five (5) refills of the original prescription, according to medical opinion of a certified Provider.
    - When medically necessary, additional prescriptions will be covered.
- Prescription Drugs must be dispensed by a pharmacy under contract with the PBM that is duly authorized under the laws of Puerto Rico, and is freely selected by the Enrollee. The PBM maintains responsibility for ensuring that the pharmacy services network complies with the terms specified by ASES.
- Prescribed drugs must be dispensed according to the time period established by the Puerto Rico Pharmacy Law.

5.4 Formulary Management Program

5.4.1 What is the "*Formulario en Cubierta de MI Salud*" (FMC) for its Spanish acronym)?

In compliance with federal regulations from the Center of Medicare and Medicaid Services (CMS), the list of medications covered by the *MI Salud*), previously known as PDL was reviewed and now medications were classified as Preferred and Non Preferred. As a result of the review changes were made to modify requirements and to include or exclude some covered medications. The final product is a revised medications formulary that is known as *Formulario de Medicamentos* en Cubierta de MI Salud (FMC). This Formulary was effective on July 1, 2016.

5.4.2 How is the GHIP Formulary of covered Medications created

MMM Multi Health has representation in the Pharmacy and Therapeutic Committee for the clinical evaluation of medications to be excluded or included in the FMC and ASES Drugs Formulary. All FMC changes are published in MMM Multi Health Web: www.multihealthpsg.com or in our InnovaMD Web www.innovamd.com

5.4.3 What includes the List of Medication by Exception (LME)?

List of medications that are not included in the FMC, but that have been evaluated and approved by ASES' Pharmacy and Therapeutics (P&T) Committee to be covered only through an exception process if certain clinical criteria are met. Covered outpatient drugs that are not included on the LME may still be covered under an Exception Request, unless statutorily excluded.

5.4.4 Can the FMC change?

Yes, The FMC changes from time to time. All FMC changes are published on our websites and Providers portal:

www.multihealthpsg.com

www.innovamd.com

5.5 Exception Request process

Physicians are encouraged to prescribe drugs on the *Formulario en Cubierta de MI Salud* whenever possible (FMC by its Spanish acronym).

- MMM Multi Health will cover drugs not included on the FMC but included in the LME, through the exception process:
    - If the drug prescribed is not part of the FMC but is included in the LME at the point of sale the pharmacy will receive the following reject message:
        - ***LME Drug: Exception request required. Validate other alternatives in FMC before proceeding.***
    - If after validation the pharmacy decides to proceed with the evaluation of the prescribed drug, it must contain the following standard information:
        - Prescription
        - A supporting statement setting forth the clinical justification and medical necessity for the prescribed medication
        - Expected duration, as required by the protocol for the medication.
    - The prescribing physician must provide a written supporting statement based on clinical evidence that the requested prescription drug is

medically necessary to treat the member's disease or medical condition. The physician's supporting statement must indicate that the requested prescription drug should be approved based on:

- The drug does not have any bioequivalent on the market; and
- The drug is clinically indicated because of:
- Contra-indication with all drugs that are in the FMC that the Enrollee is already taking, and scientific literature's indication of the possibility of serious adverse health effects related to the taking the drug;
- History of adverse reaction by the Enrollee to some drugs that are on the FMC;
- Therapeutic failure of all available alternatives on the FMC
- If the drug prescribed is not part of the FMC or the LME at the point of sale the pharmacy will receive the following reject message:
    - ***Non- FMC/LME Drug: Exception request required. Validate other alternatives in FMC/LME before proceeding.***
- If after validation the pharmacy decides to proceed with the evaluation of the prescribed drug, it must contain the following standard information:
    - Prescription
    - A supporting statement setting forth the clinical justification and medical necessity for the prescribed medication
    - Expected duration, as required by the protocol for the medication.
- The prescribing physician must provide a written supporting statement based on clinical evidence that the requested prescription drug is medically necessary to treat the member's disease or medical condition. The physician's supporting statement must indicate that the requested prescription drug should be approved based on:

- The drug does not have any bioequivalent on the market; and
- The drug is clinically indicated because of:
- Contra-indication with all drugs that are in the FMC and the LME that the Enrollee is already taking, and scientific literature's indication of the possibility of serious adverse health effects related to the taking the drug;
- History of adverse reaction by the Enrollee to some drugs that are on the FMC and LME;
- Therapeutic failure of all available alternatives on the FMC and LME

MMM Multi Health shall cover a drug that is not included on the FMC or LME, provided that the drug is not in an experimental stage and that the drug has been approved by the FDA for the treatment of a specific condition

5.6 Fraud Investigations

The Pharmacy Services Department is committed to support the comprehensive Corporate Compliance Plan to detect, correct and prevent fraud, waste and abuse related to the pharmacy benefit. Ensures the notification to MMM Multi Health, PBM and ASES Compliance Departments, of cases that may represent fraud, waste or abuse of the Pharmacy Benefit and are identified through, employees, participating pharmacies, provider and beneficiaries. Conduct Claims Audits and Utilization analysis to identify any pattern that may represent FWA:

- Controlled substances utilization,
  - Doctor/Pharmacy Shopping (prescriptions of controlled substance medications, prescribed by multiple physicians and/or dispensed by multiple pharmacies for the same beneficiary)
- Brand versus generic dispensing,

5.7 Pharmacy Department Contact Information

Pharmacy Clinical Call Center (Prior Authorizations of Medications)	
Telephone Numbers	• 1-844-880-8820 (TOLL FREE) • 787-523-2829
Fax for Physical Health	• 1-844-997-9950 • 1-844-997-9960
Fax for Mental Health	• 1-844-990-9940
Fax for J Codes	• 787-300-4897
	Internet:
MMM Multi Health	www.multihealthpsg.com
InnovaMD	www.innovaMD.com

6. Quality Improvement and Performance Program

The Quality Improvement and Performance Program provides a structure for the delivery of quality care to all enrollees with the primary goal of improving health status or, in instances where the enrollee's health is not amenable to improvement, maintaining the enrollee's current health status by implementing measures to prevent any further deterioration of his or her health status.

Objectives:

1) Measurable compliance and detailed goal setting for quality improvement activities and performance improvement projects.
2) Continuous quality assessment and probing to promote tangible and required performance improvement.
3) Targeted efforts to minimize encountered barriers that impede full continuum of care, in order to drive improved healthcare outcomes for our population.
4) Maintain partnerships with stakeholders that will maximize the plan's capability to provide adequate healthcare services and benefits.

6.1 Quality Assessment Performance Improvement Program

The Quality Assessment Performance Improvement (QAPI) Program was established specifying quality measurements and performance improvement activities based on clinically sound, nationally developed and accepted criteria standards, and taking into consideration the latest available research in the area of quality assurance. Some of the elements that comprise the QAPI Program will be described in the subsequent sections.

6.2 Advisory Board

The Advisory Board is an open discussion forum available to representatives of the Government Health Plan, such as, enrollees, family members, providers, among others, from MMM Multi Health. The stated forum convenes on a quarterly basis. The participants of the Advisory Board shall contribute in the resolution of situations related to the healthcare delivery system, the quality of covered services (for example, physical health and mental health) enrollees rights and responsibilities, resolution of enrollees grievances and appeals, and needs of the groups represented by the participants of the Advisory Board pertaining to the Puerto Rico Medicaid program. MMM Multi Health will promote an equitable representation of the Advisory Board's participants in terms of race, gender, special populations, and Puerto Rico's geographic areas in the Government Health Plan. MMM Multi Health will maintain a record of the attendees and of the activities discussed during the Advisory Board meetings. The Advisory Board's participants shall actively contribute to the discussions; none shall dominate proceedings, in order to foster an inclusive and participative environment.

6.3 Performance Improvement Projects

The Performance Improvements Projects (PIPs) are consistent with the statutes of the Federal and State government, the regulations and the requirements of Quality Assessment and Performance Improvement Program pursuant to 42 CFR 438.330. The main purpose of the PIPs is to achieve a favorable and positive effect on health outcomes and satisfaction of the enrollee. The projects are designed to achieve,

through measurements and continuous interventions, significant improvements in clinical care and administrative areas.

6.3.1 Steps for designing a program for the improvement of performance:

1) Select the need according to the current and desired situation with the purpose of achieving a measurable benefit to the member.
2) Set goals and objectives that are specific, measurable, achievable, results-oriented and time based for implementation.
3) Create quality indicators that allow the tracking of performance and improvements or select standardized indicators of performance such as HEDIS®.
4) Identify the population of the project through a probabilistic sample, non-probabilistic sample or selection of the universe.
5) Execute interventions designed to achieve the improvement in quality.
6) Collect and analyze appropriately, accurate and valid data that demonstrate the improvement in quality.
7) Evaluate the effectiveness of interventions.

For more information about the protocols of the External Quality Review Organization (EQRO) you may access: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

6.4 ER Quality Initiative Program

MMM Multi Health designed an ER Quality Initiative Program to proactively identify high users of emergency services for non-emergency situations; it includes strategies which allow early interventions, in order to ensure appropriate utilization of services and resources.

The ER Quality Initiative Program includes the following components:

1) A system for tracking, monitoring, and reporting high users of ER services for non-emergency situations.
2) Criteria for defining non-emergency situations.

3) Educational components to inform the enrollees about the proper use of ER services and how to access ER services; to inform the Primary Care Physicians (PCPs) about identifying high users or potential high users of ER services and how to refer them to the program.
4) Protocols for the identification of high users of inappropriate ER services, for referring them to Care Management for needs assessments and possible identification of other more appropriate services and resources.
5) Process for assuring the provision of physical and behavioral health services in an appropriate setting upon identification of the need.
6) Processes to evaluate the ER Quality Initiative Program effectiveness, identify areas of opportunities, and modify the program, as needed, in order to improve service utilization.

6.5 Health Care Improvement Program

The Health Care Improvement Program, as required by ASES, evaluates the following four (4) categories of performance indicators:

1) High Cost Conditions Initiative
2) Chronic Conditions Initiative
3) Healthy People Initiative
4) Emergency Room High Utilizers Initiative

6.5.1 Below a brief description of each category and respective metrics:

<table>
<tr><td rowspan="4">High Cost Conditions Initiative</td><td>Focuses on those enrollees with a high cost condition as identified by ASES. The metrics are applied to the general population as well as CHIP participants.</td></tr>
<tr><td>GENERAL POPULATION</td></tr>
<tr><td>● Cancer
● End-stage Renal Disease
● Multiple Sclerosis
● Rheumatoid Arthritis</td></tr>
<tr><td>CHIP CONDITIONS</td></tr>
</table>

	● Cancer ● Children and Youth with Special Health Care Needs ● Hemophilia ● Autism
Chronic Conditions Initiative	Focuses on improving the health conditions of enrollees identified as having a specific chronic condition and reducing preventable health complications
	General Population
	● Diabetes ● Asthma ● Severe Heart Failure ● Hypertension ● Chronic Obstructive Pulmonary Disease ● Chronic Depression ● Substance Use Disorders ● Serious Mental Illness other than Depression
	CHIP POPULATION
	● Diabetes ● Asthma ● Attention-Deficit / Hyperactivity Disorder
Healthy People Initiative	Focuses on preventive screening for enrollees including populations with high cost and/or chronic conditions.
	HEALTHY PEOPLE
	● Adult BMI Assessment – (ABA) ● Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents – (WCC) ● Childhood Immunization Status – (CIS) ● Breast Cancer Screening – (BCS)

	● Cervical Cancer Screening – (CCS) ● Chlamydia Screening in Women – (CHL) ● Colorectal Cancer Screening - (COL) ● Antidepressant Medication Management – (AMM) ● Diabetes Screening for People with Schizophrenia of Bipolar Disorder who are using Antipsychotic Medications – (SSD) ● Follow-Up after Hospitalization for Mental Illness – (FUH) ● Appropriate Treatment for Children with Upper Respiratory Infection – (URI)
	ACCESS / AVAILABILITY OF CARE
	● Adult's Access to Preventive / Ambulatory Health Services – (AAP) ● Children and Adolescents' Access to Primary Care Practitioners – (CAP) ● Annual Dental Visit – (ADV) ● Prenatal and Postpartum Care – (PPC)
	OTHER UTILIZATION
	● Frequency of Ongoing Prenatal Care – (FPC) ● Well-Child Visits in the First 15 Month of Life – (W15) ● Adolescent Well-Care Visits – (AWC) ● Frequency of Selected Procedures – (FSP) ● Ambulatory Care – (AMB) ● Identification of Alcohol and Other Drug Services – (IAD) ● Mental Health Services Utilization – (MPT)

Emergency Room High Utilizers Initiative	Design to identify high users of emergency services for non-emergency situations and to allow for early intervention to ensure appropriate utilization of services and resources.

6.6 Provider and Enrollee Satisfaction Surveys

Satisfaction surveys are performed annually. The satisfaction surveys for Enrollees are the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Experience of Care and Health Outcomes (ECHO) survey instruments. As the satisfaction surveys for Enrollees, the Provider's satisfaction survey is performed by an independent entity, thus maintaining the required confidentiality. The results of the surveys are shared with ASES. Also, the results are available to the enrollees and providers, upon request. The results of the surveys are used to monitor the service delivery and quality, and to develop quality strategies.

6.7 External Quality Review

In compliance with Federal requirements at 42 CFR 438.358, ASES will contract with an External Quality Review Organization (EQRO) to conduct annual, external, independent reviews of the quality outcomes, timeliness of, and access to the covered services. Analytical activities to assess the quality of care and services provided to Enrollees and to identify areas of opportunities for the quality program must have been established and developed.

7. Administrative and Clinical Function

7.1 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

7.1.1 Purpose

To provide guidance to our contracted physicians on EPSDT service requirements and periodicity schedule in accordance with preventive health guidelines based on the American Academy of Pediatrics (AAP)/Bright Futures Standards of Care and the Department of Health Pediatric Service Guidelines 2018, and by contractual agreement between the *MI Salud* and MMM Multi Health. The scope also includes

the provision for providers EPSDT education with service requirements, compliance and surveillance of quality measures.

7.1.2. Scope

This policy applies to all MMM Multi Health Network Providers that provide routine care for Medicaid or CHIP eligible members less than 21 years of age.

7.1.3. Definitions

- Bright Futures

Bright Futures is a national health care promotion and disease prevention initiative that uses a developmentally based approach to address children's health care needs in the context of family and the Department of Health of Puerto Rico have adapted the Bright Futures periodicity schedule to help guide health care providers for pediatric preventive care. (Please see attached schedule).

- EPSDT - The EPSDT acronym stands for:
  - ✓ **E**arly: Identifying problems early, starting at birth
  - ✓ **P**eriodic: Checking children's health at periodic, age-appropriate intervals;
  - ✓ **S**creening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems based on approved guidelines.
  - ✓ **D**iagnosis: Performing diagnostic tests to follow up when a risk is identified,
  - ✓ **T**reatment: Control, correct or reduce health problems found.
- The EPSDT Program is the child health component of Medicaid.

Is designed to addresses physical, mental and developmental health needs. EPSDT is a mandatory set of services and benefits for all individuals under age 21 who are enrolled in Medicaid. All services must be directed to prevent, treat or ameliorate physical, mental or developmental problems or conditions offered by certified providers, in sufficient amount, duration and scope on basis of medical necessity. EPSDT focuses on continuum of care by: assessing health needs, providing

preventive screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow up. Its service includes screening, vision, hearing and dental services, as well as all other medically necessary mandatory and optional services listed in the *MI Salud* contract requirements, to correct or ameliorate defects and physical and mental illness and condition identified in an EPSDT periodical screening.

7.1.4 Responsibilities

7.1.4.1 Health Services Department:

- The Chief Medical Officer (CMO) is responsible for the medical activities of the medical directors and providers, while ensuring appropriate use of medical guidelines in the operations.
- The Vice President of Clinical Operations (VP) is ultimately responsible for the Care Management process along with strategic corporate goals.
- The Directors and Managers are responsible for the day-to-day operations and establishment of improvement plans as deemed appropriate.
- The Manager and Supervisor are responsible for supervising the staff and ensuring proper execution of the policy and procedure.
- The Care Management Staff is responsible for assisting Providers as detailed by the policy and procedure and maintaining case documentation available for audit processes.

7.1.4.2 Contracting & Provider Relations:

- The President is ultimately responsible for overseeing the Contracting process.
- The VP of Contracting Department is responsible for overseeing the Contracting processes.
- The Contracting Provider Network Performance and Compliance Director are responsible for the day-to-day operations of the monitoring of Network adequacy.

- The Contracting and Provider Relations Director is responsible for the day-to-day operations of the Contracting processes.
- The AVP of Contracting is responsible for overseeing the Contracting processes of Specialists, Hospital and Ancillary Services.
- The Contracting Representatives are responsible for negotiating contracts with Primary Care Providers, Specialist, Behavioral Health practitioners and organizational providers.

7.1.5. Procedures

7.1.5.1. Provider Contractual requirements

- Primary Medical Group (PMG) and the Primary Care Physician (PCP) must implement process to ensure age appropriate screening and care coordination when member needs are identified. Providers are encouraged to utilize the *MI Salud* approved standard screening tools and chats, and complete training in the use of those tools. The Manage Care Organization (MCO) will establish a monitoring process and implement interventions for those PMG and PCP that are not in compliance.
- Health Care Provider responsibilities for EPSDT per CMS and ASES requirements are stipulated in the Network Providers and Medical Group contracts.
- The Department of Health's Pediatric Preventive Services Guidelines 2018, along with required policy for follow-up for appointments and or missed appointments process are shared with PCP.
- PCP providers must ensure that member receive required health screening in compliance with the schedule. The service intervals represent the minimum requirements, and any services determined by the PCP to be medically necessary must be provided, regardless of the interval.

- Proper coding requirements to ensure accurate reporting are also provided.
- Requirements are documented in this policy as reference for Medical Management and the Provider & Contracting department.
- Contracts also stipulate that EPSDT services are provided without cost.
- Each Municipality in Puerto Rico has a variety of free transportation services available to assist members in getting to their medical appointments for non-emergency services. The Provider office can assist members contacting the local Municipal office. If such service is unavailable, PCP may refer these members to the Care Management Program for evaluation and coordination, as needed.

7.1.5.2. Following EPSDT and Department of Health Pediatric Preventive Services 2018 requirements, checkups and services must include:

- A comprehensive health and developmental history, including assessment of both physical, and mental, emotional and behavioral development, including substance abuse disorders;
- Measurements (height, weight, body mass index; including head circumference for infants);
- Early detection, referral and treatment for mental and substance use using age appropriate screening tools (MCHAT, ASQ, CRAFFT, PHQ-9 and other approved assessments);
- An assessment of nutritional status to assist EPSDT members whose health status may improve with nutrition intervention that may include:
    - Initial comprehensive nutritional evaluation as well as nutritional follow up and assistance up to complete 5 years old;
    - Providing the required formulary and assessments necessary for initiation in the WIC Program to those children that requires special nutritional and supplement assistance;

- Nutritional assessments provided by a contracted registered dietician, when ordered by the PCP;
- These assessments should be done as part of the EPSDT screenings specified in the EPSDT Periodicity Schedule and on inter-periodic basis as determined necessary by the PCP.

- A comprehensive unclothed physical exam;
- Immunizations according to the guidance issued by the Advisory Committee on Immunization Practices (ACIP). The vaccines themselves are provided and paid for by the Department of Health Immunization Program for the Medicaid and CHIP Eligible. The vaccine is provided and paid for by the Contractor for the Other Eligible Persons in the *MI Salud*. The MCO will cover the cost related to the vaccine administration, under the fee schedule established by ASES for EPSDT member until 18 years of age. The MCO will cover the cost related to the vaccine and the vaccine administration to all EPSDT members 19-20 years of age.
- Laboratory tests; provider must ensure that members receive required health screening in compliance with schedule. The service intervals represent minimum requirements, and any services determined by PCP to be medically necessary must be provided regardless of interval.
- Lead screening for the detection of the presence of lead toxicity. The screening shall consist of two (2) components: verbal risk assessment and lead blood screening. The verbal risk assessment must be completed at each EPSDT visit done at nine (9) months of age and at ages one (1), two (2), three (3), four (4), five (5) and seven (7) years of age. Regardless of risk, the PCP shall order blood lead screening test for all EPSDT-Eligible children at ages twelve (12) and twenty-four (24) months of age. If at the age 6 years there is no record of a previous blood test, a blood test should be ordered.

- PMG and PCP must implement protocols for: care coordination for members with elevated blood lead levels to ensure timely follow-up and retesting and coordination and transitioning of a child who has an elevated blood level to another specialist provider, as necessary.
- Health education is a required component of screening services and includes anticipatory guidance. Health education and counseling to parents/guardians as well as children are required and designed to assist in understanding what to expect in terms of the child's development, and to provide information about the benefits of healthy lifestyles, practices, and accident and disease prevention in the following topics:
    - Breast feeding
    - Car seat safety
    - Smoke free environment
    - Accidents and injury prevention
    - UV protection
    - Physical activity
    - Health diet
    - Prevention of STD's and HIV
    - Clinical oral exam
    - Tooth cavity risk assessment
    - Dental radiographic assessment
    - Prophylaxis and topical fluoride
    - Fluoride supplementation
- Periodical vision screening with diagnosis and treatment services for visual defects, including eyeglasses;
- Tuberculosis testing as applicable;

- Periodic hearing screening including diagnosis and treatment services including devices for communication augmentation and cochlear implants;
- Appropriate oral health screening, as soon as the eruption of the first tooth and no later than twelve (12) months, intended to maintain oral health and to identify oral pathology, including tooth decay and/or oral lesions, conducted by the primary care physician and dental specialists. Services will also include fluoride banish, dental emergency services for pain relief, infection treatment and tooth restoration. Providers must comply with the Preventive Dental Periodicity Schedule. Other dental services may be covered in accordance to the plan's benefit and medical necessity.
- Family Planning Services will be provided to sexually active adolescents on childbearing age. Those services include orientation and education on pregnancy and sexually transmitted diseases prevention. Access to contraception methods is available under the Family Planning Program established in all regions.
- Other services – Case management service is available through the Plan's Case Management Program where all children with special needs undergo a special registration according to the identified medical diagnosis. The registry will provide access to necessary care, without the need of a PCP referral from specialized providers, clinics, surgical and medical procedure, laboratories and all necessary tests as well as medication.
- Medical supplies, including diabetes test strips, when medically necessary, for children and adolescents under age 21.
- Organ transplant are not under the current benefits for enrollees under the *MI Salud* except for corneal, bone and skin transplant. When such services are necessary, coordination with the Department of Health is

done by the Plan's Care Management team to access them through the Catastrophic Funds. Those Catastrophic Funds are identified to cover services not currently under the scope of benefits of the *MI Salud* but that could be clinically necessary, such as organ transplants, services out of Puerto Rico including United States territory, medical equipment such as adapted car seats and nutritional supplements to complementary dietary restrictions for special conditions.

- EPSDT allows coverage for items or services which are medically necessary and are not otherwise covered by Medicaid. EPSDT Special Services may be preventive, diagnostic, treatment, or rehabilitative.
- Physicians should provide these services in a culturally and linguistically competent manner, taking into account cultural beliefs and/or language barriers or limitations, and ethnically diverse groups.

7.1.5.3 Provider Outreach and Education Regarding EPSDT

- Providers will be oriented on the following:
  - EPSDT Policies and Procedures;
  - The periodicity schedule and the depth and breadth of services;
  - EPSDT benefits, preventive and evidence base practices and services guidelines;
  - The importance of comprehensive preventive health and developmental history care visits that will include: medical history, physical exam, developmental measurements, preventive laboratories, autism and depression screening and tracking system to ensure compliance.
  - New enrollee under CHIP eligible children should be seen within the first 90 days in the ambulatory setting and within the first 24 hours in the hospital setting;
  - EPSDT member identification, outreach and tracking activities;

- Quality, measures and understanding and tracking HEDIS applicable parameters;
- That services are provided without cost, including referrals to WIC, Early Health Start and other Department of Health's Early Interventions Programs;
- Non-emergency transportation to promote access to needed preventive, diagnosis and treatment services is coordinated, if needed.

- Providers in the Plan are notified of the EPSDT program through the following strategies:
  - New Provider Kit for newly contracted providers with information regarding how the EPSDT Program works with the members.
  - *MI Salud* Provider Manual
  - *MI Salud* Provider Website
  - Medical Office Notes
  - Provider outreach visits by Provider Network Account Executives
  - Monthly report of children who are due for health screens and or immunizations.
- The Provider Network Account Executive will conduct orientation sessions for EPSDT providers and offer ongoing support regarding the administration of EPSDT preventive care, billing and claims processes for EPSDT, the required components of a complete EPSDT screening, and the importance of outreach and education to EPSDT eligible members and their families.

7.1.5.4 Appointment Scheduling and Tracking

- Utilizing their current appointment system, Providers are responsible for providing timely access to EPSDT services. Monthly reports to Providers will supplement the efforts in identifying members needing care and requiring appointments.

- Missed appointments must be tracked for rescheduling to ensure periodicity schedules are met.
- Particular priority should be given for initial health and screening visits for newly enrolled CHIP Eligible children within ninety (90) Calendar Days and within twenty-four (24) hours of birth to all newborns within the Hospital Setting.

7.1.5.5 Provider Compliance

- Provider compliance will be monitored through:
  - PCP reports on members needing or past due for EPSDT Services;
  - Random EPSDT Claims Audits
  - Medical records audits
  - CMS-416 report requirements
- These EPSDT elements are part of the physician incentive program.

7.2. Prenatal Program

7.2.1 Prenatal Program Purpose and Scope

Our Prenatal Program has been developed to address overarching Maternal & Child Health concerns. The Prenatal Program will address a wide range of conditions, risk factors, health behaviors, and health system determinants that can affect the health, wellness, and quality of life of women and their children. Although slight progress has been achieved, Puerto Rico's rate of premature births continues to be unacceptably high. Low birth weight and elevated elective cesarean sections are also of concern. The main goal is to emphasize prevention, continuity of care, and coordination of care at all times in their path to health or recovery. Program standards were developed according to ASES contractual requirements, American College of Obstetricians and Gynecologists (ACOG) guidelines for pre and postnatal care, as well as other national guidelines for obstetrics practice for Medicaid enrollees.

7.2.2 Program Enrollment

Per ASES Contractual requirements, all pregnant women will be included in Special Obstetrical (OB) Coverage. The PCP or OB/Gyn may refer an eligible enrollee by utilizing the appropriate electronic tools applying the OB Special Coverage criteria.

Received referrals will be routed to the clinical management software platform for review:

- Cases can also be identified when an enrollee is required to obtain a preauthorization for a specific set of clinical services, prescription drugs or procedures as requested by the PCP or Specialist.
- Upon receipt of referral, Case Management Nurses are alerted that a new case is ready for review.
- Case Management nurses assigned to the Special OB Coverage Program will conduct an eligibility criteria review to confirm if the meets the clinical criteria for admission to the program.
- In the event that the referral does not meet with any of the required criteria, a denial letter will be sent to the enrollee and to the PCP indicating reasons for denial.
- If the referral meets all criteria, the enrollee will be registered in the program within 72 hours. Approval letters will be sent to the Provider and Enrollee for appropriate notification.
- Coverage will be provided retroactively to the Estimated Date of Conception, as determined by the Physician.
- Enrollee eligibility will be extended if eligibility review period falls within the 2nd or 3rd trimesters.
- Registered enrollees will be referred to the Prenatal Wellness & Care Management Program for interventions based on initial stratification, such as age, medical history documented by the Ob/Gyn and current status of the disease or conditions.
- Any pregnant *MI Salud* enrollee who visits the Ob/Gyn for prenatal care should begin receiving care as quickly as possible, preferably the same day.

- ❖ The pregnant enrollee must be referred to the Special OB Coverage if not currently included.
- ❖ One hundred percent (100%) of enrollees included in the Special OB Coverage will be provided with an educational packet on the importance of pre and post-natal care as well as EPSDT requirements for their child.

7.2.3 Prenatal and Postpartum Services

All enrollees enrolled in the Special OB Coverage are guaranteed access to contracted Ob/Gyms for their pre and postnatal healthcare services. Physicians who specialize in Obstetrics and Gynecology shall provide comprehensive prenatal care services in accordance with generally accepted standards of professional practices, as outlined by the AAP and ACOG.

7.2.3.1 Prenatal diagnostic and treatment services shall include but not be limited to the following:

- o Comprehensive assessment - An initial comprehensive assessment including history, review of systems, and physical examination.
- o Standard and special laboratory tests - Based on AAP/ACOG recommendations, standard and special laboratory tests and procedures should be performed at the recommended gestational age.

Pregnant women with medical, obstetrical or psychosocial problems may require more frequent visits or a referral to specialized perinatal services. This need is best determined by the prenatal care provider considering the individual needs of the woman, nature and severity of her problems, and her care and treatment plan. Of particular importance are pregnant women that meet criteria for 17-P, to help reduce her probabilities of having a repeat preterm delivery gestation.

Given the correlation between poor oral health and pregnancy outcomes, the OB/Gym shall conduct an assessment of the woman's oral healthcare needs during the first prenatal care visit. Pregnant women identified as having a current oral health problem should be referred to a dentist as soon as possible.

Pregnant women should have a dental visit during the second trimester. The prenatal care provider shall educate the pregnant woman about the importance of oral health and that dental care is safe during pregnancy.

The prenatal care provider shall schedule a postpartum visit based on the woman's identified needs and in accordance with AAP/ACOG's recommended schedule between the 21st and the 56th day after delivery, (approximately 4 – 6 weeks after delivery but no later than eight weeks after delivery; women with a complicated gestation or delivery by cesarean section should have a visit scheduled within 7 - 14 days of delivery). The visit should include an interval history and a physical examination to evaluate the enrollee's current status and how she¡¦s adapted to the newborn.

7.2.3.2 The visit shall include, but not be limited to the following:

- Pregnancy testing
- A pre-natal care card, used to document services utilized
- Medical services, during pregnancy and post-partum
- HIV testing and Counseling during the 1st and 3rd trimesters
- Dental evaluation during the second trimester of gestation.
- A RhoGAM injection for all pregnant women who have a negative RH factor according to the established protocol.
- Alcohol screening of pregnant women with the 4P-Plus instrument
- Smoking cessation counseling and treatment
- Physician and nurse obstetrical services during vaginal and caesarean section deliveries and services to address any complication that arises during the delivery.
- Treatment of conditions attributable to the pregnancy or delivery, when medically recommended.
- Hospitalization for a period of at least forty-eight (48) hours in cases of vaginal delivery, and at least ninety-six hours (96) in cases of caesarean section.

- ❖ Anesthesia, excluding epidural
- ❖ Incubator use, without limitations
- ❖ Fetal monitoring services, during hospitalization only
- ❖ Nursery room routine care for newborns
- ❖ Circumcision and dilatation services for newborns
- ❖ Transportation of newborns to tertiary facilities when necessary
- ❖ Pediatrician assistance during delivery
- ❖ Delivery services provided in free-standing birth centers, if available
- ❖ Post-partum depression screening using the Edinburgh post-natal depression scale.
- ❖ Post-partum counseling and referral to the WIC program
- ❖ Voluntary and confidential reproductive health and family planning counseling, including circumstances where the Enrollee is under the age of eighteen (18).
- ❖ Family planning services will provide education and counseling to assist women to make informed choices and understand contraceptive methods.
- ❖ Enrollees seeking prescribed family planning services should be advised on the methods available through the Puerto Rico Health Department.

7.2.4 Prenatal Wellness & Care Management Program

The Prenatal Wellness & Care Management Program will provide an array of strategies and interventions for pregnant *MI Salud* enrollees.

Dedicated team approaches may include telephonic coaching, face to face counseling, educational workshops and peer support groups. Population Health strategies will be applied in enrollee communications to advise on topics such as: the importance of prenatal and post-partum care, breastfeeding, stages of childbirth, oral health, family planning, newborn care, and behavioral health topics on domestic violence, post-partum depression, tobacco cessation, alcohol use/abstinence and substance

abuse, parenting, HIV screening and prevention, and socio emotional screening in children, among others.

Field-based teams will provide opportunities to participate in pre and postnatal wellness sessions within collaborating agencies, physician offices or other community settings.

All enrollees included in the Special OB Coverage will receive an educational packet on the importance of pre and post-natal care as well as EPSDT requirements for their child. High risk enrollees will be offered the Prenatal Care Management program to address their particular health and wellness needs and concerns, and help improve pregnancy outcomes.

A dedicated team of telephonic Prenatal Care nurses will conduct a standardized comprehensive prenatal care assessment for both maternal and fetal risks, at the earliest point of pregnancy for enrollees enrolled in the Prenatal Care Management Program. Risk assessment includes, but is not limited to:

- ❖ Analysis of individual characteristics affecting a pregnancy, such as genetic, nutritional, environmental, behavioral health, psychosocial and history of previous and current obstetrical/fetal and medical/surgical risk factors.
- ❖ Pregnant enrollees receiving 17P will be provided with intensive prenatal care management follow-up to assist in coordinating their services, educating on the risks associated to preterm delivery, as well as to promote compliance with treatment.

Identification of behavioral health risks is an integral part of the assessment and as such will be administered to all enrollees in the Prenatal Care Management Program. Assessments will include:

- 4P Plus
- Edinburgh

Completed assessments will be used to develop the enrollees' comprehensive individual care plan. Individual care plans will be jointly developed with enrollees,

addressing the problems identified as a result of the initial and ongoing risk assessments.

Women identified with behavioral health concerns will be referred for to MMM Multi Health Mental Health Services to coordinate services. Referrals will be tracked for reporting as contractually required.

Prenatal Program participants will be offered counseling about the risks of smoking during pregnancy. Those that report that they are active smokers will be offered telephonic coaching about smoking cessation or will be referred to the Smoking Cessation Line (¡*Déjalo Ya!)* of the Puerto Rico Department of Health. Participants that require more intensive counseling will be referred to the Behavioral Health Services Department.

Based on enrollee risk and care plan, prenatal care nurses shall provide pre and postnatal education based on an assessment of the pregnant woman's individual needs. Prenatal care nurses will focus on the pregnant woman's ability to comprehend the information and use materials appropriate to the educational, cultural and linguistic needs of the enrollee as well as her gestational history. The plan will be routinely updated with the pregnant woman, her family and the appropriate enrollees of the healthcare team, as needed.

7.2.5 Program Monitoring

8.2.5.1 As contractually required, MMM Multi Health will submit Quarterly Reports to ASES indicating:

- Number of pregnant women enrolled in the *MI Salud* by trimester and age.
- Number of pregnant women enrolled in the *MI Salud* by trimester and age who received HIV tests.
- Number of pregnant women screened for substance abuse with the 4P Plus screening tool; as well as the number of cases referred

to behavioral health providers for smoking cessation counseling and treatment.

- Number of pregnant women in postpartum care screened for depression with the Edinburgh screening tool; as well as the number of cases referred to the behavioral health provider with an Edinburgh score of 10 or above.
- Number of pregnant women who received educational interventions.

MMM Multi Health will collaborate with Primary Medical Groups and Ob/Gyns to develop effective outreach interventions to serve pregnant women and women in reproductive age. Through population health strategies, telephonic case management and access to pre and post-natal care services through the contracted network, an ample array of interventions will be implemented to help meet contractual outreach requirements.

7.2.5.2 Strategies may include:

- Educational materials
- Workshops and Educational Sessions
- Presentations at the Primary Care Setting
- Collaborations with state agencies such as WIC and Early Head Start, and other private or public community based organizations.
- Message Campaigns within the infrastructure of the *MI Salud* Service Line or the Triage Line

7.3 Wellness Program

The Wellness Program is developed in order to advance the goals of strengthening Preventive Services, providing integrated physical and behavioral health to all enrollees on health and wellness. Following the contract between *Administración de Seguros de Salud de Puerto Rico (ASES)* and MMM Multi Health LLC.

The Wellness Program has to reach 85% of the government health plan enrollees. A key element for the success of the wellness initiatives is the establishment of a multidisciplinary team. This team provides targeted interventions based on population needs (children, adolescents, adults, and older adults). The interventions have been designed to support and promote the integration of physical and behavioral health in a variety of settings and outreach events. These outreach initiatives were offered using diverse educational strategies, such as:

a) Group interventions
b) Workshops
c) Health fairs
d) Health clinics
e) Population health campaigns or events
f) Social Media, traditional media outlets

An important part of these interventions is to work in collaboration with government agencies in order to maximize our mutual efforts effort and to support each other for the benefit of the members in the Region. This collaboration will be focused in the establishments of intervention strategies that would support the integration of the mental and physical health. Specifically, the wellness program will coordinate join efforts with the following agencies:

- Puerto Rico Health Department
- Auxiliary Secretariat for Health Promotion
- Family Services Department
- Puerto Rico Department of Education
- ASES
- Programa de Asistencia Médica (Medicaid)
- Municipalities
- Community Based Organizations

The Wellness Program uses the following process in diverse scenarios to foster collaborations that would benefit different population groups with a variety of topics and interventions:

Topic	Population Group	Scenarios
Annual health checkup (including EPSDT for child care)	• Adult • Adolescents • Children	• Medical Provider Offices (Co-location Facility) • Government agencies (School, Head Start, Medicaid office, etc.) • Community –based and faith-based organizations
Appropriate use of the Emergency Room	• Adult • Adolescents • Children	• Medical Provider Offices (Co-location Facility) • Government agencies (Medicaid office, WIC, etc.) • Community-based and faith-based organizations
*Physical Health: • Asthma • Diabetes • Hypertension • Congestive Heart Failure • Flu • Dengue *Among others	• Adult • Adolescents • Children	• Medical Provider Offices (Co-location Facility) • Government agencies (School, Head Start, Medicaid office, etc.) • Community-based and faith-based organizations

Women's health (mammograms, pap smears, cervical screenings)	• Women	• Medical Provider Offices (Co-location Facility) • Government agencies (Medicaid office, WIC, etc.) • Community-based and faith-based organizations
Sexually Transmitted Diseases	• Adults • Adolescents	• Medical Provider Offices • Government agencies (School, Head Start, Medicaid office, etc.) • Co-location Facility • Community-based and faith-based organizations
Weight management, nutrition and physical activity	• Adults • Adolescents • Children	• Medical Provider Offices • Government agencies (School, Head Start, Medicaid office, etc.) • Co-location Facility • Community-based and faith-based organizations
Reproductive health and family planning	• Adults • Adolescents	• Medical Provider Offices (Co-location Facility) • Government agencies • (School, Head Start, Medicaid office, WIC, etc.) • Community-based and faith-based organizations
Annual dental exam	• Adults • Adolescents • Children	• Medical Provider Offices (Co-location Facility) • Government agencies (School, Head Start, Medicaid office, etc.)

		• Community-based and faith-based organizations
Behavioral Health • Stress Management • Self-esteem • Bullying	• Adults • Adolescents • Children	• Medical Provider Offices (Co-location Facility) • Government agencies (School, Head Start, Medicaid office, etc.) • Community-based and faith-based organizations
Behavioral Health (specific and high-risk diagnoses) • Depression • Bipolar disorders • Schizophrenia • Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder • Anxiety disorders • Substance Abuse • Autism	• Adults • Adolescents	• Medical Provider Offices (Co-location Facilities) • Reverse Co-location Facility • Community-based and faith-based organizations

7.3.1 Emergency Room Program

The Emergency Room Program is designed to identify high users of Emergency Services (including behavioral health) for non- emergency situations and to allow for early interventions in order to ensure appropriate utilization of services and resources.

The program offered detailed activities and interventions such as:

1. Educational campaign to educate beneficiaries about healthcare options available to then when primary care physician isn't available.
2. One on One care management interventions
3. Primary care physician (PCP) interventions on identifying high users or potential high users of ER services.
4. The Emergency Room Program is aimed at decreasing 5% of the Emergency Room (ER) visit rate.

Contact	Position	Phone Numbers	E-mail
Zoraya Moreno	Care Management Director	(787) 622- 3000 ext. 8389	Zoraya.Moreno@mmmhc.com
María del C. Díaz Ramos	Wellness-Prenatal-EPSDT Program Manager	(787) 622-3000 ext. 3672 (787) 692-2061	Maria.Diaz3@mso-pr.com
Marisol García	Wellness Supervisor	(787) 622-3000 ext. 3104 (787) 407-3523	Marisol.Garcia-Torres@mmmhc.com
Edithmar Gustavo	Wellness Supervisor	(787) 622-3000 ext. 3252 (787) 918-5992	Edithmar.GustavoRuiz@mmmhc.com

7.4 Care Management

7.4.1. Evaluation Process

7.4.1.1 Propose

The insurance counts on a full staff of nurses and other professionals capable to provide the support through our Management Programs to all the beneficiaries registered under the Special Coverage. These programs are made to also provide support to the beneficiary that receives clinical care. Talk to your beneficiaries, in regards the Special Coverage and invite them to participate and register. These programs are designed with a holistic focus, which aims the beneficiary to take control of their condition, in order to accomplish their health goals. The Case Management Program goals are the following:

1. To provide support and education to the identified beneficiaries with chronic and complex conditions.
2. Program is developed with a holistic focus addressed to promote health changes on habits and life style.
3. Made as an alliance for the care coordination, when necessary.
4. Integrates tools for the physical and mental health screening as part of the standard, in order to define the care plan.
5. Developed an individualized care plan for each participant.

7.4.2 Scope

The Case Management Program provides multiples alternatives for the care management for the identified beneficiaries as high risk. An assigned Case Manager will make interventions based on the individualized Care Plan.

Our philosophy on Care Management is the focus under a Multidisciplinary level with the collaboration of Professional Nurses, Social Workers, and Psychologist, in order to optimize the beneficiary participation under the program.

7.5 Special Coverage Protocol

7.5.1 Goals

MI Salud determines that all beneficiary, who had been diagnosed with any of the fifteen (15) conditions stablished by ASES, has the right to request Special Coverage

Registration. The Special Coverage offers the registered beneficiary major access to the required services to manage their condition, in order to have a clinical control and a better quality of life. It's important to advise them of the application process and their details, in regards the Special Coverage Registration. Should you like more detailed information, please referred to Normative Letter 15-1112.

7.5.2 Identification of Eligible Beneficiaries

The process to register a beneficiary under the Special Coverage Registration is simple, only if you complete the Special Coverage Registration Form (attached), breakdown and meet the determined clinical criteria for each condition and should include the required supporting documentation. The application for registration can be send by a Specialist Provider or by a Primary Care Physician (PCP). On HIV cases, the registration form can also be send by the Case Manager from the Immunology Center that the beneficiary attends too.

Once the insurance receives the Special Coverage Form fully completed with proper documentation, it would provide approval or denial determination at the Registry, and additional information will be requested. The insurance will maintain telephonic communication with the beneficiary and to keep them informed, in regards the application status. The insurance will also notify the Provider that requested special coverage, in regards the final case determination. As soon the case is approved, the beneficiary will receive a Special Coverage Certification Letter. This document will include information related on the effectivity of the Special Coverage and the services which has access. In case that the enrollment at the Registry was requested by a Specialist, the insurance will notify the beneficiary's Primary Care Physician by phone and also by sending a letter about the application's final determination. The insurance will need to have a final determination in regards the enrollment at the Special Coverage Registry in a period of 72 hours on normal cases or a 24 hours on cases with HIV or defined cases as expedite. For your

knowledge, the time is considered from the moment is received the documentation required for each condition defined on the Special Coverage Table.

Once the provider send the required information, the case will be reviewed and approved; the Special Coverage will have a retroactive effective date, to the date that the Specialist had stablished with the diagnostic or the pathotology date.

7.5.3 Plan of Individual care and treatment

Within program of management of care, health professional, specialized nurses develop a plan of care individualized for each beneficiary participant. This professionals Team, integrated tools of tanning and of physical and mental health, as part of the criteria for defining the individualized care plan.

7.5.4. Conditions which registered under the Special Coverage

The conditions that are registered under the Special Coverage are defined on the Attachment 7 of the MCO & ASES contract. These conditions are:

1. Aplastic Anemia
2. Rheumatoid Arthritis
3. Autism
4. Cancer
5. Chronic Renal Disease (Stage 3-5)
6. Scleroderma
7. Multiple Sclerosis and Amyotrophic Lateral Sclerosis
8. Cystic Fibrosis
9. Hemophilia
10. Leprosy
11. Systemic Lupus Erythematous
12. Children with special health conditions (Please note that on some cases diagnosis are considered as temporary conditions).
13. HIV/ AIDS

14. Obstetrics

7.5.4.1 The effective period of the Registry?

ASES defines the Special Coverage conditions as Persistent or Temporary Conditions. These definitions and conditions are the ones that determines the effective time of the Special Coverage.

- Persistent Conditions

These are complex conditions which are expected that the beneficiary keeps registered while continue been eligible under the Government Health Care Plan. This means that the Certification that the beneficiary receives will have a registration initial date; however, it will not have a termination date. The conditions defined as persistent are the following:

1. Aplastic Anemia
2. Rheumatoid Arthritis
3. Autism
4. Chronic Kidney Disease (Stage 3-5)
5. Scleroderma
6. Multiple Sclerosis & Amyotrophic Lateral Sclerosis
7. Cystic Fibrosis
8. Post- Transplant
9. Hemophilia
10. Leprosy
11. Systemic Lupus Erythematous
12. Phenylketonuria- PKU- Adults
13. Children with special health conditions (Please note that on some cases diagnosis are considered as temporary conditions).
14. Phenylketonuria- PKU-Children
15. HIV/ AIDS

- Temporary Conditions

These conditions are different than the persistent, which has a defined period. This period are defined based on a treatment plan which the specialist generates for the beneficiary due to the condition. If beneficiary requires an additional period to complete their treatment; you or the Specialist will need to send the required documentation prior the Registry expiration date, in order to inquire a coverage extension period. These conditions defined as temporary are the following:

1. Cancer
2. Some conditions associated with children with health care necessities.

7.5.4.2 Some of the services that require pre-authorization, even though if beneficiary is under a Special Coverage are the following:

a. Computerized Tomography (CT Scan)
b. Magnetic Resonance Imaging (MRI)
c. Cardiac Catheterizations
d. Holster Test
e. Doppler Test
f. Stress Test
g. Lithotripsy
h. Electromyography
i. SPECT
j. Orthopantomography
k. Other neurological, cerebrovascular and Cardiovascular procedures (Invasive & Non Invasive)
l. Nuclear Imaging
m. Diagnostic Endoscopy
n. Genetic Studies

o. Pathologic and clinical laboratories Test that needs to be process outside of Puerto Rico.

7.5.4.3 Special Coverage - Obstetric Registry

To enroll a beneficiary on the Obstetric Registry, the provider will need to complete the Registry OB Form (attached on this statement). This form can be completed and send by the Primary Care Physician (PCP) or by the Obstetric Gynecologist. As part of the enrollment process, each application should have the OB form and positive pregnancy evidence (laboratory result or sonogram).

As soon as the case is registered, the beneficiary will receive by mail a Certification of the Obstetric Registry. This document will include the effective coverage date and a description of the services that will have access.

❖ Which is the effective period of the Obstetric Registry?

The registry will be effective since the last menstruation date (LMP) until 56 days after estimated birth date (EDD). On cases that the pregnancy was terminated due to a miscarriage before the 20th week; coverage will be for thirty (30) days after the miscarriage date.

❖ Eligibility loss during the Registry period

Beneficiaries, who had loss the eligibility on the Government Health Care Plan for a period more than a one (1) year, it will be to provide a new certification from his medical service provider, to validate the current treatment plan, in order re-active the Special Coverage Registry. If beneficiary had loss eligibility for less than twelve (12) months, it will be reintegrated under the registry without the necessity of documentation or additional certifications; only if

other limitations are specified or requirements are indicated on a specific registry that attends to.

7.6. Disease Management Program

7.6.1 Intervention Process:

The Disease Management Program has a staff of nurses and other health care professionals, in order to provide the support for all the beneficiaries that are identified with chronic conditions and are eligible to participate on the Program. These are the following conditions:

a. Asthma
b. Depression
c. Diabetes Mellitus type 1 &2
d. Congestive Heart Failure (CHS)
e. Hypertension
f. Morbid Obesity
g. Chronic Renal Disease

Beneficiaries are categorized on three (3) sub-stratification levels using algorithms that are incorporated by the Individualized General Assessment and available medical documentation.

The Stratification levels represents the severity of the beneficiary's condition, a scale is used indicating (1)- low, (2) Medium, (3)-high, and (4) Severe, it measures the intensity of the interactions in each beneficiary; these can also include phone call, educative material provided, etc.

7.6.2 Mental Health Integration

1. As part of the Process, every beneficiary enrolled on the Program, a PHQ-9 estimate (tool that helps identified symptoms related to Depression) will be completed. If a result indicates Depression symptoms, beneficiary will be referred to the Mental Health Department for proper assessment.

Recommendation is provided to the beneficiaries to inform the Primary Care Physicians, related to their health condition and treatment. The Care Management is the link between the beneficiary and the physician, in order to promote the adherence on the treatment plan. The Program promotes the following:

7.6.3 Plan of Individual care and treatment

Within program of management of care, health professional, specialized nurses develop a plan of care individualized for each beneficiary participant. This professionals Team, integrated tools of tanning and of physical and mental health, as part of the criteria for defining the individualized care plan.

7.6.2.1 Monitoring

1. Beneficiary Auto management, in regards his condition.

2. Preventive Health

7.6.2.2 Management

1. Comorbidities

2. Education regarding healthy life styles

3. Education regarding Medication Adherence

4. Mental Health Referrals, if necessary

7.6.3 Definitions

1. **Eligible Beneficiaries**: Beneficiaries identified that have the criteria to participate on the Program.
2. **Voluntary Process**: Is a process which the beneficiary decides to enroll on the Disease Management Program.
3. **Refuse:** Process that the beneficiary refuses to participate on the Disease Management Program.

4. Care Management: A health care professional evaluates, plans, and coordinate the necessary services to satisfy the beneficiary's necessities.

7.7 Clinical Guidelines

We adopt nationally approved clinical practice guidelines as the basis for our Care Management Programs. Clinical guidelines are systematically developed; evidence based statements that help practitioners make decisions about appropriate healthcare for specific clinical circumstances. The effectiveness of the guideline is determined by scientific evidence, or in the absence of scientific evidence, expert opinion and professional standards. The Care Management Programs have adopted clinical guidelines from recognized sources. Clinical practice guidelines are reviewed and revised annually. Physicians or specialists will perform a review of research and literature prior to the adoption of guidelines. Upon notification of new information, all protocol information will undergo a review of the information source and an assessment of costs and benefits to enrollees in terms of the ability to improve outcomes prior to the decision to implement the change.

7.8 Organizational Structure

The professional personnel of the Care Management Program is made up of doctors, nurses, social workers, nutritionist, health educators among others. Administrative official's beneficiaries support all functions.

7.8.1 Roles and Responsibilities

- Medical Directors: Supervises development of clinical guides, resolution of clinical problems and implementation of doctor's education related to the Program.
- Social Worker: helps with the implementation of referral at social level as well home evaluation as necessary.
- Nutritionist: Evaluated nutritional needs and creates individualized nutritional plans for the beneficiaries.
- Health Educator: Develops, implement and evaluated participant's educational activities and identifies resources and community

organizations regarding comorbid such as diabetes, CHF, Cardiovascular disorders, etc.

- **Care Manager**: Evaluates, facilitates, plans and advocates for health needs individually, including identification and management solutions providing alternatives care, coordination of resources and beneficiaries referrals.
- **Data Analyst:** Monitors and identifies possible candidates through data. Supervises and evaluated results from program activities and determines results. Helps out with the production of reports and evaluated claims data.
- **Outcomes Measures:** Care Management Programs uses (Utilizers) indicators in order to determine the success of the beneficiaries and professionals interventions. Though a yearly revision process the points of reference are identified and goals of the following year are established. The indicators are measured against objectives in an annual base. Program indicators include cost and quality.

Should you like more information, please contact the Provider Services Line calling the following phone number at 787-993-2317 (Metro Area) or 1-866-676-6060 (free of charge); available from Monday through Friday from 7:00 a.m. until 7:00 p.m.

Also can contact us by email to the following: CareManagementPSG@mmmhc.com

7.8.2 Health Support Program

The Following Table represents additional Care Management Support Programs:

Health Support Program	General Description
Smoking Cessation Program	Designed to help beneficiaries who wish to stop using snuff product to prevent relapse
Making Contact	Medical advice line, available, 24 hours a day, 7 days a week, 365 days a year.
Wound Care	Helps to improve healings rates of chronic wounds, reduce amputations and disability,

	thus greatly improving the quality of life of those it serves.

8. Coding and clinical documentation practice

The following information includes key guidelines of medical documentation and coding to assist our providers; however, coding and documentation requirements are not limited to the content of this document. Every provider is responsible to revise contractual agreements, applies official guidelines and resources to his or her daily medical practice and be updated to current changes.

8.1 General concepts in clinical documentation

"If it isn't documented, it hasn't been done" is a principal in the healthcare setting (CMS, 2015).

Medical documentation is a key instrument used in planning, evaluating, and coordinating patient care in both the inpatient and outpatient settings. The content of the medical record is essential for patient care, accreditation, and reimbursement purposes. Each encounter should detail information pertinent to the care of the patient, documentation of the performance of billable services, and serve as legal document that describes a course of treatment. Periodic audits, whether internal and external, ensure that the record adequately serves these purposes and meets federal and state regulations (Grider, 2011). Regardless the format, electronic (EHR) or handwritten, all entries in the patient record must be: legible to another reader, reliable, precise, complete, consistent, clear, and timely (Hess, 2015).

8.1.1 Please take in consideration the following key points (First Coast, 2006):

- Plan expects documentation to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame (24-48 hrs.) are acceptable for purposes of clarification, error

correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.

- Late entries must comply with addendum guidelines:
  - The date the record is being amended
  - The details of the amended information
  - A statement that the entry is an addendum to the medical record (An addendum should not be added to the medical record without identifying it as such.)
  - The date of the service being amended
  - Legible name and signature of the provider writing the addendum

- The medical record cannot be altered. Errors must be legibly corrected so that the reviewer can draw an inference as to their origin. These corrections or additions must be dated, preferably timed, and legibly signed or initialed.
- Notes must include member's name and date of service on each page. Provider's name, credentials, license number and signature must also be present.
- Every encounter (note) must stand alone, i.e., the performed services must be documented at the outset. Delayed written explanations will be considered (see addendum guidelines above). They serve for clarification only and cannot be used to add and authenticate services billed and not documented at the time of service or to retrospectively substantiate medical necessity. For that, the medical record must stand on its own with the original entry corroborating that the service was rendered and was medically necessary.
- Do not use codes in clinical documents; write instead the diagnosis and service in medical terminology (words) and standard abbreviations. Verify

and call your EHR carrier if the program is not describing the diagnosis or procedure in a complete and acceptable format.

- Common in EHR; do not copy and paste medical information from encounter to encounter. Patient's care must be verified individually to ensure accuracy avoiding medical errors and overpayment.
- Documentation must clearly describe any other information required by CMS, CPT, HCPCS or ICD-10.

8.1.2 Follow these additional guidelines for notes written by scribers (office staff) or dictation:

- Scriber's name, signature, dictation and scribing date/time must be present in the note
- Provider must review what is documented by the scriber and make a statement indicating if he or she agrees with documentation

8.1.3 Follow these additional guidelines for medical student/residents:

CMS required that teaching physician was physically present during the critical or key portions of the service. Herein are some key guidelines but please refer to Medicare Claims Processing Manual, chapter 12 for more information:

- Ensure that the care provided was reasonable and necessary
- Review the care provided by the resident during or immediately after each visit. This must include a review of the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies) and statement indicating if he or she agrees with the resident's documentation.
- Document the extent of his/her own participation in the review and direction of the services furnished to each patient.
- Entry must be cosigned and dated by the teaching physician.

8.1.4 Additional documentation guidelines for evaluation and management services (E/M)

According to CMS, medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT/HCPCS code. It would not be medically necessary or appropriate to bill a higher level of E/M when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

8.1.4.1 The documentation of each E/M patient encounter should include:

- Reason for the encounter (Chief complaint)
- Relevant present, past, social and family medical history
- Pertinent physical examination; any abnormal finding must be described
- Any objective data reviewed or interpretation of findings in labs or imaging studies
- Assessment, clinical impression, or diagnosis
- Medical plan of care for each diagnosis
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented
- Time must be documented; especially, time expended in counseling or coordination of care
- Documentation must clearly describe any other information required by CMS, CPT, HCPCS or ICD-10

8.1.4.2 Provider must select and use one of the following E/M documentation guidelines:

- 1995 Documentation Guidelines for Evaluation and Management Services. Retrieved from:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

- 1997 Documentation Guidelines for Evaluation and Management Services. Retrieved from:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

- Additional guidelines provided by CMS: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

8.1.5 Additional documentation guidelines for surgeons or any provider performing surgical procedures (Grider, 2011)

❖ Surgery reports (note) must include at least the following:
  - If applicable, name of co-surgeon or assistant physician
  - Indications to perform the procedure, pre and postoperative diagnoses
  - Positioning and draping of the patient
  - Anesthesia administration
  - Detailed description of the actual procedure performed; surgical approach, identification of incisions, instruments used, any abnormality, hemostasis, closure of surgical site and any other pertinent information
  - Condition of patient when he or she left operating room
  - Documentation must clearly describe any other information required by CMS, CPT, HCPCS or ICD-10

8.1.6 Additional documentation guidelines for radiologists or any provider performing imaging diagnostic/screening studies (ACR, 2014):

- ❖ The following components must be present in the report, please refer to a detail version of it in the corresponding professional association or official regulation:
  - Demographics
  - Relevant clinical information
  - Body of the report
  - Procedure and materials
  - Findings
  - Potential limitations
  - Clinical issues
  - Comparison studies and reports
  - Impression (conclusion or diagnosis)
  - Standardized computer-generated template reports
  - Documentation must clearly describe any other information required by CMS, CPT, HCPCS or ICD-10
    - Refer to section 5.7.3 if the performed service includes procedures such as catheterization, joint injections, and biopsy. These services may require both imaging interpretation report and surgical note to comply with documentation standards.
    - For medical orders please see section 5.7.4

8.1.7 Additional documentation guidelines for clinical laboratories or any provider performing these types of services:

Documentation of the laboratory report must clearly describe any information required by CMS, CPT, HCPCS or ICD-10

8.1.7.1 Documentation of orders:

- According to CMS, an order may be delivered via the following forms of communication:
  - A written document signed by the treating physician/eligible professional, which is hand-delivered, mailed, or faxed to

the testing facility. Documentation in the medical record must show intent to order and medical necessity for the testing.

- A telephone call by the treating physician/eligible professional or his/her office to the testing facility for transcription of a verbal order.
- An electronic mail by the treating physician/eligible professional or his/her office to the testing facility.
- If the order is communicated via telephone, both the treating physician/eligible professional or his/her office, and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records. While a physician/eligible professional order is not required to be signed, the physician/eligible professional must clearly document, in the medical record, his or her intent that the test be performed.

8.2 General concepts in coding and billing

8.2.1 International Classification of Diseases 10th Rev. (ICD-10):

Is an approved coding set for entities covered under the Health Insurance Portability and Accountability Act (HIPAA). The Clinical Modification of the coding set (ICD-10-CM) is used for reporting diseases, disorders, symptoms, and medical conditions. The Procedure Coding System (ICD-10-PCS) is used to report inpatient (hospital Part A) services -hospitals under DRG contracts-. Both coding systems include Official Guidelines for Coding and Reporting that must be applied by providers in their coding and documentation practices.

In addition to the above General Concepts in Clinical Documentation, for ICD-10-CM coding the provider must document for each encounter:

- Complete assessment, co-existing diagnoses including the underlying condition and its complications/manifestations.
- The manner the diagnosis is being treated, addressed, monitored and/or evaluated.
- Do not code and report diagnosis stated as "rule-out" or other similar terms indicating uncertainty. Rather, code signs, symptoms, abnormal test results, or other reason for the encounter. Please refer to Section II. H of the ICD-10-CM Official Guidelines for Coding and Reporting for special instructions for inpatient facilities.
- Always code the final result of a diagnostic test or procedure. If the final result is "normal", code sign and/or symptoms.
- Always code the postoperative diagnosis of a medical procedure. Do not code the preoperative diagnosis since it may be changed once the procedure is done.

8.2.2 Healthcare Common Procedure Coding System (HCPCS):

Has been selected as the approved coding set for entities covered under HIPAA, or reporting outpatient procedures. The first HCPCS's level is Current Procedure Terminology, Fourth Edition (CPT-4). It is based upon the American Medical Association. It includes three levels of codes and modifiers. Level I contain most common used codes for medical services and procedures. Level II (commonly referred as just "HCPCS") contains alpha-numeric codes primarily for items and non-physician services not included in CPT; e.g., ambulance, DME, orthotics, and prosthetics. These are alpha-numeric codes maintained jointly by CMS and other institutions.

According to CMS, providers must report services correctly. Procedures should be reported with the most comprehensive CPT/HCPCS code that describes the services performed. Providers must not unbundle the services described by a HCPCS/CPT code. Some examples follow, providers should not:

- ✓ Report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes these services.
- ✓ Fragment a procedure into component parts.
- ✓ Unbundle a bilateral procedure code into two unilateral procedure codes.
- ✓ Unbundle services that are integral to a more comprehensive procedure.

Providers must avoid downcoding and upcoding. If a HCPCS/CPT code exists that describes the services performed, the provider must report this code rather than report a less comprehensive code with other codes describing the services not included in the less comprehensive code. A HCPCS/CPT code may be reported only if all services described by that code have been performed.

Providers must report units of service correctly. Each HCPCS/CPT code has a defined unit of service for reporting purposes. A provider should not report units of service for a HCPCS/CPT code using a criterion that differs from the code's defined unit of service.

8.2.3 Plan's policies, contractual agreements and industry's official reference:

- ❖ Must also be used and followed when coding and billing for medical procedures and services including non-physician services. Some of these references are listed below:
  - o Medicare National Coverage Determinations (Pub. 100-03)
  - o Medicare Local Coverage Determinations
  - o Medicare Claims Processing Manual (Pub. 100-04)
  - o CMS Evaluation and Management Service Guide
  - o National Correct Coding Initiative Policy Manual for Medicare Services

Important, every code transmitted on a billing format (e.g., 1500) to the Plan must be the exact word-to-code translation of what is documented in the clinical note, diagnostic or procedure report for the specific member and date of service. The

code must be in compliance with the above standards and official references. Continued education and industry updates are essential in the providers' practice and to maintain a high level of compliance.

8.2.4 Record keeping:

All services billed may be subjected for future audits by the Plan or regulate agencies. Therefore, providers must maintain patients' medical record according to HIPAA and CMS guidelines. This includes keeping copy for at least 6 years from the date the service was performed.

Each provider is responsible to supply copy of the patient's record even if the service is performed in other facility that is not his or her own, for example, the physician billed an inpatient visit 99223, he or she must keep copy of this visit note at his or her office even though the service was performed at the hospital.

8.2.5 References:

Centers for Medicare and Medicaid Services, Department of Health and Human Services. 2016. 1995 and 1997 Guidelines for Evaluation and Management Services. Retrieved from: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html

First Coast. 2006. Medicare B Update! Newsletter 3rd Quarter 2006 Vol. 4 Num. 3. Retrieved from: https://medicare.fcso.com/Publications_B/2006/141067.pdf

Grider, Deborah J. 2011. Medical Record Auditor: Documentation rules and rationales, with exercises, 3rd edition. Chicago, IL: AMA

Hess, Pamela Carroll. 2015. Clinical Documentation Improvement: Principles and Practice. Chicago, IL: AHIMA

ACR. 2014. Practice Parameter for Communication of Diagnostic Imaging Findings. Retrieved from:

https://www.acr.org/~/media/ACR/Documents/PGTS/guidelines/Comm_Diag_Imagig.pdf

CMS. 2017. National Correct Coding Initiatives. Retrieved from: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

9. Integration of physical and behavioral health

In accordance with the contract between ASES and MMM Multi Health, we must ensure an integration model were physical and behavioral health services are fully integrated to guarantee optimal detection, prevention, and follow up treatment of physical and behavioral health illness. Primary Medical Groups (PMG) shall facilitate the placement of behavioral health professional that could be a licensed professional psychologist, or a master level social worker with professional license, in each facility. The behavioral health provider shall be present and available to provide assessment, consultation, and behavioral health services to enrollees.

The standard minimum criteria for weekly access must be four (4) hours per week for every five thousand (5,000) beneficiaries assigned to a PMG setting, starting with PMG with one thousand (1,000) or more beneficiaries. The behavioral health provider housed within the PMG shall conduct screening evaluations, crisis intervention, and limited psychotherapy, between four (4) and six (6) sessions, according to the needs of the enrollee.

MMM Multi Health shall ensure that the services provided are compliant with Law 408, Mental Health Code, and the Puerto Rico Patient's Bill of Rights Act, as well as other applicable Federal and Puerto Rico laws.

For PMG that has less than one thousands (1,000) assigned beneficiaries, they will not be required to have an available mental health provider. In these cases, the PMG may refer the beneficiary to other PMG with greater capacity and having a provider of mental health available for consultations. This model virtual colocation model aims to

provide access to mental health services and coordinate necessary level of services. Mental health providers will be available for consultation and case discussions.

In the event that a PMG does not allow placing a master level licensed social worker or a psychologist with master's degree within the structure of the PMG for the minimum time required as explained above, MMM Multi Health will notify ASES and ask the PMG for a Corrective Action Plan (CAP). The PMG must respond the CAP within seven (7) days from the receipt of notification. MMM Multi Health must evaluate and approve or deny the CAP within seven (7) days of the date of receipt. Each PMG with an approved CAP must comply with the terms of the same and achieve the colocation of a mental health provider within the established timeframes.

In a same way, MMM Multi Health shall guarantee that an integrated care model in which physical health services are available to enrollees being treated in behavioral health settings, known as reverse collocation model.

The **reverse collocation model** is an integrated model of care in which medical services are available to members being treated in behavioral health facilities. It has been known that patients with co-morbid conditions, that include chronic or acute medical conditions and behavioral health diagnoses, are at higher risk for increased utilization and costs in health care.

In the reverse collocation model a Primary Care Physician (PCP) is located part or full time in a behavioral health facility to monitor the physical health of patients. The requirements for reverse collocation are the following:

1. Ambulatory services units (clinics) must have at least one collocated PCP (four) 4 days per week for (four) 4 hours.
2. Addiction services units must have at least one (1) collocated PCP three (3) days per week for four (4) hours.
3. Partial Hospitalization Units must have at least one (1) collocated PCP two (2) days per week for four (4) hours.

4. Stabilization units and psychiatric hospitals must have one (1) PCP for consultation (on call) on a daily basis.

10. Utilization Management

A service performed by MMM Multi Health which seeks to ensure that Covered Services provided to Enrollees are in accordance with, and appropriate under, the standards and requirements established by the Contract, or a similar program developed, established, or administered by ASES. MMM Multi Health will provide assistance to Enrollees and Providers to ensure the appropriate Utilization of resources. MMM Multi Health will have written Utilization Management Policies and Procedures included in the Provider Guidelines.

10.1 Authorizations and Referrals

MMM Multi Health will not require a Referral from a PCP when an Enrollee seeks care from a Provider who is part of the MMM Multi Health's Preferred Provider Network (PPN). In case where the provider is not in the PPN, the Primary Care Provider (PCP) must submit an electronic referral request to the Specialist Contracted Provider. MSO will offer to the PCP the alternative of generating the electronic referral through InnovaMD web page and IVR, at no expense to the provider. The PCP should provide a copy of the referral to the patient. A Referral from the PCP will be required:

1. For the Enrollee to access specialty care and services within the MMM Multi Health's General Network but outside the PPN.
2. For the Enrollee to access an Out-of-Network Provider (with the exception of Emergency Services).
3. A Referral for either the General Network or out-of-network services must be provided during the same visit with the PCP but no later than twenty-four (24) hours of the Enrollee's request.
4. When a Provider fails or refuses to provide the Referral within specified period (24 hours)l an Administrative Referral will be issued by MMM Multi Health , according to established process.

5. Neither MMM Multi Health nor any Provider may impose a requirement that Referrals be submitted for the approval of committees, boards, Medical Directors, etc. MMM Multi Health will strictly enforce this directive and will issue Administrative Referrals whenever it deems medically necessary.
6. If the Provider Access requirements of this Contract cannot be met within the PPN within thirty (30) Calendar Days of the Enrollee's request for the Covered Service, the PMG will refer the Enrollee to a specialist within the General Network, without the imposition of Copayments. However, the Enrollee will return to the PPN specialist once the PPN specialist is available to treat the Enrollee.
7. MMM Multi Health will ensure that PMGs comply with the rules stated in this Section concerning Referrals, so that Enrollees are not forced to change PMGs in order to obtain needed Referrals, impose limit quotas or restrain services to subcontracted providers for medically necessary services (Laboratory, Pharmacies, or other services). Furthermore, any denial, unreasonable delay, or rationing of services to patients is expressly prohibited.

The referral is valid for a 60 days period from the issued date.

10.2 Timeliness of Prior Authorization

MMM Multi Health will ensure that Prior Authorization is provided for the Enrollee in the following timeframes, including on holidays and outside of normal business hours:

1. The decision to grant or deny a Prior Authorization must not exceed seventy-two (72) hours from the time of the Enrollee's Service Authorization Request for all Covered Services; except that, where MMM Multi Health or the Enrollee's Provider determines that the Enrollee's life or health could be endangered by a delay in accessing services, Prior Authorization must be provided as expeditiously as the Enrollee's health requires, and no later than twenty-four (24) hours from the Service Authorization Request.
2. ASES may, in its discretion, grant an extension of the time allowed for Prior Authorization decisions for up to fourteen (14) Calendar Days, where: The

Enrollee, or the Provider, requests the extension; or MMM Multi Health justifies to ASES a need for the extension in order to collect additional Information, such that the extension is in the Enrollee's best interest.

3. If ASES extends the timeframe, MMM Multi Health must give the Enrollee written notice of the reason behind granting the extension and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision.

The notice of the determination must be sent as expeditiously as the Enrollee's health condition requires and no later than the expiration date of the extension.

4. For services that require Prior Authorization by MMM Multi Health, the Service Authorization Request will be submitted promptly by the Provider for the MMM Multi Health's approval, so that Prior Authorization may be provided within the timeframe.
5. The MMM Multi Health will submit to ASES Utilization Management clinical criteria to be used for services requiring Prior Authorization. ASES will previously approve in writing such Utilization Management clinical criteria.
6. MMM Multi Health will ensure that the PMG complies with the rules laid down in this section on referral, so that beneficiaries are not obliged to change the PMG to obtain a referral.
7. If the referral system that is developed by MMM Multi Health requires the use of electronic media, such system will be installed in the providers office.
8. Any denial, unreasonable delay, or rationing of Medically Necessary Services to Enrollees is expressly prohibited. MMM Multi Health will ensure compliance with this prohibition from Network Providers or any other entity related to the provision of Behavioral Health Services to *MI Salud* Enrollees. Should MMM Multi Health violate this prohibition, MMM Multi Health will be subject to the provisions of Article VI, Section 6 of Act 72 and 42 CFR Subpart I (Sanctions).
9. MMM Multi Health will employ appropriately licensed professionals to supervise all Prior Authorization decisions and will specify the type of personnel responsible for each type of Prior Authorization in its policies and procedures.

Any decision to deny a Service Authorization Request or to authorize a service in an amount, duration, or scope that is less than requested will be made by a Provider who possesses the appropriate clinical expertise for treating the Enrollee's condition. For Service Authorization Requests for dental services, only licensed dentists are authorized to make such decisions,

10. Neither a Referral nor Prior Authorization will be required for any Emergency Service, no matter whether the Provider is within the PPN, and notwithstanding whether there is ultimately a determination that the condition for which the Enrollee sought treatment in the emergency room was not an Emergency Medical Condition or Psychiatric Emergency.
11. MMM Multi Health will not require a Prior Authorization or a Referral for dental services except for maxillofacial surgery, which requires Prior Authorization from a PCP.
12. MMM Multi Health will require Prior Authorization for filling a drug prescription for certain drugs specified on the PDL. Require a Countersignature from the Enrollee's PCP in order to fill a prescription written by a Provider who is not in the PPN. Any required Prior Authorization or Countersignature for pharmacy services will be conducted within the timeframes provided.

MMM Multi Health will comply with the Utilization Management policies and procedures for pharmacy services.

10.3 InnovaMD

InnovaMD is a Care Coordination Platform that has been designed to join patients, providers and partners allowing them to work together. InnovaMD utilizes a highly secure, powerful and efficient network platform that serves as a rendezvous point for all sectors within the healthcare industry. Upon joining, members of InnovaMD have the liberty of exchanging medical and administrative information instantly, while operating under strict regulations that guarantee compliance privacy and confidentiality.

Through a formula based on increased interoperability coupled with the effective flow of medical information, InnovaMD becomes an extremely valuable tool that keeps the healthcare industry well prepared while providing patients with high quality services so they receive the best quality treatment.

It is also the preferred communication channel between the providers and the MSO.

10.3.1 Benefits

1. Enables the providers to manage their medical panel more efficiently by using the Beneficiary Center functionality.
2. Facilitates an efficient communication platform among the group of health professionals who work with the patient.
3. Search and filter options are available across all enhanced applications allowing an intuitive and uniform use.
4. Capability to manage multiple sessions of selected beneficiaries during the creation and submission of services, encounters, etc.
5. Integrated functionalities to request services such as Referrals and Pre-authorizations.
6. Info Center serves as a centralized repository of administrative documents (Document Center), Clinical Guidelines, learning modules (Learning Center), reports (My Documents).
7. Providers have more options to grant their office staff access to InnovaMD transitioning their initial role from contacts to delegates.
8. Logged user is displayed more information regarding their role or roles within InnovaMD to facilitate switching between them.
9. Both *MI Salud* and Group Administrators can benefit of the availability of the Beneficiary Center functionality.
10. PCPs can enter additional contact information of their beneficiary's profile.
11. Secure and personalized access to clinical and financial information.

12. Streamlined, secure and confidential communication with the provider.
13. Interoperability platform.
14. Protects patients clinical information as required by HIPAA regulations

10.3.2 Available Application Tools and Functionalities

The following is a list of some of the tools and functionalities available to contracted providers:

1. Beneficiary Center – Allows PCPs to manage their medical panel more efficiently by having an easy access to a Clinical Profile and requests services such as Referrals, Pre-authorizations, etc. for one or more beneficiaries simultaneously.
2. Beneficiary Eligibility - Allows all providers to validate patient eligibility by searching with the Beneficiary ID and obtaining Demographic Information, Benefit Plan Information, Patient Coverage Information, Eligibility History and access to print the Certificate of Eligibility.
3. Practice Center – Allow all providers to centralized view of services referred by their practice.
4. Providers Directories – Allows all providers' access to all active and contracted network providers. Providers can filter by Company, Product, Doctors and Health Care Professionals, Medical Facilities. Searches can be performed Service Facility (Specialty), IPA groups, Name, Location, Zip Code, etc. Results include information such as office addresses, office telephone and map and other details.

10.3.3 Clinical Viewer

Allows providers access through InnovaMD using the Clinical functionality. This functionality has the capability to transmit electronically clinical information among a variety of health care systems to consolidate clinical

data that gains a new meaning in patient treatments and medical outcomes by improving the care offered by MMM.

- Benefits:
  1. Provides updated and accurate overview regarding the beneficiary clinical data.
  2. Allows the provider to directly access information regarding the patients results directly from the laboratories, x-rays, etc. and reduces delay in receiving these results from their patients.
  3. Avoids duplicity of therapies, doses, tests and procedures.
  4. Ensures the accuracy and clarity of diagnoses and prescriptions.
  5. Is aligned with Federal Government requirements in the management of electronic health records.

For more information visit the:

InnovaMD portal at www.innovamd.com, or contact

InnovaMD Support Team at:

Monday to Friday

7:00 a.m. a 7:00 p.m.

787-993-2317 or 1-866-676-6060

or by email at InnovaMDAlert@mmmhc.com.

10.4 Provider Call Center

The health plan providers of the Government of Puerto Rico have available the services of our call center which is open from 7:00 am to 7:00 pm. The call center offers services related to eligibility verification, claims status, pre-authorizations, payments among others, and serves primary service providers, specialists, health professionals, ancillary services facilities, dentists and hospitals. Telephone numbers are included below to access the Representatives of the provider call center.

Provider Call Center	787-993-2317 (Área Metro) 1-866-676-6060 (libre de cargos)
Dental Provider Call Center	787-522-5699 (Área Metro) 1-877-522-670 (libre de cargos)

3

4 **10.5 Interactive Voice System (IVR) Services**

The interactive voice system (IVR) is available to our entire provider. Through this system, providers can obtain automated information 24 hours a day, 7 days a week. It is convenient, easy to use and fast. In addition, the system provides the information you need at the moment in a confidential manner. The services available through this system are: verification of eligibility, referrals, and preauthorization's among others.

5 **10.6 InnovaMD Support Group**

The InnovaMD portal is an excellent tool for sharing health information of assigned lives with other providers within the health industry. The portal has been developed in a highly secure and efficient platform complying with strict regulations that guarantee compliance with privacy and confidentiality.

Providers can verify the beneficiary's eligibility, create, review and print referrals and pre-authorizations. In addition, they can check their payment history, review and print news, forms and guides, among others.

The use of the portal is free of charge and is available 24 hours a day, 7 days a week, and can be accessed at www.innovamd.com.

To offer a complete service, we have technical staff in the InnovaMD Support Group. This dedicated staff offers to our providers, technical support, guidance, education and all the necessary support during the registration and navigation process through our

portal. This team's service is also offered from 7:00 am to 7:00 pm and you can contact them through our Provider Call Center.

10.7 Electronic Health Record (EHR)

The providers will need to have updated their Electronic Health Record (EHR) to version 2015, this link takes indicates the Certification Companion Guides (https://www.healthit.gov/topic/certification-ehrs/2015-edition-test-method).

And, comply with Medicaid Promoting Interoperability Program requirements (see below); these requirements are most likely to be modified sometime in October 2018. (https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_Stage3_2018.pdf)

Medicaid eligible professionals promoting interoperability program stage three (3) objectives and measures for 2018:

Eligible Professional Objectives and Measures	
1.	Protect electronic protected health information created or maintained by the certified electronic health record technology (CEHRT) though the implementation of appropriate technical, administrative, and physical safeguards.
2.	Generate and transmit permissible discharge prescriptions electronically.
3.	Implement clinical decision support interventions focused on improving performance on high-priority health conditions.
4.	Use computerized provider order entry for medication, laboratory, and diagnostic imaging orders directly entered by any licensed health care professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local and professional guidelines.
5.	Patient Electronic Access – The eligible hospital or critical access hospital (CAH) provides patients (or authorized representative) with timely electronic access to their health information and patient-specific education.

6.	Coordination of Care – Use CEHRT to engage with patients or their authorized representatives about the patient's care.
7.	Health Information Exchange – The eligible hospital or CAH provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into the HER using the functions of CEHRT.
8.	Public Health Reporting – The eligible hospital or CAH is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.

Also, among the requirements are the eCQMs (https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CQM_Table.pdf).

11. Inpatient utilization management

11.1 Vision

The main objective is to ensure excellence in the provision of necessary medical services with the highest sense of responsibility and cooperation between providers and company facilities.

11.2 General Description

The management of inpatient medical use is a process designed to monitor a set of integrated components, including but not limited to:

- ✓ Case Number Notification
- ✓ Admission Review
- ✓ Concurrent Review

- ✓ Retrospective Review
- ✓ Discharge Planning
- ✓ Individual Case Management

The Puerto Rico Health Department and the Government Health Plan have delegated to MMM Multi Health, the Northeast and Southeast regions the medical review area, utilization processes and authorization of hospital stays in physical health services for adult and pediatric services as well as acute inpatient and partial mental health care to MSO of Puerto Rico, LLC (MSO).

MSO's Inpatient Utilization Review Department works with our medical providers to determine medical necessity, cost-effectiveness and quality of services provided at inpatient settings. All decisions are made according to current industry standards, contract agreements and clinical guide management based on updated medical evidence.

The process covers inpatient services rendered in acute and subacute levels of care, including the transition between these and the patient's home. The purpose of said processes is for our members to achieve optimal recovery in the required and appropriate level of care to maximize the benefits of their medical coverage.

11.2.1 Goals:

- Evaluate any case admitted to a hospital facility concurrently or retrospectively.
- Using clinical management guidelines for authorizing any admission to a subacute level of care, ancillary services, home care or equipment needed for optimal recovery.
- Implementation of medical care guidelines to prompt required services and promote excellence in our members medical management.
- Mediate an effective communication between facilities and providers to help identify possible medical necessities that a member may require during a

hospital admission, thus promoting an efficient and effective discharge planning process.

- Identify deviations and preventable events that may risk a patient's health and optimal recovery.

11.3 Inpatient Utilization Review Program Description:

This program is designed with the objective of evaluating all inpatient admissions concurrently and/or retrospectively in contracted facilities. The following principles govern the program:

- The Chief Medical Officer, Regional Medical Directors, Vice President of Clinical Operations and other components of the department are responsible for administering the program's review process and inpatient utilization management.
- The policies and procedures designed by the Inpatient Utilization Review Department are reviewed and approved by the Chief Medical Officer. MSO reserves the right to review these policies and procedures.
- The department is responsible for determining medical necessity of services in accordance with program policies and procedures. All clinical / medical determination is supported by updated evidence – based on medical care guidelines. MSO is currently using MCG. MSO reserves the right to select clinical care guidelines that will be utilized in concurrent and retrospective cases reviews in contracted facilities.
- The Inpatient Utilization Review Department is also responsible for identifying trends in overutilization or low utilization by monitoring referrals, encounter data, pharmacy data, review of records and requests for authorizations.
- MSO assigns responsibility of the concurrent and retrospective review process to highly qualified professional clinic staff (CRN and SCR) with extensive clinical experience in a hospital setting. The CRN and SCR receive direct support from Associate Medical Directors on *MI Salud* (AIMD), which

make the final decision to approve or deny the service.

- MSO reserves the right to reassign CRN and SCR staff to the contracted hospital facilities. This process of rerouting or changing facility is conducted every six (6) months or at the company's discretion depending on its needs.
- Any service that has been determined to not be medically necessary or not covered under the beneficiary's existing contract will be denied. Suppliers will have the right and opportunity to make an appeal about any adverse determination by Appeals and Grievances (A&G) Department Health *MI Salud* MMM Multi Health. The provider must meet the pre-deviation process and discussion of cases as established in this manual to be appropriate to evaluate the appeal.
- All service providers have the right to file an appeal from 30 days after the case is closed. To apply for appeal by hospital provider, it must submit all documentation complete (true and exact copy of medical records, a letter where indicating the reason to be validated the non-compliance days) required by the Appeals and Grievance Department. The appeal must be signed by a licensed physician to practice medicine in the Commonwealth State of Puerto Rico.

At MSO we are committed in providing excellent medical services. We work closely with utilization departments within contracted medical institutions and with patients' physician during the admission period to provide the greatest benefit to the patient. To achieve this, our utilization management decisions are based on medical necessity and timeliness of services provided based on the application of clinical care guidelines authorized by the company at the time of review. **MSO does not compensate people assigned to the review and manage utilization for denying services and does not provide financial incentives for approving or denying requested services.**

11.3.1 Organization:

1. Associate Inpatient Medical Director (AIMD) *MI Salud*

a. Health professional specialized in the field of medicine, certified and licensed by the Board of Medical Examiners to practice medicine in Puerto Rico.
b. Our AIMD is general medicine practitioner and we have various specialists and sub-specialists that support medical decisions and determinations during the utilization review process of inpatient cases.
c. AIMD it's the only responsible in the highlighting and determining non-compliant days in regards to services or a hospital stay. All decisions are supported by the utilization of medical management guidelines approved by MSO at the time of review or when providing a service.

2. Concurrent Review Nurse (CRN)
    a. A health professional specialized in nursing, certified and licensed as a General Nurse or Nurse Specialist by the Nursing Board of Puerto Rico to practice nursing in Puerto Rico.
    b. Our Concurrent Review Nurses are highly qualified professionals with clinical expertise, who have been certified and trained in the use of medical care guidelines approved by the company. Our CRN staff carries out the concurrent and retrospective review process validating provided medical care based on the documentation provided in the medical record.
    c. CRN staff may approve services as long as they comply with all clinical criteria as established in authorized medical care guidelines at the time of review and when services were provided.
    d. CRN staff is responsible for detecting administrative and medical treatment deviations, reporting them to the AIMD for corresponding action.
3. Senior Concurrent Reviewer (SCR)

a. A health professional with Doctor in Medicine degree, with 3 years minimum of experience in medical review.
b. Our Senior Concurrent Reviewer is a professional with extensive clinical experience that have been certified and trained in the application of clinical Care guidelines authorized by the company. Our SCR staff preforms concurrent review process and validating retrospective medical care based on the documentation provided in the medical record.
c. The SCR staff may approve services provided they meet all the criteria set by the guidelines approved at the time of the review or provision of services.
d. The SCR staff is responsible for detecting deviation in medical treatment or in administrative functions, referring them to the AIMD for appropriate action.

4. Discharge Planning Unit (DPU)
    a. Unit created by the company to support CRN and SCR, social work Department and utilization departments from institutions to facilitate and expedite the transition process from hospital to home or the assigned continued care facility.
    b. DPU, TU, CRN, SCR teams and MSO staff will act as a support entity in the discharge planning process with hospital providers and the attending physician.
    c. The hospital provider and the attending physician are responsible for conducting the discharge planning process, make necessary referrals and transmit them no less than three (3) calendar days before the discharge date.
    d. The hospital provider will coordinate the transition of care from hospital to home or assigned center with DPU staff.

11.3.2 Definition of Concepts:

1. Concurrent Review Process:
    a. The process by which the CRN and/or SCR assigned to the institution physically evaluates the clinical record at the hospital facility during the patient's stay. It is defined as concurrent review of the records when it occurs prior to the discharge date. The CRN and/or SCR must have contact with the medical record at least once to be considered a concurrent review prior to the patient's discharge.
2. Deviation Notification Process
    a. Intermediate phase of communication during the concurrent review process between the CRN, SCR and/or AIMD with the hospital provider and/or admitting physician.
    b. The CRN, SCR or AIMD will verbally notify the designated staff member or admitting physician from the hospital facility about any clinical and/or administrative deviation that should be corrected immediately by the hospital provider or the admitting physician.
    c. The provider will have a period lasting no longer than two (2) business days, from the date the deviation was notified verbally to present evidence of the correction of the deviation or have direct communication with the CRN, SCR or AIMD to justify said deviation.
    d. The objective of the process is to maintain information flow, promote clinical discussion of the case to facilitate management and minimize possible denial of days to either the hospital provider or the admitting physician.
    e. In case of a discharge that was seen by our CRN, SCR during the concurrent review process, the hospital provider has the right to invoke a Deviation Notification Process for the final days of stay (weekends or holidays) that were not reviewed by our CRN and/or SCR within a period of no more than ninety (90) calendar days from the case discharge date.

f. This process does not apply to the retrospective review process

11.4 Retrospective Review Process

a) Process by which the CRN, SCR physically evaluates the medical record at the hospital facility after the discharge date. Retrospective review will be defined as any revision or first contact with a medical record by our CRN and/or SCR after the discharge date. During this process, the patient is physically absent from the hospital facility due to discharge, transfer to another institution, discharge against medical recommendation or death.

b) The hospital facility has a period lasting no longer than ninety (90) calendar days from the discharge date to present the record to our CRN, SCR for evaluation, without an administrative penalty for exceeding the established period.

c) If a hospital provider presents a case exceeding the ninety (90) calendars day period after the case discharge date, the case will not be reviewed by our personnel. It will be filed with the recommendation of an administrative denial, subject to the Policies and Procedures between MMM Multi Health and the contracted facility at the moment the services were rendered.

d) The Deviation Notification Process does not apply to retrospective review processes.

11.5 Discharge Planning Process

a) The discharge planning process analyzes the patient's bio-psychosocial needs in a holistic manner during the hospital admission. This analysis is performed by a health professional.

b) The hospital provider and admitting physician are responsible for initiating, developing and implementing this process.

c) Any deviation from the hospital provider that delays this process and extends a patient's stay may cause an administrative denial of payment for excess days.

d) The hospital provider is responsible for providing all patients written instructions upon discharge, including the *Important Discharge Notice* and DNOD as per CMS and ASES regulations.

e) The hospital provider will provide every discharged member a Discharge Summary of their admission. It is the patient's responsibility to deliver the Discharge Summary to their Primary Care Physician (PCP).

f) As long as there is an agreement between the parties; an MSO Discharge planner can access the patient and family to help coordinate the discharge planning process including medication reconciliation, health education, follow-up appointments with their PCP or specialist and any services that require coordination with the health plan at the time of discharge.

11.6 Medical Care Guidelines

a) CMS endorses the use of medical care guidelines in the review of medical records and to support the authorization of services. The guideline that are currently being used and approved by MSO are MCG, it is used for clinical revision of records and the authorization of services as they are covered under GHP.

b) All personnel from the Inpatient Utilization Review Department have been trained and qualified in the application and use of these medical care guidelines. These care guidelines and company staff trainings are reviewed periodically.

c) MSO reserves the right to select the medical care guidelines based on business needs and in benefit of the member.

11.7 Skilled Nursing Facility (SNF) (non-coverage service)

a) Sub-acute level of care hospital facility specialized in rendering nursing care and physical rehabilitation services. The patient has surpassed the acute level of care needs of their condition and is currently in full recovery of their condition.

b) These services must be authorized by MSO's Inpatient Utilization Review Department prior to admission to the facility regardless the services are not covered under the *MI Salud* coverage.

c) Authorization to a SNF facility will be given after the revision of submitted clinical information and compliance with the criteria established by the authorized guidelines.

As part of the clinical evaluation of the record, it must include an estimate prior to admission and/or transfer (pre-admission screening). This should be done by a specialist in Physical Medicine and Rehabilitation. There must be included a detailed description of the patient's current condition, the need for rehabilitation therapy and the medical treatment. The same should be done within a 48-hour period prior to admission to the Skilled Nursing Facility.

d) A pre-admission screening that includes all the necessary elements, but that was performed more than 48 hours prior to the transfer may be accepted. It would require an update to document the patient's medical and functional status within the 48 hours immediately prior to the transfer.

e) The rehabilitation facility must provide full and detailed information. It should include, but is not limited to: functioning level prior to the event or condition that caused the patient to need intensive rehabilitation, expected level of improvement and the expected duration of time required to reach this level of improvement. It should also include an assessment of patient risk for clinical complications, the conditions that caused the need for rehabilitation, indicated treatments (physical therapy, occupational therapy, speech and language or prosthetics/orthotics), estimated duration, intended destination at time of discharge, any need anticipated after discharge and any other information relevant to the patient's needs.

f) The rehabilitation facility must provide further evaluation after admission, made within a maximum period of 24 hours immediately after admission. The same should be done by a specialist in Physical Medicine and Rehabilitation

and must include the patient's condition at the time of admission. This evaluation aims to compare it with the pre-admission documentation to begin developing the expected course of treatment of the patient with the information provided by the interdisciplinary team.

11.8 Rehabilitation Center (Rehab) (non- coverage service)

a) Hospital facility specialized in providing intensive physical rehabilitation as per CMS Manual definition. The patient has surpassed the acute phase of their condition and the goal is focused on physical rehabilitation.

b) These services must be authorized by MSO's Inpatient Utilization Review Department prior to admission to the rehab facility, as they are not covered under the *MI Salud* services.

c) Authorization to the rehab facility will be granted after the revision of submitted clinical information and compliance with the criteria established by the authorized guidelines.

d) As part of the clinical evaluation of the record, it must include an estimate for any diagnostic prior to admission or transfer (*pre-admission screening*) performed by a specialist in Physical Medicine and Rehabilitation. It should include a detailed description of the current condition of the patient, the need for rehabilitation therapy and medical treatment. The same should be done within a 48-hour period prior to admission to the rehabilitation center.

e) An examination prior to admission that includes all the necessary elements (pre-admission screening), but was done over 48 hours prior to transfer could be accepted. It will require an update to document the medical and functional status of the patient within the 48 hours immediately prior to the transfer.

f) The rehabilitation facility should provide full and detailed information. This should include, but is not limited to: functional capacity prior to the event or condition that requires intensive rehabilitation for the patient, expected level of improvement and the foreseen amount of time needed to reach said level

of improvement. An evaluation of the patient's risk for clinical complications should also be included, the conditions that caused the need for rehabilitation, the indicated treatments (physical, occupational, speech and language therapy or prosthesis/orthotics), estimated duration, expected destination after discharge, any need to be anticipated post-discharge and any other information relevant to the patient's needs.

g) The rehabilitation facility must provide further evaluation upon admission, done within a 24 hour period immediately after admission. It should be completed by a specialist in Physical Medicine and Rehabilitation and must include the patient's condition at the time of admission. The purpose of this evaluation is for comparison to preadmission documentation and to develop the patient's expected course of treatment with the information provided by the interdisciplinary team.

11.9 Policy for Admissions Notification and Medical Discharge: Acute level, SNF and Rehab (Non-coverage service)

1. Admissions:
    a. Hospital provider is responsible for notifying all admissions to our coordinators on a daily basis via telephone to the following numbers: 787-622-3000; ext. 8369, 8368, 8372, 8368, 8371, 8362, 8364, 8374, 8304, 8295, 8334 y 8367. They can notify admissions and discharges via fax to 787-999-1744, using the provided form.
    b. The form provided for notify the admissions and discharge must include Member ID, Member Full Name, Admitting Physician Full Name, Admission Diagnosis Code (ICD-9 or ICD-10), Admission Date, Discharge Date, Patient Room and the Admission Type. This information is requires for register the admission in the system and provide the reference number to the Hospital Provider.

c. The provider has a maximum of three (3) calendar days from the admission date to notify the admission to MSO's Inpatient Utilization Review Department to request a hospital case number.
d. MSO's Inpatient Utilization Review Department will verify member eligibility with the plan for the corresponding dates for which services were provided. If they are eligible, the coordinator from MSO will notify the case number to the hospital provider, either by telephone or by fax within twenty four (24) hours of the hospital provider's request. MSO is not responsible for the payment of services rendered to the member if the member is not eligible at the moment the services were provided.
e. The assigned case number does not guarantee payment of admission and the same is subject to the review of records by CRN, SCR staff.

2. Discharges:
    a. The hospital provider is responsible for notifying all discharges from MMM Multi Health patients to MSO within a period of time no greater than 24 business hours form the case discharge date to the same numbers as previously mentioned.
3. Notification Hours:
    - Office hours are Monday thought Friday, from 7:00 a.m. to 5:00 p.m.
    - They can notify admissions and discharges on weekends using the form they were provided by fax at 787-999-1744. The reference number for reported admissions notified on weekends will be offered the next business day.

11.10 Medical File Review Policy for the Contracted Hospital Facility

a) The Hospital provider is responsible for providing and assuring adequate physical facilities so that the CRN/SCR may perform a record review process from Monday to Friday from 8:00 a.m. to 5:00 p.m.

b) The hospital provider is responsible for having hospital staff accessible to help and attend the CRN/SCR during scheduled visits as agreed by MSO and the contracted hospital.
c) Concurrent review of our CRN / SCR will be assigned based on the volume of members admitted to the institution.
d) The hospital provider is responsible for compliance with the above mentioned processes to avoid delay in the concurrent review process or an increase in retrospective case reviews.
e) The healthcare provider must submit a census or list of hospitalized cases of MMM Multi business day. This Census must include all postpartum cases and born babies (whether babies in good health) that are in the Nursery.
f) The hospital provider should notify all new admissions and all discharges to CRN and/or SCR staff.
g) The concurrent review process for admitted cases should be initiated with the evaluation of the first day of hospitalization.
h) The hospital provider is responsible for presenting the CRN/ SCR with 100% of all admitted cases during the CRN's/SCR's visits to the facilities, including Emergency Room admission cases and TAU.
i) Cases that are not presented by the hospital provider to our CRN/SCR staff will be subject to denial if the medical record's documentation does not justify the days incurred.
j) Any post-stabilization period of admission by non-participating providers of MSO will be subject to denial in its entirety, as long as the case is not considered an emergency, if this is not transferred to the service of a network participant doctor.
k) The nonparticipating physician will perform the transfer of care process to a participating physician within the facility.
l) Participating hospital staff will cooperate with MSO so that nonparticipating physicians effectively transfer medical services to another participating

physician of MSO's Network without affecting the continuity of the patient treatment.

11.11 Inpatient Concurrent Review Policy for Acute and Sub-acute Level of Care

a) Concurrently reviewed cases will be evaluated by the CRN, SCR who will discuss all clinical and administrative deviations with the AIMD. Afterwards, the AIMD will apply the medical care guidelines established and notified by the company for final determination.
b) The process of determining medical necessity by concurrent review will continue in accordance with the policies and procedures as set out in this manual. The medical directors **will not** alter the processes of medical necessity determination and will continue to apply the MCG Care Guidelines.
c) The priority in the evaluation of medical records on behalf of the plan will be the concurrent review process and as second priority the retrospective review process.

11.12 Deviation Notification Policy

a) The deviation notification processes apply to the cases evaluated during concurrent review process.
b) The deviation notification process may be applied to the hospital provider, the medical provider, or both parties. The process will depend on whether the deviation is administrative, clinical or a combination of both.
c) After verbal notification of a possible deviation by the CRN/ SCR or AIMD to the personnel assigned by the hospital or medical provider, they will have a period lasting no longer than two (2) business days, from the date of verbal notification, to provide additional clinical information that will justify the deviation.
d) This information must be notified to our CRN/SCR or AIMD with the supporting documentation, clinical or administrative, for final determination of approval or denial of the days.

e) If the hospital or medical provider does not present additional clinical information or supporting documentation needed for final determination in the established timeframe, the initial decision for the deviation will proceed as a final determination, after being discussed between the CRN/SCR and AIMD assigned to the case.

11.13 Retrospective Admissions Review Policy

a) CRN and/or SCR personnel will physically evaluate the medical file in the area designated by the hospital facility after a member's discharge date.

b) The hospital facility will have a period lasting no longer than ninety (90) calendar days from the case discharge date, to present the review to the CRN and/or SCR for evaluation without administrative penalty of denial for exceeding the assigned timeframe.

- This process may be subject to current written contractual agreements between both parties (MSO and the contracted institution) at the moment the services were rendered.

c) The CRN and/or SCR will verify the eligibility of the retrospective case and notify the hospital provider for the dates to provide the services.

d) If a case is presented after the assigned period has passed, the case will not be audited by our CRN and/or SCR. We will proceed to stamp the record indicating an administrative denial and will be subject to the Policies and Procedures of MSO's Claims Department.

e) This process may be subject to current written contractual agreements between both parties (MSO and the contracted institution) at the moment the services were rendered.

f) In retrospective cases with denials from Original Medicare or other health plans, the provider must present our CRN and/or SCR with the denial letter as evidence to initiate the retrospective review process.

g) The hospital provider has a period lasting no more than ninety (90) calendar days, from receiving the denial from Original Medicare or another health plan to present the case to the CRN and/or SCR.

h) If a record is presented after the assigned period after receiving the denial from Original Medicare or another health plan, the case will not be audited by our CRN and/or SCR. We will proceed to stamp the record indicating an administrative denial, which will be subject to current written contractual agreements between both parties (MSO and the contracted institution) at the moment the services were rendered.

i) The process to determine medical necessity during the closure of retrospective admissions will continue in accordance with policies and procedures as established in this manual. The AIMD **Will Not** alter the processes of medical necessity determination and will continue to apply MCG Care Guidelines.

11.14 Admissions Denial Days and Level of Care Adjustment Policy

a) The CRN and/or SCR is responsible for initiating the evaluation of the clinical file and identifying possible deviations that affect the management or stay of a patient, by applying the medical care guidelines approved by MSO at the time the services were provided.

b) The CRN and/or SCR will only take into consideration the evidence documented in the clinical file at the moment of the evaluation.

c) The deviation notification process will be activated with a hospital provider or admitting physician and the personnel assigned by the institution will be notified verbally. It is the hospital institution's responsibility to initiate the communication process with its medical staff to promote the flow of information, legible documentation, and availability of information that will support the member's hospital stay and the level of care provided. The hospital facility has ten (10) calendar days to discuss the cases with deviations.

d) The CRN and/or SCR will have daily discussions with the AIMD in regards to all potential deviations that may cause denial of days, medical visits or services.

e) If the hospital or medical provider does not comply with the deviation notification process and there is no documentation supporting or justifying the member's hospital stay and level of care, the determination of denial days or the adjustment in level of care will prevail.

f) The CRN and/or SCR will complete the case review process and will give the provider the final notification letter or a report with the summary of completed cases indicating approved or denied days on the date of closure of the file.

11.15 Discharge Cases Closure Policy

a) The hospital provider will cooperate in handing in cases with medical discharge to the CRN and/or SCR to close the case in a period no greater than ninety (90) calendar days from the discharge date.
   - This process may be subject to current written contractual agreements between both parties (MSO and the contracted institution) at the moment the services were rendered.

b) The CRN and/or SCR will deliver written notification to the hospital provider indicating authorized days, non-compliance days or adjustments in the level of care.

c) If the hospital provider does not present the discharged cases to the CRN and/or SCR within a ninety (90) calendar day period from the case discharge date, the AIMD will recommend an administrative denial of the days that were not audited.

11.16 Concurrent Review Process to Prolonged Admission Stay at Emergency Room (TAU) Policy

a) This policy only applies to providers that have a contractual agreement with MSO that establishes contracting services under TAU (Transitional Admission Unit).

b) Assessment criteria and current notification policies from MSO's Inpatient Utilization Review Department, deviation notification policies, the retrospective case review policy and policies relating to notification of noncompliance days or adjustment in level of care will be applied.

c) The CRN and/or SCR apply the scope of contractual clauses providing medical services to the patient. The approval or denial of services for not meeting the criteria established in TAU, adjustments in level of care or medical visits lies exclusively on the AIMD.

d) For hospital facilities that MSO contracts with per diem rates who do not have a written and valid TAU contract or other contractual agreements at the time the services were provided; the days that the patient remains in Emergency Room facilities without being transferred to the patient's appropriate level of care as recommended in the medical orders, will be denied by the AIMD due to administrative reasons.

   - Any hospital provider without a TAU contract will have until 12:00 am (midnight) of the admission day to transfer the patient to the appropriate level of care recommended in the medical order to avoid a noncompliance day.

e) Admissions with prolonged Emergency Room stays and located in the assigned TAU unit will not be able to exceed a period of twenty four (24) hours starting from the date and time of the admission order. This may vary depending on the conditions stipulated in the contract. Excess days will be

documented as non-compliance days by the AIMD due to administrative reasons.

11.17 Notification of Medical Consultations for Specialists or Sub-Specialists Policy

a) The hospital provider will have a period of no more than twenty four (24) hours from the date and hour of the medical order for the medical consultant to evaluate the patient.
b) If the consultant exceeds the established twenty four (24) hour period to evaluate the patient and makes recommendations or adjustments that alter the treatment or the patient's hospital stay, then the excess days incurred waiting for the consultant's evaluation will be denied by the AIMD due to administrative reasons.
c) This policy may be subject to current written contractual agreements between both parties (MSO and the contracted institution) at the moment the services were rendered.

11.18 Report of events HAC & SRAE Policy

a) Never Events, HAC or SRAE are defined as everything related to quality care, any acquired conditions and or preventable clinical event that occurs during a patient's hospitalization and that was not identified as a condition Present on Admission (POA) or has been acquired in the hospital as defined by the CMS and ASES.
b) The hospital provider will allow personnel access to medical files for investigation HAC or SRAE within five (5) working days from the moment when the event occurs, to allow the health plan to respond within the ten (10) day period, as established by CMS and ASES. The event will also be notified by the hospital provider to MSO's CRN and/or SCR.
c) The hospital provider will be accessible to attend and discuss the case with a representative from MSO if it is required to discuss the case and observations.

d) The Sentinel events or Serious Reportable Adverse Events will be evaluated in every concurrent and retrospective case review.

e) For more information regarding regulations related to Sentinel Events, HAC or SRAE, please visit the following link where you will also find an updated list of conditions considered SRAE:

www.cms.gov

f) MSO reserves the right to implement the policy of events, HACs o SRAE as per existing regulations or new changes from CMS.

11.19 Report Hospital Special conditions diagnosed Policy

a) Is defined as a special condition that all or congenital chronic condition that requires specialized medical care as defined by the *MI Salud* (see list) who has been diagnosed during the period of hospital admission.

b) The hospital provider will allow the CRN and/or SCR access the medical record and other relevant data and studies to support and certify the diagnosis of this condition to permit the plan to report it to the PCP and ASES.

c) The PCP proceeds to request special ASES cover that corresponds to the beneficiary as required.

d) The cases with special conditions will be evaluated by the CRN and/or SCR across concurrent review and retrospective case when appropriate.

Special Condition list:

- HIV/AIDS
- Tuberculosis
- Lepra
- Lupus
- Scleroderma
- Multiple Sclerosis
- Cystic Fibrosis
- Cancer

- Hemophilia
- Aplastic Anemia
- Rheumatoid Arthritis
- Autism
- Clinical Renal Failure (Stage 3, 4 & 5)
- Obstetrics
- Post-transplant status
- Child with special conditions

11.20 Letter Delivery Process NDMC, NOMNC, DENC and DNOD Policy

A. NDMC:

- Following federal regulations from CMS, handing a member this written notification is the responsibility of CRN and/or SCR from MSO in close collaboration with the provider. This regulation applies to acute level of care hospital facilities.
- The reasons for delivering an NDMC are specified in the CMS Manual.

B. NOMNC:

- The delivery of this written notification to the member is established under Federal CMS regulations as the responsibility of the CRN and/or SCR from MSO in close collaboration with the hospital provider. This regulation applies to SNF/Rehab subacute care facilities.
- The delivery of the NOMC letter must be done two (2) calendar days before the patient's programmed discharge.
- The reasons for delivering an NOMNC letter are specified in the CMS Manual.

C. DENC:

- Detailed Explanation of Non Coverage; detailed letter of non-coverage.
- The delivery of this written notification to the member is established under Federal CMS regulations as the responsibility of the CRN and/or SCR from MSO in close collaboration with the hospital provider.

- This regulation applies to subacute care level facilities (SNF/Rehab).
- If the member, or their authorized legal representative, does not agree with the NOMNC letter, they have the right to invoke an appeal in writing or by phone to ASES before 12:00 p.m. of the day after the letter was delivered.
- ASES will contact the plan or personnel from MSO's Inpatient Utilization Review Department so that they may deliver the DENC notification to the member in the following hours, but no later than the following calendar day.
- If deemed necessary, the health plan's representative will deliver the DENC notification when the NOMNC letter is delivered.
- Reasons for delivery of letter are specified in the CMS Manual.

D. DNOD:

- Detailed Notice of Discharge; detailed written notice delivered to the member or their authorized representative who appealed their discharge through ASES.
- The notice provides a detailed explanation of why both the hospital and the plan are in agreement with the member's admitting physician that the member's inpatient hospital services should end on the date indicated on the notice.
- It is the hospital's responsibility to deliver the letter to the member or authorized representative on or before 12:00 p.m. the next day after ASES notified the company of the appeal request.

11.21 Transition care of level for hospitalized patients from acute to sub acute (SNF/Rehab) level or ambulatory (by exclusion of coverage)

1. SNF/Rehab center Planned/Not planned:
    a. SNF/Rehab Center services must be authorized by MSO's Inpatient Utilization Review Department, before admission, in coordination with

the CRN, SCR or AIMD and the hospital provider, prior to the patient's transfer.

b. MSO's AIMD will apply criteria and corresponding guidelines to determine medical necessity of services based on submitted documentation in the authorization request.

c. Cases must be transferred only to facilities with a contract with MSO and with prior authorization from the plan.

- If the case is transferred without prior authorization, it may be denied in its entirety by the AIMD.

d. The request for SNF/Rehab services must be notified with a period of no less than two (2) calendar days before the patient's acute care discharge date. It should be accompanied by all necessary clinical evidence and the patient's rehabilitation plan to make it easier to evaluate and authorize it.

2. Planned and unplanned ambulatory services:

a. Services to transition to an ambulatory level of care require authorization from MSO's Discharge Planning Unit (DPU).

b. The services requested will be evaluated for medical necessity following established guidelines at the moment of request.

c. The hospital and medical providers are responsible for the discharge planning process and may use CRNs and/or SCR, DPU, TU and other components of MSO's Inpatient Utilization Review Department as facilitators.

d. All services or durable medical equipment must be requested in the format established by MSO. It must be requested to 1-844-337-3332 (toll free), by a participating medical provider of MSO's Provider Network that serves MMM Multi Health members on/or before three (3) calendars days before the expected date of the medical discharge.

DPU Contact Telephone Numbers:

1-844-330-8330

Fax: 1-844-550-3550

Availability of DPU Services are Monday to Friday 8:00 a.m. a 5:00 p.m. and after business hours; Calling to 1-844-330-8330.

11.22. Non Urgent, Non-Emergency Transportation Authorization Policy (by exclusion of coverage)

- All requests for non-urgent, non-emergency transportation services must be directed to PAU and or DPU Units via fax to:

PAU 1-844-220-3220

DPU 1-844-550-3550

To verify the status of a transportation request, call:

1-844-330-1330, Monday to Friday at 8:00 a.m. to 5:00 p.m.,

and after business hours.

11.23 Hospital Mental Health Services

a. Hospital services for the management of mental health conditions are contracted by MSO.
b. These services must be authorized by MSO.
c. The hospital and medical provider for an acute or subacute case are responsible for initiating and completing the coordination of these services and the transfer of mental health services. Contact number:
    - 1-866-676-6060
    - Fax: 1-844-990-6990

11.24 Appeals and Grievances Policy (Hospital Provider)

a. The hospital provider has the right to appeal submit by any adverse determination made by the plan to the Appeals and Grievances; provided it complies with the foregoing processes including deviation process and concurrent review cases discussion.
b. Appeals process is one in which the medical record submitted is evaluated in its entirety, which may result in a greater number of days with adverse

determination, revocation and / or modification of the existing determination for the same. The same is done by an AIMD that was not involved in the original determination of the case.

c. The hospital provider has a period of no more than thirty (30) calendar days from the member's discharge date in a case seen during the concurrent review or retrospective to initiate the formal appeal process in writing. The letter should be giving the reasons with evidence to validate noncompliance days signed by a licensed physician to practice medicine in the Commonwealth of Puerto Rico.

d. The hospital provider must send within the established time period an exact copy of the medical record along with an appeal letter indicating the reason for the dispute and evidence that supports the services and procedures rendered to the member to the following address:

Postal Address:

Appeals and Grievances *MI Salud* Department

PO Box 72010 San Juan P.R., 00936-7710

Physical Address:

Edificio Fundación Ángel Ramos (Anexo),

Avenida Chardón, Hato Rey, PR 00936

e. If the hospital provider does not send the request in writing to initiate the appeals process to MMM Multi Health, within the thirty (30) calendars day period established, the process will not be activated and the initial determination will remain, notifying the provider t in writing. The case will be dismissed.

f. Appeals and Grievances Department will have a period lasting no longer than sixty (60) calendar days, to respond.

g. A medical director of MMM Multi Health will review all documentation submitted for re-consideration and determine whether full admission meets

clinical criteria based on MCGs. MMM Multi Health will determine if additional days are added to the initial denial.

11.25 Re-consideration Appeal Process

a. To consider case appeal reconsideration the hospital provider must meet the pre-deviation process, cases discussion and appeal. I not full with the established process the request for reconsideration will be dismissed and will not be evaluated.
b. The provider must submit a written request accompanied by evidence justifying and service, no later than ten (10) business days starting in from the written notice of A & G.
c. The hospital provider will have a period not exceeding ten (10) labors day from the date of receipt of the letter in reply to ease to evoke the at appeal process determination.
d. The application will be considered if the hospital provider sends a letter requesting a reconsideration process stating the specific reason and detailed evidence to justify the services or procedures. If not received any additional information to support the services to be reconsidered, the application will not be evaluated and will be dismissed. This documentation must be sent to the following address:

MMM Multi Health (GHP)

Postal Address:

Appeals & Grievance Department

PO Box 72010 San Juan, PR 00936-7710

Physical Address:

Fundación Angel Ramos Building (Anexx)

Chardón Avenue, Hato Rey PR 00936

e. The A&G Department notifies the determination of the application in writing via regular mail, fax or electronic mail.

f. The provider may submit a dispute to the plan ten (10) days after the notice of determination of the review of the reconsideration. MMM Multi Health will have 15 days to determine. The dispute processes apply only if the supplier complied with the requirements of the review.

11.26 Definition and Description of the Admitting Physician Program (APP)

a. APPs are regional programs endorsed by medical groups (IPA Groups), contracted by the company, which have privileges in diverse hospitals or institutions around the island for the provision of inpatient services.
b. APPs include physicians with the following specialties: Internal Medicine, Geriatric, Generalist, Pediatrician or Family Medicine.
c. The particular details of each APP may vary by region according to the needs of medical providers, participating institutions and our members.
d. The fundamental purpose of these programs is to promote the necessary inpatient coverage so that the *MI Salud* MMM Multi Health members receive the appropriate treatment in the appropriate place and time.
e. APPs and medical groups to which they belong are independent entities and MSO reserves the right to hire or renew contracts with these groups. These contractual provisions are strictly tied to quality parameters, timeliness, utilization, service and cooperation of these groups with contracted institutions, PCP's in the region and the members they serve.
f. Medical groups in APP programs are responsible for:
    - Creating an on call program for patients in different hospitals in the region.
    - Coordinating all medical management, discharge process and transition of a level of care for all patients under their care.
    - Maintaining communication with peers, the medical institution, UM from *MI Salud* MMM Multi Health the patient's PCP.
    - Ensuring that service quality is not affected, adapting to clinical management guidelines and protocols authorized by the plan.
    - Emergency coverage 24 hours a day, 7 days a week.

- Provide clear and concise instructions to patients at the time of discharge along with a summary of admission.
- Send an admission summary including relevant information of the hospitalization and outcome of relevant studies to the member's PCP.

11.27 "APP Exchange" Policy and Procedure (Exchange between physician non-participating in APP program to physician participating in the APP Program)

a) Policy and process that applies to institutions where there are physicians participating in inpatient managed care programs (APP).
b) If a physician not participating in this program is consulted to evaluate and / or admit a beneficiary from *MI Salud* MMM Multi Health

member, they must transfer the medical care to a staff member that does participate in the program after the member has been stabilized. The transition process must be activated by the nonparticipating physician only after the member's post-stabilization period; ensuring the wellbeing and continuity of medical management.

c) The non-participating physician or institution should call; toll free 1-855-944-9441 for assistance in the practitioner exchange process.
d) If the exchange is not solve I a period no longer than one 1 hour from receiving the call, the non-participating physician will receive the authorization number and the hospital will be able to bill said services to MSO.
    - An authorization number is not a guarantee of payment and any admission will be subject to evaluation and application of medical necessity criteria according to the clinical guidelines authorized by MSO (MCG)
e) If the exchange process does not happen within the first 24 hours after stabilizing the member, the case may be denied administratively to the hospital.

f) The hospital staff will cooperate with MSO so that the non-participating physician transfers the medical services in an effective manner to a staff member that does participate in an APP without affective the services or the patient's continuity of care.

12. Provider Network and Contracting Process

12.1. Sanctions or fines applicable in cases of non-compliance

ASES will review each executed Provider Contract against the approved model of Provider Contracts. ASES reserves the right to cancel Provider Contracts or to impose sanctions or fees against MMM Multi Health for the omission of clauses required in the contracts with Providers.

The Credentialing Department verifies excluded providers and the Medicare/Medicaid Opt-Out list, on monthly basis, prints and files copy of the reports available in the following links:

a. http://oig.hhs.gov/fraud/exclusions/supplement_archive.asp
b. http://medicare.fcso.com/Opt_out/

If a Credentialing Department becomes aware that a provider has been excluded or has opted-out, the Coordinator informs the Network Operation Departments start the process of removing that provider from *MI Salud* network. The specific reasons to consider the exclusion of a provider are as follow:

- 1001.201 - Conviction relating to program or healthcare fraud.
- 1001.301 - Conviction relating to obstruction of an investigation.
- 1001.401 - Conviction relating to controlled substances.
- 1001.501 - License revocation or suspension.
- 1001.601 - Exclusion or suspension under a Federal or State healthcare program.
- 1001.701 - Excessive claims or furnishing of unnecessary or substandard items and services.

- 1001.801- Failure of HMOs and CMPs to furnish medically necessary items and services.
- 1001.901 - False or improper claims.
- 1001.951 - Fraud and kickbacks and other prohibited activities.
- 1001.952 - Exceptions.
- 1001.1001 - Exclusion of entities owned or controlled by a sanctioned person.
- 1001.1051 - Exclusion of individuals with ownership or control interest in sanctioned entities.
- 1001.1101 - Failure to provide payment information.
- 1001.1301 - Failure to grant immediate access.
- 1001.1401 - Violations of PPS corrective action.
- 1001.1501 - Default of health education loan or scholarship obligations.
- 1001.1601 - Violations of the limitations on physician charges.
- 1001.1701 - Billing for services of assistant at surgery during cataract operations.
- MMM Multi Health will not make a payment to any Provider who has been barred from participation based on existing Medicare, Medicaid or CHIP sanctions, except for Emergency Services.

12.2 Provider Qualifications

A group of Network Providers that *MI Salud* Enrollees may access without any requirement of a Referral or Prior Authorization; provides services to *MI Salud* Enrollees without imposing any Copayments; and meets the Network requirements described in Article 9 of this Contract. The *MI Salud* will comply with the requirements specified in 42 C.F.R. §438.207(c), §438.214 and all applicable Puerto Rico requirements regarding Provider Networks.

12.2.1 Provider Qualifications and Categories

Primary Care Physician, Specialist & Ancillary

Physician	● A person with a license to practice medicine as an M.D. or a D.O. in Puerto Rico, whether as a PCP or in the area of specialty under which he or she will provide medical services through a contract with the GHP; and is a Provider enrolled in the Puerto Rico Medicaid Program; and has a valid registration number from the Drug Enforcement Agency and the Certificate of Controlled Substances of Puerto Rico, if required in his or her practice. PCP Example: ● General Medicine ● Internal Medicine ● Geriatric Medicine ● Family Medicine ● Pediatric Medicine Other specialist to be consider Primary Care under special circumstance are the following: ● Obstetrics & Gynecology ● Hematology ● Gastroenterology ● Nephrology
Ancillary	● Federal Qualified Health Centers (RQHC) ● Hospital ● Rural Health Clinic (RHC) ● Non-Hospital Providing Facility ● Schools of Medicine ● Detoxification Facility ● Short Term Intervention Center ● X-Ray Facilities ● Clinical Laboratories

	● Providers and facilities for Behavioral Health Services ● Specialized Service Providers ● Urgent care centers and emergency rooms ● Any other Providers or facilities needs of the Service Region.
Non-Medical Practicing Provider	● Physician Assistant ● Nurse
Specialist	● Podiatrists ● Optometrists ● Ophthalmologists ● Radiologists ● Endocrinologists ● Nephrologists (ENTS) ● Pulmonologist ● Otolaryngologists (Ents) ● Cardiologists ● Urologists ● Gastroenterologists ● Rheumatologists ● Oncologist ● Neurologist ● Infectious Diseases ● Orthopedists ● Physical & Rehabilitative (Physiatrist) ● General Surgeons ● Chiropractors
Behavioral Health Providers	● Psychiatrist ● Clinical or Counseling Psychologist ● Social workers (“MSW”) ● Care Managers

	● Certified Addiction Counselors ● Behavioral Health Facilities

12.3 Preferred Provider Network ("PPN") Standards

A Preferred Provider Network ("PPN") refers to a group of contracted Network Providers that *MI Salud* Enrollees may access without the requirement of a Referral from their PCP. An added benefit to the Enrollees is that by using a PPN provider there are no co-pays that the enrollee is responsible for. The PPN is composed of: physician specialists, clinical laboratories, radiology facilities, Hospitals and ancillary service providers that will render Covered Services to persons enrolled in the *MI Salud* (Enrollees). The objectives of the PPN model is to increase access to Providers, improve timely receipt of services, improve the quality of Enrollee care, enhance continuity of care, and facilitate effective exchange of Personal Health Information between Providers and MMM Multi Health.

The PPN can be divided in two categories:

- A general PPN contracted by MMM Multi Health available to all Enrollees within the region
- A more limited PPN contracted directly through the individual Primary Medical Group ("PMG's") of the region. The particular PMG PPN can be accessed by the Enrollees who selected a PCP participating in such PMG.

Through the MMM Multi Health PPN, regional Enrollees will be allowed to receive services from all Providers within the PPN without Referral from their PCP. Enrollees who receive a prescription from a PPN Provider are allowed to fill the prescription without the requirement of a countersignature from their PCP.

In addition to the general PPN, Enrollees within a PMG that has its own PPN, can access such Providers without the need of a referral from their PCP as well as acquiring a prescription without the countersignature of their PCP. Providers within the PMG PPN could be co-located at the PMG facilities.

Through this PPN model MMM Multi Health shall improve access to care while improving the quality of services in a cost effective manner. *MI Salud* is an integrated

program that includes both Physical and Behavioral Health Services, and must also explain the concepts of Primary Medical Groups and Preferred Provider Networks. The General Network will be comprised of all Providers available to Enrollees including those Providers who are designated as PPN and those Providers who are not included in the general or particular PMG PPN.

12.4 Provider Credentialing

Provider Enrollment as Medicaid Providers

According the PRHIA-ASES contract requirement, MSO needs to verify that all Providers for *MI Salud* are Medicaid-enrolled Providers consistent with the Provider disclosure, screening and enrollment requirement of 42 CFR part 455, subparts B and E as incorporated in 42 CFR 438.608(b). If provider isn't enrolled as Medicaid Provider, the process cannot start with MSO Credentialing Department. The provider needs to comply and satisfy first the Medicaid enrollment requirement before beginning the initial credentialing process. All request of initial credentialing process without Medicaid Enrollment will be automatic rejected by MSO Credentialing Department.

ASES will issue to MSO a list of providers who have applied and who have been approved weekly. We will use this list to update our records to validate which network providers have registered properly in Puerto Rico. All providers must ensure revalidation with the state every 5 years.

12.4.1 Standard for Credentialing and Re-credentialing

A. Credentialing is required for:

- All physicians who provide services to the MMM Multi Health Enrollees and all other types of Providers who provide services to the MMM Multi Health Enrollees, and all other types of Providers who are permitted to practice independently under Puerto Rico law including but not limited to: hospitals, X ray facilities, clinical laboratories, and ambulatory service Providers.

B. Credentialing is not required for:

- Providers who are permitted to furnish services only under the direct supervision of another practitioner; Hospital-based Providers who provide services to Enrollees Incident to hospital services, unless those Providers are separately identified in Enrollee literature as available to Enrollees; or Students, residents, or fellows.

C. Professionals / suppliers who are invited and / or wish to be part of the network of MSO providers, must:

- Comply first with the enrollment requirement through the Health Insurance Administration (ASES) and the Medicaid program in accordance with the mandates of state and federal laws.
- Send to the Network Management Department a complete initial application for the evaluation process to participating in the network. A complete application consists of current documents and is defined with the following credentials:
    - Signed application form from requesting provider
    - Evidence of enrollment in the Medicaid program
    - DEA Certificate
    - Malpractice insurance
    - ASSMCA certificate
    - License issued by the Department of Health of Puerto Rico (Facility / Physician).
- Practitioners/Providers will not be included in the network until the credentialing process is completed.

D. Selection will be based on a number of factors including but not limited to:

✓ Enrollee needs, including accessibility and availability
✓ Network needs
✓ Successful completion of the credentialing process.

MSO will not discriminate against any physician solely on the basis of certification or specialty, race, color, ethnic/national identity, gender, genetic information, age, languages, sexual orientation, HIPAA, disabilities or the type of procedures in which the practitioner specializes.

Nondiscrimination Oversight review is done proactively, and through an ongoing monitoring process. Credentialing Committee members sign an attestation that they do not practice discrimination during the credentialing process, and the Credentialing Department monitors practitioner complaints for allegations of discrimination, and reports their findings to the QIC.

Network Adequacy reports are generated on an annual basis. After analysis, a moratorium on specific provider classification may be in effect if there is no need for that specific provider in the network. Thereafter the moratorium of new PCP physicians (General Practitioner (GP), Internal Medicine (IM), and Family Practice (FP), Geriatric, Pediatric and Obstetrics & Gynecology (OB-GYN) will be waived considering the following:

1. The requesting PCP will become part of an MSO Group, and all his contracting documentation has been approved by the MSO.
2. Non-Contracted PCP provides services in an underserved area where his specialty is required (Applies only to IM and FP providers).
3. Non-Contracted IM or FP is a Board certified provider; that accepts participation in the Plan Educational Program for Admitting Physicians (CHAMMP); when applicable.
4. In instances when provider receives, inherits or buys a practice from a retiring physician who is currently a member of MSO.

MSO through verifies information for credentialing and re-credentialing by using oral, written, and Internet data. Primary source verification includes:

- ✓ A current valid license to practice in Puerto Rico (Good Standing)
- ✓ Evidence of education and training
- ✓ Information from the NPDB and HIPDB query

- ✓ Any information regarding sanctions and/or limitations to licensure
- ✓ Any sanction or Opt-Out activity by Medicare
- ✓ DEA Certificate
- ✓ AMSSCA Certificate
- ✓ Medicare number for institutional provider and practitioner that submits prescriptions.

MSO of PR or any of its contracted providers will not contract with, or employ any individual who has been excluded from participation in the federal and state programs. MSO will recredentialize providers at least 36 months through a process that updates information obtained during initial credentialing and considers performance indicators collected by MSO and the appeals and grievances department.

When primary source verification have not been received after 15 days of the receipt of application, the provider will be notified. A provider will not be credentialed if after 45 days from the date the application was received the primary source verification of education and license has not been received. A letter will be sent to the provider notifying the decision and advising to resubmit another application.

A physician will have the right to review information, excluding the NPDB/HIPDB, submitted by an outside primary source to MSO of PR in support of his/her credentialing and re-credentialing process and to correct any erroneous information.

Upon request, all practitioners have the right to be informed of the status of their credentialing and re-credentialing applications. Practitioners receive notification of these rights and how to contact the Provider Contact Center, as stated on the credentialing application.

12.5 Credentialing Committee Review and Decision Process

All credentialing time factors must be in compliance and within 180 days' time required at the time of the Credentialing Committee decision. For those files reviewed by the Credentialing Committee, under Categories I, II, or III, primary source verification, malpractice history, sanction activity, a practitioner's health status, any history of loss or limitation of privileges or disciplinary activity is reviewed for both credentialing and

re-credentialing. Site visit results are only considered for Primary Care Physicians with 10 lives or more and Psychiatrics with more than 3 claims in the last 12 months. Practitioners with less than 10 lives or 3 claims, when apply, are excluded and a letter for this exclusion will be included in the re-credentialing file. Quality of Care results are considered for all organizational providers when the Quality Department performed this as a result of an appeal and grievances referral. Practitioner applications that are assessed by the credentialing staff as "clean" files are identified as Category I are reviewed and approved by the Credentialing Committee. For Categories II and III, the committee reviews any positive responses on the Practitioner Questionnaire regarding health issues which may be physically or psychologically unable to perform the essential functions of the position with or without accommodation, and malpractice claims resulting in individual judgments of $100,000 or less and the practitioner's credentials do not fall within the scope of the criteria described above. The Credentialing Committee may recommend approval without conditions, approval with conditions, denied participation, or defer the decision for further investigation. All applicants receive written notice within calendar days after the Credentialing Committee has rendered a final decision.

12.6. Delegation

Delegation is a formal process by which MSO gives a provider group or an entity (delegate) the authority to perform certain functions on its behalf, in a manner consistent with the applicable regulations.

This process may involve delegation of credentialing responsibilities such as: information gathering, verification of some or all of the credentialing elements, or it can include delegation of the entire credentialing process, including decision-making. Other processes may be delegated such as: utilization management, and claims processing, among others. It should also be noted that a function may be fully or partially delegated.

The decision of what function may be considered for delegation is determined by the type of contract a provider group has with MSO, as well as the ability of the provider group or an entity to perform the function.

Although the MSO can delegate the authority to perform a function, it cannot delegate the responsibility. If a provider wants to delegate any services, such delegation must be preapproved by the MSO and set forth in a separate addendum that shall include the following requirements:

1. Specify delegated activities, reporting responsibilities, and performance guarantees.
2. The organization evaluates the entity's ability to perform the delegated activities prior to delegation. The organization must document that it has approved the entity's policies and procedures with respect to the delegated function.
3. Written arrangements must provide for revocation of the delegation activities and reporting requirements in instances where the delegate has not performed satisfactorily.
4. Specify that the performance of the parties is monitored by the MSO on an ongoing basis.

All contracts or written arrangements must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare and Medicaid laws, regulations, reporting requirements, and CMS instructions.

The MSO Delegation Oversight Program incorporates the following requirements, at minimum:

1. Evaluation of the entity’s ability to perform the delegated or administrative activities prior to delegation.
2. The MSO Delegation Oversight Audit Team will conduct on-site audits to review activities performed by delegated entities.
3. Site reviews shall be conducted in accordance with regulatory requirements and MSO and Health Plan policies, procedures, and performance standards.

4. Audit results will be reported to the Health Plan Delegation Oversight Committee.
5. The MSO requires the delegated entity to enter into a written, mutually agreed upon contract or agreement.
6. The MSO will assess the entity's ability to perform delegated or administrative functions on an ongoing basis, by monitoring entity in an annual audit, and through regular monitoring reports.
7. The MSO uses a delegated audit tool to assess and assure entity compliance with regulatory requirements.
8. The MSO requires non-performing entities to submit a Corrective Action Plan (CAP). A CAP is a formal written response that identifies all entity deficiencies cited during the audit and/or monitoring activity. The CAP addresses each deficiency, and outlines the corrective action(s) required from the entity.
9. If a delegated entity remains non-compliant with MSO requirements, the MSO retains the right to take final actions which may include but are not limited to:
    - Revocation of delegation of all or parts of delegated or administrative functions.
    - Contract Termination.

    For more detailed information on delegation, you may contact MSO.

12.7. Confidentiality

All information obtained in the credentialing process is kept confidential. Credentialing documents, committee minutes, and peer review files are kept in locked cabinets. Only appropriate staff has access to these documents.

12.8. Reinstallation Process

MSO does not have a reinstallation process. Once a sanction is removed or has expired and the provider wants to participate in the network, the provider needs to presents a request again as new provider to Evaluation Committee process . If the

Committee accepts the provider, then the contracting and credentialing process will start.

12.9. Regulatory References:

a. 42 CFR §422.204(b)(2); Manual Ch.6 – Section 60.3
b. 42 CFR §422.204(b)(2)(iii); Manual Ch.6 – Section 20.2
c. 42 CFR §422.204(b) (1); Manual Ch.6 – Section 70
d. 42 CFR §422.205: Manual Ch. 6 – Section 50
e. NCQA 2010 Credentialing Standards

12.10. Definitions

1. Primary Care Physicians (PCP) - A doctor of medicine (M.D.) or osteopathy (D.O). The Plan's primary care physicians are limited to General Practitioner (GP), Internal Medicine (IM) and Family Practice (FP). The PCP possesses skills, and knowledge, which qualify them to provide continuing and comprehensive medical care, health maintenance and preventive services to their patients.
2. Physician Specialists - Doctors of Medicine (MDs), Doctors of Osteopathy (DOs),who provide specialty care services including, but not limited to geriatricians, surgeons, obstetricians/gynecologists, cardiologists, anesthesiologists, emergency medicine physicians, pathologists and radiologists, psychiatrists and physicians who are certified in addiction medicine.
3. Behavioral Health Specialists – Doctoral and/or master level psychologists who are state certified or state licensed; masters level clinical social workers for applicable network(s) who are state certified or state licensed; masters level social workers who are state certified or state licensed; masters level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified and state licensed; addiction medicine specialists and other behavioral health specialists who are licensed, certified, or registered by the state to practice independently. Behavioral Specialists represent the contribution of the

behavioral sciences to medicine and encompasses a broad field of knowledge and practice.

4. Chiropractors - Doctors of Chiropractic (DC) Provide care for musculoskeletal conditions using manipulation as a primary intervention that includes articulations of the vertebral column and the neuro-musculoskeletal system.
5. Podiatrists - Doctors of Podiatric Medicine (DPM) who diagnose and treat, surgically, ailments of the foot, and those anatomical structures of the leg governing the functions of the foot, and the administration and prescription of drugs.
6. Dental Specialists - Doctor of Dental Surgery (DDS) and Doctor of Dental Medicine (DMD) who provide specialty dental care services including dental anesthesiologists, oral & maxillofacial pathologists, oral maxillofacial surgeons, oral maxillofacial radiologists, and orthodontists.
7. Physical Therapists (PT) - master level trained who are state certified or state licensed; are qualified to work as a general practitioner in physical therapy and may be contracted as an independent practitioner in private practice, hospitals, rehabilitation centers, geriatric centers, sports medicine centers, health promotion programs, private practice, community programs, and others. Physical therapists provide services to individuals and populations to develop maintain and restore maximum movement and functional ability.
8. Credentialing Clean File - A complete credentialing application which all practitioner specific criterion is met and there is no malpractice history, no disciplinary action or sanction activity, or other negative information obtained during the verification process and, when applicable, a passing site visit score.
9. 180 DAY RULE- At the time the provider file is presented to the Credentialing Committee the application must not be more than six months old.

12.11. Procedure

The Credentialing Department contacts practitioner approved in Evaluation Committee. In case of specialty changes within the 45 days of the credentialing

process, the Credentialing Department contacts the provider to request a new application with the specialty change.

The complete file with all primary verifications and CMS requirements includes a complete practitioner application electronically signed and dated, and includes, but is not limited to reasons for any inability to perform the essential functions of the position, with or without accommodations, Lack of present illegal drug use, history of loss of license and felony convictions, history of loss or limitations of privileges or disciplinary activity, attestation by the applicant to the correctness and completeness of the application, licensure documentation of a current Certificate of Good Standing, evidence of current adequate malpractice ($100,000/300,000) on practitioner application or copy of certificate, evidence of NPI number (Provider application serves as attestation) query results, a copy of OIG and GSA query results, documentation of Medicare Opt out and Sanction status on the Clarification Verification Form (Attachment B), a copy of Board Certification query results (if applicable), primary Source Verification of Education, Practitioner Application Attestation of clinical privileges at hospital, a copy of current DEA license, results of query of the NPDB and HIPDB report, results of query of the Sex Offender and/or Child Abuse Registry, work history attestation – more than 5 years of experience and no more than 6 months of work history gap, provider acceptance/rejection form, Initial Credentialing Checklist.

The OIG/GSA/Medicare Exclusion lists are review to identify all providers excluded for any of the following reasons:

1. Conviction relating to program or healthcare fraud
2. Conviction relating to controlled substances
3. License revocation or suspension
4. Exclusion or suspension under a Federal or State healthcare program
5. Excessive claims or furnishing of unnecessary or substandard items and services

6. Failure of HMOs and CMPs to furnish medically necessary items and services
7. False or improper claims.
8. Fraud and kickbacks and other prohibited activities.
9. Exclusion of entities owned or controlled by a sanctioned person.
10. Exclusion of individuals with ownership or control interest in Sanctioned entities
11. Conviction relating to obstruction of an investigation
12. Failure to provide payment information.
13. Failure to grant immediate access.
14. Violations of PPS corrective action.
15. Default of health education loan or scholarship obligations.
16. Violations of the limitations on physician charges.
17. Billing for services of assistant at surgery during cataract operations.

If the practitioner credentialing evidence differs from the primary source verification, the Credentialing Department contacts the practitioners via e-mail, phone, fax or letter.

If all documentation is complete as per CMS requirements and all primary source verification, the Credentialing Department submits the credentialing application with Acceptance/Rejection form to the Credentialing Chairman for approval.

The Credentialing Specialist verifies if the initial credentialing is completed in 45 calendar days. If the request is not completed in 45 days, the Specialist presents the case in Credentialing Committee.

All requesting providers received notification of determination, within 2 calendar days, from the Credentialing Committee determination. If a Credentialing Committee denial any file, a certified letter is send to the provider with the denial reason. To appeal, the provider needs to submit the appeal request in written within 30 days of the Credentialing Committee denial letter.

The practitioner is loaded into the contract database, which ensures the listing in the practitioner directories and other materials so enrollees can access consistent with credentialing data, including education, training, board certification and specialty.

If there are adverse findings on any provider, but not limited to cases with no adverse findings, the Credentialing Specialist will prepare the provider file with all primary source verification and the case is presented to the Credentialing Committee for determination.

If the Credentialing Committee rejects a provider, the Credentialing Supervisor sends a certified letter to the provider notifying the reason for rejection within 10 days after committee determination.

To appeal, the provider must submit a written request within 60 days from the date reject letter received.

All provider appeals will be discussed in the Appeals Committee for final decision.

12.12. Program Integrity Plan Development

The complete file with all primary verifications and CMS requirements includes a complete practitioner application signed and dated, and includes, but is not limited to, the Conflict of Interest Form. Is a require that the provider/practitioner completes the Conflict of Interest Form reporting all persons who have a 5 percent or greater (direct or indirect) ownership in the supplier, if and only if, the supplier applicant or provider is a corporation (whatever for profit or nonprofit), officers and directors of the supplier / applicant / provider, all managing employees or the supplier/applicant/ provider (including secretary, reception, amongst others), supplier/applicant/provider (all who have managing control), all individuals with a partnership interest in the supplier / applicant / provider, regardless of the percentage of ownership the partner has and/or authorized delegate officials. In case of Organizations is requiring that report Corporations (profit or nonprofit), Partnerships and limited partnership, limited liability companies, charitable and/or religious organizations and Governmental and/or Tribal Organizations.

The findings or each Conflict of Interest, based on the previous, is delivered to Fraud Waste and Abuse Department (Manager) of MMM Multi Health for the corresponding process.

The OIG/GSA/Medicare Exclusion lists are review to identify all providers excluded for any of the following reasons:

1. Conviction relating to program or healthcare fraud
2. Conviction relating to obstruction of an investigation
3. Conviction relating to controlled substances
4. License revocation or suspension
5. Exclusion or suspension under a Federal or State healthcare program
6. Excessive claims or furnishing of unnecessary or substandard items and services
7. Failure of HMOs and CMPs to furnish medically necessary items and services
8. False or improper claims
9. Fraud and kickbacks and other prohibited activities.
10. Exclusion of entities owned or controlled by a sanctioned person.
11. Exclusion of individuals with ownership or control interest in sanctioned entities.
12. Failure to provide payment information.
13. Failure to grant immediate access.
14. Violations of PPS corrective action.
15. Default of health education loan or scholarship obligations.
16. Violations of the limitations on physician charges.
17. Billing for services of assistant at surgery during cataract operations.

This validation applies for every credentialing and re-credentialing practitioner or staff in the organizational providers. As an ongoing monitoring, the OIG monthly exclusions and reinstate list is validate against the providers data base to guarantee that any excluded provider continue as participant provider. These process includes nonparticipant providers to avoid make payments until is reinstate, if apply.

12.13. Regulatory References

a. 42 CFR §55.104
b. 42 CFR §55.105
c. 42 CFR §55.106

12.14 Monitoring of Licenses and Credentials

MSO has established policies for ongoing monitoring of the license and credentials of of *MI Salud* participating providers. The credentials are updated annually and consist, as a minimum, of the following documents: JLDMPR / SARAFS license, DEA license, medical malpractice insurance and ASSMCA license.

The ongoing monitoring process is a different process of quality and is not equal and do not replace the process of initial credentialing and recredentialing. All participating providers must ensure that they keep their licenses and credentials valid and update with MSO and will be receiving a communication 60 days in advance indicating the specific documents that must be updated with us and the effective date that the credentials have to date. The providers can send us the credentials by different was as following:

USPS mail	Credentialing Department PO Box 71500 San Juan, P.R. 00936-8014
Email	CredentialingUpdates@mso-pr.com
Fax	787-625-3374

For MSO and the Credentialing Department it is essential to comply with all the regulations from ASES and CMS, those providers that do not meet this requirement could be cause for contract cancellation.

13. PCP's Responsibilities, Duties and Obligations

Provider Type	Explanation
PCP Services	1) Physical exams will 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. 2) Routine For minors less than twenty-one (21) years of age routine physical exams. 3) Routine evaluations for Primary Care will be provided within thirty (30) Calendar Days, unless the Enrollee requests a later time. 4) Covered Services will be provided within fourteen (14) Calendar Days following the request for service. 5) Is required the PCP to inform and distribute Information to Enrollee patients about instructions on Advance Directives, and will require the PCP to notify Enrollees of any changes in Federal or Puerto Rico law relating to Advance Directives, no more than ninety (90) Calendar Days after the effective date of such change. 6) 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 a physician may see them 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). 7) Primary care services or consultations Monday through Saturday of each Week, from 8:00 a.m. to 6:00 p.m. The following Holidays the PMG will not have to comply with this requirement: January 1st, January 6Th, Good Friday, Thanksgiving Day and December 25th. The PMG has the sole discretion to decide whether or not to provide primary care services during the previously listed Holidays. 8) The in-person prescription fill time (ready for pickup) will be no longer than forty (40) minutes. A prescription phoned in by a practitioner will be filled within ninety (90) minutes. ASES highly recommends that the Providers implement an electronic prescribing system. 9) Primary Medical outpatient appointments for urgent conditions will be available within twenty-four (24) hours. 10) Network Providers are prohibit from having different hours and schedules for *MI Salud* Enrollees than what is offered to commercial Enrollees. 11) Providers cannot establish specific days for the delivery of Referrals and requests for Prior Authorization for *MI Salud* Enrollees. 12) Is prohibit denied medically necessary services to *MI Salud* enrollees as established in the contract 13) It's prohibited to deny any medically necessary services to *MI Salud* enrollees as established in the contract. 14) Copy of each Enrollee's Medical Record is made available, without charge, upon the written request of the Enrollee or Authorized

	Representative within fourteen (14) Calendar Days of the receipt of the written request. 15) All Enrollee information, Medical Records, Data and Data elements collected, maintained, or used in the administration will be protected by MMM Multi Health from unauthorized disclosure per the HIPAA Privacy and Security standards codified at 45 CFR Part 160 and 45 CFR Part 164, Subparts A, C and E. 16) Needs full compliance with reverse co-location and co-location terms. 17) Appeal of a denial that is based on lack of Medical Necessity. The *MI Salud* do not take any punitive action with Provider who requests a Grievance, Appeal or an Administrative Law Hearing or supports an Enrollee's Grievance, Appeal or Administrative Law Hearing.
Specialist Services	1) Be provided within thirty (30) Calendar Days of the Enrollee's original request for service. 2) Provider who is a member of the PPN will prohibit the Provider from collecting Co-Payments from *MI Salud* Enrollees. 3) 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 a physician may see them 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).

	4) The in-person prescription fill time (ready for pickup) will be no longer than forty (40) minutes. A prescription phoned in by a practitioner will be filled within ninety (90) minutes. ASES highly recommends that the Providers implement an electronic prescribing system. 5) Network Providers are prohibit from having different hours and schedules for *MI Salud* Enrollees than what is offered to commercial Enrollees. 6) Providers cannot establish specific days for the delivery of Referrals and requests for Prior Authorization for *MI Salud* Enrollees. 7) It's prohibited to deny medically necessary services to *MI Salud* enrollees as established in the contract. 8) Copy of each Enrollee's Medical Record is made available, without charge, upon the written request of the Enrollee or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request. 9) All Enrollee information, Medical Records, Data and Data elements collected, maintained, or used in the administration will be protected by MMM Multi Health from unauthorized disclosure per the HIPAA Privacy and Security standards codified at 45 CFR Part 160 and 45 CFR Part 164, Subparts A, C and E. 10) Appeal of a denial that is based on lack of Medical Necessity. The *MI Salud* do not take any punitive action with Provider who requests a Grievance, Appeal or an Administrative Law Hearing or supports an Enrollee's Grievance, Appeal or Administrative Law Hearing.
Dental Services	1) Be provided within sixty (60) Calendar Days following the request, unless the Enrollee requests a later date.

	2) Provider who is a member of the PPN will prohibit the Provider from collecting Co-Payments from *MI Salud* Enrollees. 3) 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 a physician may see them 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). 4) Dental outpatient appointments for urgent conditions will be available within twenty-four (24) hours. 5) Network Providers are prohibit from having different hours and schedules for *MI Salud* Enrollees than what is offered to commercial Enrollees. 6) It's prohibited to deny medically necessary services to *MI Salud* enrollees as established in the contract. 7) Copy of each Enrollee's Medical Record is made available, without charge, upon the written request of the Enrollee or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request. 8) All Enrollee information, Medical Records, Data and Data elements collected, maintained, or used in the administration will be protected by MMM Multi Health from unauthorized disclosure per the HIPAA Privacy and Security standards codified at 45 CFR Part 160 and 45 CFR Part 164, Subparts A, C and E.

Hospitals and Emergency Rooms	1) Placing a lower priority on *MI Salud* Enrollees than on other patients, and from referring *MI Salud* Enrollees to other facilities for reasons of economic convenience. Contracts sanctions penalizing this practice. 2) Emergency Services will be provided, including Access to an appropriate level of care, within twenty-four (24) hours of the service request. 3) Network Providers are prohibit from having different hours and schedules for *MI Salud* Enrollees than what is offered to commercial Enrollees. 4) Hospitalization or extended services that exceed thirty (30) Calendar Days, the Provider may bill and collect payments for services rendered to the Enrollee at least once per month. 5) It's prohibited to deny medically necessary services to *MI Salud* enrollees as established in the contract. 6) Copy of each Enrollee's Medical Record is made available, without charge, upon the written request of the Enrollee or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request. 7) All Enrollee information, Medical Records, Data and Data elements collected, maintained, or used in the administration will be protected by MMM Multi Health from unauthorized disclosure per the HIPAA Privacy and Security standards codified at 45 CFR Part 160 and 45 CFR Part 164, Subparts A, C and E.
Urgent care services	1) Will 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.

	2) Network Providers are prohibit from having different hours and schedules for *MI Salud* Enrollees than what is offered to commercial Enrollees. 3) It's prohibited to deny medically necessary services to *MI Salud* enrollees as established in the contract. 4) Copy of each Enrollee's Medical Record is made available, without charge, upon the written request of the Enrollee or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request. 5) All Enrollee information, Medical Records, Data and Data elements collected, maintained, or used in the administration will be protected by MMM Multi Health from unauthorized disclosure per the HIPAA Privacy and Security standards codified at 45 CFR Part 160 and 45 CFR Part 164, Subparts A, C and E.
Diagnostic Laboratory	1) Diagnostic imaging and other testing appointments will be provided consistent with the clinical urgency, but no more than fourteen (14) Calendar Days, unless the Enrollee requests a later time. 2) If a "walk-in" rather than an appointment system is used, the Enrollee wait time will be consistent with severity of the clinical need. 3) Urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability will be consistent with the clinical urgency, but no longer than forty-eight (48) hours. 4) Network Providers are prohibit from having different hours and schedules for *MI Salud* Enrollees than what is offered to commercial Enrollees. 5) It's prohibited to deny medically necessary services to *MI Salud* enrollees as established in the contract.

	6) Copy of each Enrollee's Medical Record is made available, without charge, upon the written request of the Enrollee or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request. 7) All Enrollee information, Medical Records, Data and Data elements collected, maintained, or used in the administration will be protected by MMM Multi Health from unauthorized disclosure per the HIPAA Privacy and Security standards codified at 45 CFR Part 160 and 45 CFR Part 164, Subparts A, C and E.
Behavioral Health	1) Behavioral Health Services will be provided within fourteen (14) Calendar Day following the request, unless the Enrollee requests a later date. 2) Behavioral Healthcare outpatient appointments for urgent conditions will be available within twenty-four (24) hours 3) Crisis services, face-to-face appointments will be available within two (2) hours; and Detoxification services will be provided immediately according to clinical necessity. 4) Network Providers are prohibit from having different hours and schedules for *MI Salud* Enrollees than what is offered to commercial Enrollees. 5) Providers cannot establish specific days for the delivery of Referrals and requests for Prior Authorization for *MI Salud* Enrollees. 6) It's required for Behavioral Health Facilities to have opening hours covering twelve (12) hours per day, seven (7) days per Week and will have available one (1) nurse, one (1) social worker and one (1) psychologist/psychiatrist. 7) It's prohibited to deny medically necessary services to *MI Salud* enrollees as established in the contract.

	8) Copy of each Enrollee's Medical Record is made available, without charge, upon the written request of the Enrollee or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request. 9) All Enrollee information, Medical Records, Data and Data elements collected, maintained, or used in the administration will be protected by MMM Multi Health from unauthorized disclosure per the HIPAA Privacy and Security standards codified at 45 CFR Part 160 and 45 CFR Part 164, Subparts A, C and E. 10) Needs full compliance with reverse co-location and co-location terms. 11) Appeal of a denial that is based on lack of Medical Necessity. The *MI Salud* do not take any punitive action with Provider who requests a Grievance, Appeal or an Administrative Law Hearing or supports an Enrollee's Grievance, Appeal or Administrative Law Hearing.

14. Compliance

14.1 Compliance Program

14.1.1 MMM Multi Health, LLC. ("MMM MH") established a Compliance and Integrity (Fraud, Waste and Abuse "FWA") Programs to ensure that the organization and its first tier, downstream and related entities conduct business in a manner that materially complies with applicable federal and state laws and regulations. In addition, the organization is subject to statutes and regulation required by multiple federal and local resources.

The Compliance Program has been designed in accordance with relevant and applicable requirements of the Centers for Medicare & Medicaid Services (CMS), Office of the Inspector General (OIG), Health Insurance Portability and

Accountability Act (HIPAA), *Administración de Seguros de Salud* (ASES), the Office of the Advocate for Patient Bill of Rights of the Commonwealth of Puerto Rico, the Offices of State Insurance Commissioners, among others. The main objective is to comply with reporting requirements, identify risk areas, prevent FWA, misconduct, operational inefficiencies and enhance operational functions, improve the quality of healthcare service, and decrease the cost of healthcare.

The Compliance Program is intended to provide a framework for compliance efforts on an individual, departmental and enterprise-wide basis and to apply to all personnel and functions. Detailed policies and procedures, and work plans developed by individual departments shall fit within the scope of this Program. This Program provides for the existence of a Compliance Officer (CO) who has the overall responsibility and accountability for compliance matters. However, every Provider, Employee, Client, Contractor, Subcontractor or Agent remains responsible and accountable for their compliance with applicable laws and regulations as well as MMM MH's policies and procedures.

The Compliance Program contains policies and procedures relative to the business of MMM MH, and all its Beneficiaries. This Compliance Program is not intended to serve as the Compliance Program for clients or contractors of MMM MH; they should adopt their own program. MMM MH does not assume the responsibility of developing a Compliance Program for their clients. However, it is the responsibility of Clients, Contractors, Subcontractors and Delegated Entities to report any non-compliance issue, FWA incidents and violations of law to MMM MH in a timely manner.

14.1.2 Training and Education

MMM MH acknowledges that the Compliance Program can only be effective if communicated and explained to company personnel, Providers, Contractors and Subcontractors on a routine basis and in a manner that clearly explains its requirements. To that end, MMM MH requires all personnel to attend specific

training programs on a periodic basis. Training requirements and scheduling are established by MMM MH and each of its affiliates based on the needs and requirements of each affiliate. Employees are trained early in their employment, annually and more often if required based on regulatory and contractual changes.

Training programs include appropriate training in federal and state statutes, regulations, guidelines, the policies and procedures set forth in this Compliance Program, and corporate ethics. Training programs also include sessions highlighting this Compliance Program, summarizing fraud and abuse laws, physician self-referral laws, claims development and submission processes, and related business practices that reflect current legal standards. All formal training undertaken as part of the Compliance Program is documented.

14.2 Confidentiality and Privacy:

MMM Multi Health, has implemented a confidentiality policy that requires all Employees, Compliance Committee members and Board of Directors to sign a Confidentiality Statement based on MMM Multi Health commitment to comply with federal and state regulations. Provider Service Agreement also includes provisions, which stipulate that each provider will comply with all provision of the HIPAA law to protect the confidentiality, integrity and availability of the members protected health information. Providers will respect the confidential nature of information contained in medical records and business documentation, in accordance with all applicable federal and local regulatory requirements.

MMM Multi Health requires that each provider adopt a confidentiality policy for their office and requires that all staff members comply with all applicable privacy and security regulations. MMM Multi Health, as well as the Centers for Medicare and Medicaid Services (CMS) and ASES, monitor providers with respect to the handling of protected health information and confidential information. Privacy, confidential, and security policies, procedures, and practices of contracted providers are reviewed in

credentialing visits during the contracting process and prior the effective date. A broad summary of applicable rules and provisions related to confidentiality is outlined below.

14.3 Laws and Regulations

14.3.1 Health Insurance Portability and Accountability Act (HIPAA):

The privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), apply to health information created or maintained by healthcare providers who engage in certain electronic transactions, health plans, and healthcare clearinghouses. The statute protects medical records and other individually identifiable health information, whether it is on paper, computers or communicated orally. A covered entity is a healthcare provider that conducts certain transactions in electronic form regulated by HIPAA (called here a “covered healthcare provider”), a healthcare clearinghouse, or a health plan.

A covered entity must obtain the individual’s written authorization for any use or disclosure of protected health information that is not for treatment, payment or healthcare operations or otherwise permitted or required under HIPAA Law. A covered entity may not condition treatment, payment, enrollment, or benefit eligibility on an individual granting an authorization, except in limited circumstances.

An authorization must be written in specific terms. It may allow use and disclosure of protected health information by the covered entity seeking the authorization, or by a third party. US Congress provided civil and criminal penalties for covered entities that misuse personal health information. For civil violations of the standards, the Civil Rights Office may impose monetary penalties.

14.3.2 Code of Federal Regulations:

Federal regulations require that a Medicaid Provider Organization, such as MMM Multi Health, must establish procedures to abide by all Federal and States laws regarding confidentiality, enrollment and disclosure of medical records, or other health information. Organizations must safeguard the privacy of any information that

identifies an enrollee. Protected Health Information is defined as any information that identifies an individual, which is transmitted, maintained or recorded orally or by any medium or form, including electronic medium, and that:

1. It's created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university or healthcare clearinghouse.
2. Relates to the past, present or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual. (42 C.F.R. § 160.103).

14.3.3 State Law:

In Puerto Rico, the Patient's Bill of Rights (Article 11) establishes, among others, that a patient can have full confidence that their medical and health information will be kept strictly confidential by their health care providers. Every supplier and every insurance company must take steps to protect the privacy of their patients, safeguarding their identity.

14.3.4 Contractual Arrangements:

MMM MH agreements with ASES request compliance with federal regulations regarding privacy, confidentiality and HIPAA administrative simplification rules. These rules address the transmission and disclosure of patient information between covered entities. According to the rules, MMM MH must safeguard protected health information to limit incidental uses or disclosures made pursuant to an otherwise permitted or required use or disclosure. The transmission of information with providers will only be conducted according to HIPAA Law. Like a provider's obligation to comply with applicable federal and Commonwealth laws and regulations, a Provider must abide by the contract

provisions that apply to them in the agreements and must maintain all relevant safeguards.

6 14.4 Fraud, Waste & Abuse (FWA):

MMM MH will not tolerate fraudulent or abusive activities, behavior or conduct against State and Federal health care programs. The organization has established methods for the prevention, detection, investigation and correction of potential fraud, waste, and abuse, in accordance with all applicable laws and regulations, through adequate education and the implementation of a Fraud, Waste and Abuse Compliance Program, policies and procedures, and a Program Integrity Plan.

14.4.1 Definitions:

Fraud - refers to 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 affects adversely insured enrollees, health plans and professionals and entities that render health services.

The most common types of fraud and abuse in the Medicaid program include:

- Medical identity theft;
- Billing for unnecessary services and items;
- Billing for services or items not rendered;
- Upcoding, or billing for services at a level of complexity that is higher than the service provided;
- Unbundling, it refers to the practice of a physician billing for multiple components of a service that must be included in a single fee;
- Billing for non-covered services, as a covered service;
- Kickbacks; defined as offering, soliciting, paying, or receiving remuneration (in kind or in cash) to induce, or in return for referral of items or services reimbursable by a Federal health care program;

- Beneficiary fraud, e.g. eligibility fraud, card sharing, doctor shopping, and drug diversion.

Abuse - is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost 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 beneficiary practices that result in unnecessary cost to the Medicaid program. Some examples are:

- Overuse of services that are not medically necessary, such as constantly using the emergency room instead of going to the Primary Care Physician;
- Excess in the orders for diagnostic tests that do not have a medical justification;
- Waiving health plan Copayments or Coinsurances to attract customers.

Waste - is the overutilization of services, misuse of resources or other practice that, directly or indirectly, result in unnecessary costs. Some examples are:

- Prescribing high cost medications instead of similar generic or lower cost medication;
- Billing errors due to inefficient billing systems;
- Inflated prices on services or devices.

14.4.2 Federal False Claims Act:

The False Claims Act applies to the submission of claims by health care Providers for payment of Medicare, Medicaid and other federal health care programs. The False Claims Act is the federal government's primary civil remedy for improper or fraudulent claims.

The False Claims Act prohibits;

- Knowingly presenting or causing to be presented to the federal government a false or fraudulent claim for payment or approval;

- Knowingly making or using, or causing to be made or used, a false record or statement to have a false or fraudulent claim paid or approved by the government;
- Conspiring to defraud the government by a false or fraudulent claim allowed or paid; and
- Knowingly making or using, or causing to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the government.

Enforcement:

The United States Attorney General may invoke civil actions for violations of the False Claims Act. As with most other civil actions, the government must establish its case by presenting preponderance of the evidence rather than by meeting the higher burden of proof that applies in criminal cases.The False Claims Act allows private individuals to bring "qui tam" actions for violations of the Act.

Protection for "Whistleblowers":

If any Employee has knowledge or information that any such activity may be occurring or may have taken place, the employee must notify his or her supervisor or director, the Compliance Officer, or Ethics Point line at 1-844-256-3953 or www.psg.ethicspoint.com, or by writing to the following e-mail address GHP_SIU@mmmhc.com. Information may be reported anonymously. Employees are encouraged to contact their Supervisor or the Compliance Officer if they have questions as to whether certain practices violate the Federal False Claims Act.

In addition, federal regulation and MMM MH policy prohibits any retaliation against persons who in good faith report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she and been subject to any such retribution or retaliation should also report this to Ethics Point.

Program Fraud Civil Remedies Act of 1986 (PFCRA):

The Program Fraud Civil Remedies Act of 1986 (PFCRA) authorizes federal agencies such as the Department of Health and Human Services (HHS) to investigate and assess penalties of the submission of false claims to the agency. The conduct prohibited by the PFCRA is like that prohibited by the False Claims Act. For example, a person may be liable under PFCRA for making, presenting, or submitting, or causing to be made, presented, submitted, a claim that the person knows or has the reason to know:

- Is false, fictitious, or fraudulent;
- Includes or is supported by any written statement which asserts a material fact which is false, fictitious or fraudulent;
- Includes or is supported by any written statement that;
- Omits a material fact;
- Is false, fictitious, or fraudulent because of such omission; and
- Is a statement in which the person making, presenting or submitting such statement has a duty to include such material fact; or
- Is for payment for the provision of property or services which the persons have not provided as claimed.

If a government agency suspects that a false claim has been submitted, it can appoint an investigating official to review the matter. The investigating official may issue a subpoena to further the investigation or may refer the matter to the Department of Justice for proceedings under the False Claims Act. If, based on the investigating official's report, an agency concludes that further action is warranted, it may issue a complaint (following approval from the Department of Justice) regarding the false claim. A hearing would be held, following the detailed due process procedures set forth in the regulations implementing the PFCRA.

Disclosure of False Claims:

Under the False Claims Act, the organization may avoid treble damages and civil penalties if it discloses to the relevant federal health care program any false or

fraudulent claims, and makes appropriate restitution of any overpayments, within 30 days of discovery of the false claim.

Education:

MMM MH provides regulatory Compliance and FWA trainings to Employees, Board of Directors, Contractors, Subcontractors including components addressing the False Claims Act, and is also provided to providers through various types of educational activities performed by the Provider Network Department.

14.4.3 The Physician Self-Referral Law (Stark Law):

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements.

14.4.3.1 Designated Health Services are:

- Clinical Laboratory Services;
- Physical therapy, Occupational therapy, and Outpatient Speech-language Pathology services;
- Radiology and certain other imaging services;
- Radiation therapy services and supplies;
- DME and supplies;
- Parenteral and enteral nutrients, equipment, and supplies;
- Prosthetics, orthotics, and prosthetic devices and supplies;
- Home health services;
- Outpatient prescription drugs; and
- Inpatient and outpatient hospital services.

Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in the Federal health care programs.

14.4.4 The Anti-Kickback Statute:

Makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal healthcare program. Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration. Each party's intent is a key element of their liability under the anti-kickback statute (AKS).

14.4.4.1 Kickbacks in health care can lead to:

- Overutilization;
- Increased program costs;
- Corruption of medical decision making;
- Patient steering;
- Unfair competition.

Criminal penalties and administrative sanctions for violating the AKS include fines, jail terms, and exclusion from participation in the Federal health care programs. Under the CMPL, physicians who pay or accept kickbacks also face penalties of up to $50,000 per kickback plus three times the amount of the remuneration.

Eliminating fraud, waste, and abuse (FWA) is a shared responsibility of everyone involved in providing healthcare and administrative services. You play a vital role in protecting the integrity of the Medicaid Program. To combat fraud and abuse, you need to know what to watch for to protect your organization from potential abusive practices, civil liability, and criminal activity. Below, are included some recommendations to assure minimize the risks of FWA while providing a quality care:

- Knowing the regulations and laws governing the health services;

- Screening potential and existing employees and contractors for current exclusion, or grounds for exclusion, by HHS-OIG; and
- Implementing a compliance program;
- Maintain accurate and complete medical records and documentation of the services you provide. Also, ensure your documentation supports the claims you submit for payment;
- Make sure your billing is accurate and correct: When you submit a claim for services, you are certifying you earned the payment requested and complied with the billing requirements.

Examples of improper claims include:

- Billing for services that you did not actually render;
- Billing for services that were not medically necessary;
- Billing for services performed by an improperly supervised or unqualified employee;
- Billing for services performed by an employee excluded from participation in Federal health care programs;
- Billing for services of such low quality that they are virtually worthless;
- Billing separately for services already included in a global fee, like billing for an evaluation and management service the day after surgery.

The FWA Compliance Unit of the *MI Salud* of MMM MH is responsible of detecting, preventing, conducting investigations, and referring to regulatory agencies, situations that raise suspicions or allegations of potential fraud, waste or abuse. It is important to report FWA concerns in a timely manner. To report a concern or ask a question, please contact:

Hotline: 1-844-256-3953

Web page: www.psg.ethicspoint.com

Email: GHP_SIU@mmmhc.com

14.4.4.2 Training:

Under the Centers for Medicare & Medicaid Services (CMS) and ASES regulations, providers enrolled in the Medicaid program are required to take the annual compliance, fraud waste and abuse training. You will receive a notification from us regarding fulfillment of this requirement.

7 14.5 Cultural Competency Plan:

To work effectively with individuals of different cultures is imperative to value the importance of ethnicity, race and religion in the delivery of services. MMM MH has developed a Cultural Competency Plan to ensure that the unique and diverse needs of all beneficiaries of the *MI Salud* are met.

Our goal is to improve communication to members with cultural or linguistic barriers; decrease disparities in the healthcare received by the minorities we serve; and improve understanding among employees, contractors, and providers regarding the cultural and religious diversity within the population served.

14.5.1 For this purpose our Plan covers the following components:

- Data Analysis – to collect information and needs of the population MMM MH served;
- Linguistic Services – to develop written material and coordinate interpreter services and others;
- Religious beliefs – to ensure Employees and Providers are sensitive and become knowledgeable regarding religious beliefs;
- Provider Education;
- Electronic Media – to provide access to the TTY/TDD line for hearing impaired services;
- Cultural Competency Survey– to increase awareness and identify training needs.

15. Grievance System

In accordance with 42 CFR Part 438, Subpart F, MMM Multi Health has an internal Grievance System under which Enrollees, or Providers acting on their behalf, may challenge the denial of coverage of, or payment for, covered services. MMM Multi Health Grievance System includes (i) a Complaint process, (ii) Grievance process, (iii) Appeal process, and (iv) Access to the Administrative Law Hearing process. MMM Multi Health designate, in writing, an officer who has primary responsibility for ensuring that Complaints, Grievances, and Appeals are resolved and for signing all Notices of Action. MMM Multi Health has a written Grievance System, and policies and procedures that detail the operation of the Grievance System.

At a minimum, MMM Multi Health Grievance System policies and procedures include the following:

1. Process for filing a Complaint, Grievance, or Appeal, or seeking an Administrative Law Hearing.
2. Process for receiving, recording, tracking, reviewing, reporting, and resolving Grievances filed verbally, in writing, or in-person.
3. Process for receiving, recording, tracking, reviewing, reporting, and resolving Appeals filed verbally or in writing.
4. Process for requesting an expedited review of an Appeal.
5. Process and timeframe for a Provider to file a Complaint, Grievance or Appeal on behalf of an Enrollee.
6. Process for notifying Enrollees of their right to file a Complaint, Grievance, or Appeal with the Patient Advocate Office and how to contact the Patient Advocate Office.
7. Procedures for the exchange of Information with Providers, ASES, and the Enrollees regarding Complaints, Grievances, and Appeals.

8. Process and timeframes for notifying Enrollees in writing regarding receipt of Complaints, Grievances, Appeals, resolution, action, delay of review, and denial of request for expedited review.
9. MMM Multi Health Grievance System fully complies with the Patient's Bill of Rights Act and with Act No. 11 of April 11, 2001 (known as the Organic Law of the Office of the Patient Advocate), to the extent that such provisions do not conflict with, or pose an obstacle to Federal regulations.
10. MMM Multi Health processes each Complaint, Grievance, or Appeal in accordance with applicable Puerto Rico and Federal statutory and regulatory requirements.

15.1. Complaint

The Complaint process is the process for addressing Enrollee's complaints, defined as expressions of dissatisfaction about any matter other than an Action that are resolved at the point of contact rather than through filing a formal grievance. An Enrollee or Enrollee's Authorized Representative may file a complaint either orally or in writing. The Enrollee or Enrollee's Authorized Representative may follow-up an oral request with a written request. However, the timeframe for resolution begins with the date MMM Multi Health receives the oral request. An Enrollee or Enrollee's Authorized Representative will file a complaint any time the date of occurrence that initiated the complaint.

MMM Multi Health will resolve each complaint within seventy-two (72) hours of the time MMM Multi Health received the initial complaint, whether orally or in writing. If the complaint is not resolved within this timeframe, the complaint will be treated as a grievance. The Notice of Disposition will not exceed ninety (90) Calendar Days from the date of the occurrence and include the results and date of the resolution of the complaint and will include notice of the right to file a grievance or appeal and information necessary to allow the Enrollee to request an Administrative Law Hearing, if appropriate, including contact information necessary to pursue an Administrative Law Hearing.

15.2. Grievance Process

An Enrollee or Enrollee's Authorized Representative may file a Grievance with MMM Multi Health or with the Office of the Patient's advocate of Puerto Rico either orally or in writing. A Provider cannot file a Grievance on behalf of an Enrollee unless the Enrollee grants consent. The timeframe for filing a Grievance will not exceed ninety (90) Calendar Days from the date of the occurrence. MMM Multi Health will acknowledge receipt of each Grievance in writing to the Enrollee (and the Provider, if the Provider filed the Grievance on the Enrollee's behalf, if the enrollee authorized the provider) within ten (10) Business Days of receipt. MMM Multi Health will provide written notice of the disposition of the Grievance as expeditiously as the Enrollee's health condition requires, but in any event, within ninety (90) Calendar Days from the day MMM Multi Health receives the Grievance.

15.2.1 The Notice of Disposition will include the following:

- The resolution of the Grievance
- The basis for the resolution
- The date of the resolution.

MMM Multi Health may extend the timeframe to provide a written notice of disposition of a Grievance for up to fourteen (14) Calendar Days if the Enrollee requests the extension or MMM Multi Health demonstrates (to the satisfaction of ASES, upon its request) that there is a need for additional Information and how the delay is in the Enrollee's interest. If MMM Multi Health extends the timeframe, it will, for any extension requested by the Enrollee, give the Enrollee written notice of the reason for the delay prior to the delay.

15.3. Appeal Process

The Enrollee, the Enrollee's authorized representative, or the provider may file an appeal either orally or in writing. Unless the Enrollee requests expedited review, the Enrollee, the Enrollee's authorized representative or the provider acting on behalf of the Enrollee with the Enrollee's written consent, must submit an oral filing with a

written, signed, request for appeal. Oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal), but Enrollees must confirm oral requests for appeals in writing within ten (10) calendar days of the oral filing, unless the Enrollee requests expedited resolution, then no additional follow-up is required. The requirements of the appeal process will be binding for all types of appeals, including expedited appeals, unless otherwise established for expedited appeals. The Enrollee, the Enrollee's Authorized Representative, or the Provider acting on behalf of the Enrollee with the enrollee's written consent, may file an appeal to MMM Multi Health within sixty (60) calendar days from the date on MMM Multi Health notice of action. Appeals must be filed directly with MMM Multi Health. The appeals process provides the Enrollee, the Enrollee's authorized representative, or the provider acting on behalf of the Enrollee with the Enrollee's written consent, a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing. MMM Multi Health informs the Enrollee of the limited time available to provide this in case of expedited review. The appeals process provides the Enrollee, the Enrollee's authorized representative or the provider acting on behalf of the Enrollee with the Enrollee's written consent, opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records considered during the appeals process and provide copies of documents contained therein without charge. The appeals process includes as parties to the appeal the Enrollee, the Enrollee's Authorized Representative, the Provider acting on behalf of the Enrollee with the Enrollee's written consent, or the legal representative of a deceased Enrollee's estate. MMM Multi Health resolves each standard appeal and provide written notice of the disposition, as expeditiously as the Enrollee's health condition requires but no more than thirty (30) calendar days from the date MMM Multi Health receives the appeal. MMM Multi Health establishes and maintains an expedited review process for appeals, subject to prior written approval by ASES, when MMM Multi Health determines (based on a request from the Enrollee) or the Provider indicates (in making

the request on the Enrollee's behalf) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function. The Enrollee, the Enrollee's authorized representative, or the provider acting on behalf of the Enrollee with the Enrollee's written consent, may file an expedited appeal either orally or in writing.

MMM Multi Health resolves each expedited appeal and provides a written notice of disposition, as expeditiously as the Enrollee's health condition requires, but no longer than seventy-two (72) hours after MMM Multi Health receives the appeal and make reasonable efforts to provide oral notice.

If MMM Multi Health denies an Enrollee's request for expedited review, it utilizes the timeframe for standard appeals specified herein and makes reasonable efforts to give the Enrollee prompt oral notice of the denial, and follow-up within two (2) calendar days with a written notice. If the Enrollee disagrees with the decision to change the prescribed timeframe, he or she has the right to file a grievance and is resolved within twenty-four (24) hours. MMM Multi Health also makes reasonable efforts to provide oral notice for resolution of an expedited review of an appeal. MMM Multi Health may extend the timeframe for standard or expedited resolution of the appeal by up to fourteen (14) calendar days if the Enrollee, Enrollee's authorized representative, or the provider acting on behalf of the Enrollee with the Enrollee's written consent, requests the extension or MMM Multi Health demonstrates (to the satisfaction of ASES, upon its request) that there is need for additional information and how the delay is in the Enrollee's interest. If MMM Multi Health extends the timeframe, for any extension not requested by the Enrollee, give the Enrollee written notice of the reason for the delay. MMM Multi Health informs the Enrollee of the right to file a Grievance if the Enrollee disagrees with the decision to extend the timeframe.

MMM Multi Health provides written notice of disposition of an appeal to the Enrollee (and the Provider, if the Provider filed the Appeal on the Enrollee's behalf) as well as a copy to ASES within two (2) business days of the resolution.

- ❖ The written notice of disposition includes:

1. The results and date of the appeal resolution
2. For decisions not wholly in the Enrollee's favor
3. The right to request an Administrative Law Hearing
4. How to request an Administrative Law Hearing
5. The right to continue to receive benefits pending an Administrative Law Hearing;
6. How to request the continuation of benefits
7. Notification if MMM Multi Health action is upheld in a hearing.

15.4. Administrative Law Hearing

MMM Multi Health is responsible for explaining the Enrollee's right to and the procedures for an Administrative Law Hearing, including that the Enrollee must exhaust MMM Multi Health grievance, complaints, and appeals process before requesting an Administrative Law Hearing. The parties to the Administrative Law Hearing include MMM Multi Health as well as the Enrollee or his or her authorized representative, or the representative of a deceased Enrollee's estate. If MMM Multi Health takes an action, the Enrollee appeals the action and the resolution of the appeal is not in the Enrollee's favor, and the Enrollee requests an Administrative Law Hearing, ASES will grant the Enrollee such hearing. The right to such Administrative Law Hearing, how to obtain it, and the rules concerning who may represent the Enrollee at such hearing is explained to the Enrollee and by MMM Multi Health. ASES shall permit the Enrollee to request an Administrative Law Hearing within one hundred and twenty (120) Calendar Days of the Notice of Resolution of the Appea.

16. Claims and Coding Processing

8 16.1 Claims Processing

MSO will receive claims from contracted providers and process them in a timely, accurate manner. MMM Multi Health shall process paper and electronic claims according to the requirements established in the Contract with the Government Health

Plan. Claims payments shall also be based on the terms specified in the provider's contract. Providers shall send Electronic Encounter Data to MSO on a weekly basis.

16.1.1 Definitions:

1. Clean Claims: A claim received for adjudication, which can be processed without obtaining additional information from the provider of the service or from a third party. This includes claims with errors originated in the MMM Multi Health Claims System, and does not include claims from a provider who is under investigation for fraud, waste, or abuse, or a claim under review to determine medical necessity.
    - ✓ 95% of clean claims will be paid in 30 days from the receipt date.
    - ✓ 100% of clean claims will be paid in 50 days from the receipt date.
2. Unclean Claims: A claim for which additional documentation or corrections from an outside source is required to make the claim payable. This includes claims from providers who are under investigation for fraud, waste, or abuse, or a claim under review to determine medical necessity.
    - ✓ 90% of unclean claims will be paid in 90 days from the received date.
    - ✓ 9% of unclean claims will be paid in 6 months (180 days) from the receipt date.
    - ✓ 1% of unclean claims will be paid one year (12 months) from the receipt date.
3. Correct Billing

It is important to follow the billing guides established by the National Correct Coding Initiative. This includes and does not limit to the correct use of modifiers, incidental codes, etc., as these edits will be taken in consideration when bill is being processed.

4. Electronic Claims

MSO, LLC has the capability to accept electronic claims transaction thru the clearinghouses Inmediata or Assertus. This should be the first alternative to submit the claims. To summit the claims use the following Payer ID:

- ✓ MMM Multi Health 660653763

If not possible to submit the claims thru the clearinghouses, the paper claims should be sent to:

MMM Multi Health
PO Box 71307
San Juan, PR 00936

5. Adjustments

In the event a claim is denied for any reason, the provider shall re-submit such claim along with any applicable documentation to MSO consistent with the terms of the agreement, and no later than thirty (30) days*. If the provider does not re-submit the applicable documentation to MSO for services rendered within said time period, the provider claim for compensation with respect to the detailed services shall be deemed waived.

The provider must include all support information that may be considered vital for the resolution of the case, including a list of the enrollees involved in the appeal case. For example: payment receipt or evidence, additional medical documentation of the patient, HCFA 1500 and/or UB04 Form, etc.

MSO has established a format to request an adjustment. This format must be included in all adjustments requests and should not be modified.

*For time frame reference see your contract.

16.2 Payment Schedule

MSO will run one (1) Provider Payment cycle per Week. This applies for Fee for Services claims. For Capitation services a monthly payment will be generated.

16.3 Timely Filling

The provider shall submit claims on or before ninety (90) days from the date of service with all required information to receive a correct payment and to receive it on time.

In the event that a claim is submitted to MSO with more than ninety (90) days after the date of provider's provision of Covered Services, the claim will be denied.

As established in the Contract, the provider shall submit all claims data through electronic format. For paper claims the provider should submit with all applicable documentary support (if applicable), to the following address:

MMM Multi Health

PO Box 71307

San Juan PR. 00936

16.4 Unclean claims process

No later than the fifth (5th) Business Day after a received claim has been determined that it does not meet Clean Claim requirements, the claim will be suspended and a letter will be sent requesting all outstanding Information so that the claim can be deemed clean.

The provider shall submit the claim with the information requested, no more than ninety (90) Calendar days. Upon receipt of all the requested information from the Provider, MSO shall complete processing of the Claim, and finalize (to a paid or denied status) within ninety (90) Calendar Days. In denied claims, if the provider does not agree with the resolution (determination), they must follow the Adjustment process defined in the Claims Processing Section.

9 16.5 Dispute resolution system

MSO has established a process to resolve disputes related to billing, payments and other administrative disputes between providers and MMM Multi Health that arise under the provider's contract. Through this process, the provider has the opportunity to submit their complaint in writing to the MSO. MSO will issue a written decision regarding the provider's dispute within fifteen (15) calendar days of receipt of the

supplier's written complaint. The written decision of MSO that is in some way adverse to the provider will include an explanation of the reasons for the decision and a notification of the rights and procedures that the provider must follow for a legal administrative hearing with ASES.

16.6 Financial Recovery

MMM Multi Health has a process to handle audits to determine whether it has paid a Claim incorrectly. It identifies potential overpayments and requests the reimbursement from the Provider or recoupment through the payment system. The Provider will have a period of ninety (90) Calendar Days to appeal the recovery determination made by MSO.

17. Administration and Management

17.1 Hours of Business Operations

MI Salud will be responsible for the administration and management of all the requirements and in accordance with the rules of Medicaid managed care 42 CFR Part 438. Since registration occurs mainly in the administrative offices, the *MI Salud* will ensure that its administrative offices are physically accessible to all beneficiaries and fully equipped to perform all functions related to the implementation of this Agreement. *MI Salud* keeps administrative offices in each service region. *MI Salud* will accommodate any request from ASES to visit the administrative offices of the *MI Salud* to ensure that the offices are compatible with the requirements of the Disability Act ("ADA") for public buildings, and all other rules and regulations applicable federal and state. *MI Salud* must keep one (1) administrative headquarters and an additional

administrative office in each region of services covered by this contract. *MI Salud* office is in the center and accessible on foot and vehicle traffic place.

MI Salud can set more than one (1) administrative office within each of its service regions but must designate one (1) office as the central administrative office. All written communications *MI Salud* beneficiaries must contain the address of the place identified as the legal, administrative headquarters licensed. This administrative office must be open at least between the hours of 9:00 AM and 5:00 PM (Atlantic Time), Monday through Friday. Furthermore, in accordance with the enrollment *MI Salud* Promotion (see Section 6.12), the administrative office of *MI Salud* should have extended open hours (until 7:00 pm (Atlantic Time) at least one (1) day business of the week. and must be open (to the extent necessary to permit enrollment activities) one Saturday a month from 9:00 am to 5:00 pm (Atlantic Time) the *MI Salud* will ensure that the (s) office (s) are properly staffed throughout the term of the contract, to ensure that potential beneficiaries can visit the office to enroll at any time during the hours of operation. This provision will ensure that beneficiaries and providers receive prompt and accurate response to queries.

MMM Multi Health has a process in place to audit the payment process to determine if a claim has been paid correctly or not, identify potential overpayment and request reimbursement through the provider payment system.

The provider shall have a period of ninety (90) calendar days to appeal the determination of the recovery made by MSO.

18. Acronyms

The acronyms included in these Provider Guidelines stand for the following terms:

ACH	Automated Clearinghouse
ACIP	Advisory Committee on Immunization Practices
ADFAN	Administración de Familias y Niños en Puerto Rico, or Families and Children Administration in Puerto Rico
AHRQ	Agency for Healthcare Research and Quality
AICPA	American Institute of Certified Public Accountants
ASES	Administración de Seguros de Salud, or Puerto Rico Health Insurance Administration.
ASSMCA	The Puerto Rico Mental Health and Against Addiction Services Administration or Administración de Servicios de Salud Mental y Contra la Adicción.
ASUME	Minor Children Support Administration
BC-DR	Business Continuity and Disaster Recovery
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CLIA	Clinical Laboratory Improvement Amendment
CMS	Centers for Medicare & Medicaid Services

CRIM	Center for the Collection of Municipal Revenues
DM	Disease Management
DME	Durable Medical Equipment
DOJ	The Puerto Rico Department of Justice
ECHO	Experience of Care and Health Outcomes Survey
ECM	Electronic Claims Management
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EIN	Employer Identification Number
EMTALA	Emergency Medical Treatment and Labor Act
EPLS	Excluded Parties List System
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQRO	External Quality Review Organization
ER	Emergency Room
FAR	Federal Acquisition Regulation
FDA	Food and Drug Administration
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
HEDIS	The Healthcare Effectiveness Data and Information Set
HHS	US Department of Health & Human Services

HHS-OIG	US Department of Health & Human Services Office of the Inspector General
HIE	Health Information Exchange
HIO	Health Information Organization
HIPAA	Health Insurance Portability and Accountability Act of 1996
HITECH	The Health Information Technology for Economic and Clinical Health Act of 2009, 42 USC 17391 et. Seq.
IBNR	Incurred-But-Not-Reported
ICD-10	International Statistical Classification of Diseases and Related Health Problems (10th edition)
LEIE	List of Excluded Individuals and Entities
MAC	Maximum Allowable Cost
M-CHAT	Modified Checklist for Autism in Toddlers
MCO	Managed Care Organization
MD	Medical Doctor
MHSIP	Mental Health Statistics Improvement Program
MMIS	Medicaid Management Information System
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
NPI	National Provider Identifier
NPL	National Provider List
NPPES	National Plan and Provider Enumeration System

NQMC	National Quality Measures Clearinghouse
ONCHIT	Office of the National Coordinator for Health Information Technology
P&T	Pharmacy and Therapeutics
PBM	Pharmacy Benefit Manager
PCP	Primary Care Physician
PDL	Preferred Drug List
PHI	Personal Health Information
PIP	Performance Improvement Projects
PMG	Primary Medical Group
PPA	Pharmacy Program Administrator
PPACA	Patient Protection and Affordable Care Act
PPN	Preferred Provider Network
PRHIEC	Puerto Rico Health Information Exchange Corporation
QAPI	Quality Assessment Performance Improvement Program
QIPRFP	Request for Proposals
RHC	Rural Health Center/Clinic
SAMHSA	Substance Abuse and Mental Health Services Administration
SAS	Statements on Auditing Standards
SMI/SED	Serious Mental Illness/Serious Emotional Disability
SSN	Social Security Number
SUDs	Substance Use Disorders
TDD	Telecommunication Device for the Deaf

TPL	Third Party Liability Quality Improvement Procedure
UM	Utilization Management
US	United States of America
USC	United States Code