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

Puerto Rico Government Health Plan

Providers Guidelines

MMM
MULTI HEALTH

Tel. 1-866-676-6060
(toll free)

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1. Eligibility

1.1. Enrollee eligibility & MA-10

The Puerto Rico Medicaid Program's determination that a person is eligible for MMM Multi Health is contained 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, CHIP, and Commonwealth Enrollees receive an MA-10 and may access Covered Services with 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 with the Medicaid Program Office; they will be eligible to be enrolled as of that date. 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 with 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 or 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– (Internet base portal)
www.innovamd.com

MSO Provider Call Center Telephones

(Metro area) 787-993-2317

(Free Charge) 1-866-676-6060

2. Enrollment & disenrollment functions

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 Medicare Part A premium or Deductible.

- Dual Eligible Enrollees Who Receive Medicare Part A and Part B

- MMM Multi Health will not cover the Medicare Part B premium or Deductible.
- MMM Multi Health will cover Medicare Part B Deductibles and coinsurance.

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 disenroll 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 disenroll 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, if applicable; and Disenrollment will occur according to the following timeframes (the Effective Date of Disenrollment).

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. 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 wishing to request Disenrollment must submit an oral or written request to ASES or to MMM Multi Health. If the request is made to MMM Multi Health, MMM Multi Health will forward the request to ASES, within ten (10) Business Days of receipt of the request, with a recommendation of the action to be taken.

An Enrollee may request Disenrollment from MMM Multi Health Plan without cause during the ninety (90) Calendar Days following the Effective Date of Enrollment with the Plan or the date that MMM Multi Health sends the Enrollee notice of Enrollment, whichever is later. An Enrollee may request Disenrollment without cause every twelve (12) months thereafter. In addition, an Enrollee may request Disenrollment without cause in the event that ASES notifies the Enrollee that ASES has imposed or intends to impose on MMM Multi Health the intermediate sanctions.

An Enrollee may request Disenrollment from MMM Multi Health for cause at any time. ASES will determine whether the reason constitutes a valid cause. The following constitute cause for Disenrollment by the Enrollee:

- The Enrollee moves to a Service Region not covered by MMM Multi Health, 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 services separately would subject the Enrollee to unnecessary risk.

- Other acceptable reasons for Disenrollment at an Enrollee's request include, but not limited to, poor quality of care, lack of Access to Covered Services, or lack of Providers experienced in dealing with the Enrollee's healthcare needs.

If MMM Multi Health fails to refer a Disenrollment request within the timeframe or if ASES fails to make a Disenrollment determination so that the Enrollee may be disenrolled by the first day of the second month following the month when the Disenrollment request was made, the Disenrollment will be deemed approved at that time. ASES will make the final decision on Enrollees' requests for Disenrollment. ASES may approve or disapprove the request based on the reasons specified in the Enrollee's request, or upon any relevant Information provided to ASES by MMM Multi Health about the Disenrollment request. If the Enrollee's request for Disenrollment under this Section is denied, MMM Multi Health will

provide the Enrollee with a notice of the decision. The notice will include the grounds for the denial and will inform the Enrollee of his or her right to use the Grievance System, and to have Access to an Administrative Law Hearing after first exhausting MMM Multi Health Grievance System. If ASES notifies MMM Multi Health of its intention to terminate the Contract, ASES may allow Enrollees to disenroll immediately without cause. In the event of such a Termination, ASES must provide Enrollees with the notice required by 42 CFR 438.10, listing their options for receiving services following the Termination Date of the Contract. ASES will ensure, through the obligations of MMM Multi Health under this Contract that Enrollees receive the notices (see Re-Enrollment Procedures). While these notices will be issued by MMM Multi Health, ASES will provide MMM Multi Health with the information on Certifications and Negative Redetermination Decisions needed for MMM Multi Health to carry out this responsibility.

2.9. Standard or expedited

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 will be filed directly with MMM Multi Health, or its delegated representatives. MMM Multi Health may delegate this authority to an Appeal committee, but the delegation will be in writing.

- Provide 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 will inform the Enrollee of the limited time available to provide this in case of expedited review.

- 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 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.

- 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 a deceased Enrollee's estate.

3. Enrollee rights and responsibilities

3.1. Advance Directives

Information on Advance Directives, including the right 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 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 these policies and procedures to all Enrollees eighteen (18) years of age and older and will advise Enrollees of: Their rights under the laws of Puerto Rico, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives; 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 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 and must reflect changes in laws as soon as possible and no later than ninety (90) Calendar Days after the effective change. 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. 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.

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 PMGs or PCPs, 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.

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; 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, the policies and procedures will specify the Enrollee's right to:

- Receive information pursuant to 42 CFR 438.10.
- Be treated with respect and with due consideration for the Enrollee's dignity and privacy.
- Have all records and medical and personal information remain confidential.

- Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand.

- Participate in decisions regarding his or her healthcare, including the right to refuse treatment.

- Be free from any form of restraint or seclusion 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 seclusion.

- 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.

- Choose an Authorized Representative to be involved as appropriate in making care decisions.

- Provide informed consent.

- Be furnished with healthcare services in accordance with 42 CFR 438.206 through 438.210.

- Freely 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.

- Receive Information about Covered Services and how to access Covered Services and Network Providers.

- Be free from harassment by MMM Multi Health or its Network Providers with respect to contractual disputes between MMM Multi Health and its Providers;
- Participate in understanding physical and behavioral health problems and developing mutually agreed-upon treatment goals.

- Not be held liable for MMM Multi Health's 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's 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 in excess of 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.

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 failure, kidney failure, or diabetes will be recommended to choose an internist as a 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, The Enrollee's name; The Enrollee's date of birth; A designation of the Enrollee as a Medicaid Eligible, CHIP Eligible, or an Other Eligible Person; The Enrollee's Medicaid or CHIP identification number, if applicable; The Enrollee's Plan group number, when applicable; If the Enrollee is eligible for MMM Multi Health as a Dependent, the Enrollee's relationship to the principal Enrollee; The Effective Date of Enrollment in MMM Multi Health; The Master Patient Identifier; The applicable Copayment 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 eighteen (18) years under any circumstances; The 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 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; and Instructions to obtain Emergency Services.

4. MMM Multi Health Covered Services

Evidence of a current "Advance Directives" should be noted in a prominent place in the patient's record.

4.1 Advance Directives

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. Advance directives generally may be a living will, power of attorney or healthcare proxy.

4.2. Actionable medical orders

Written instructions regarding initiation, continuation, withholding or withdrawal of particular forms of life-sustaining treatment.

4.2.1. Living wills

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

4.2.2. Surrogate decision maker

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

4.2.3. Oral statements

Conversations with relatives or friends about life-sustaining treatment 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 notated in the medical record during the measurement year.

Notation in the medical record of a discussion with a provider or the initiation of a discussion by a provider was documented in a prominent place in the record.

5. MMM Multi Health Covered Services

MMM Multi Health will, at a minimum, provide Medically Necessary Covered Services to Enrollees as of the Effective Date of Enrollment (including the retroactive period pursuant to the program requirements of MMM Multi Health, and the Puerto Rico Medicaid State Plan and CHIP Plan. MMM Multi Health will not impose any other exclusions, limitations, or restrictions on any Covered Service, and will not arbitrarily deny or reduce the amount, duration, or scope of a Covered Service solely because of the diagnosis, type of illness, or condition.

In accordance with Section 2702 of the PPACA, MMM Multi Health must have mechanisms in place to prevent payment for the following Provider preventable conditions:

- All hospital acquired conditions as identified by Medicare other than deep vein thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients for inpatient hospital services.

- Wrong surgery or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient for inpatient and non-institutional services.

- MMM Multi Health will not deny Covered Services based on pre-existing conditions, the individual's genetic information, or waiting periods.
- MMM Multi Health will not be required to provide a Covered Service to a person who is not an Eligible Person.

- MMM Multi Health will not be required to pay for a Covered Service if:

    - The Enrollee paid the Provider for the service. This rule does not apply in circumstances where a Medicaid or CHIP Eligible Enrollee incurs out-of-pocket expenses for Emergency Services provided in the US. In such a case, the expenses will be reimbursed under MMM Multi Health.

    - The service was provided by a person or entity that does not meet the definition of a Network Provider (with the exception of Medical Emergencies and cases where the service was previously authorized by MMM Multi Health).

5.1. 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's 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.

5.2. 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.

5.3. 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:

Covered Services	
	• 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

Covered Services	
	("DSM IV or DSM V"). The following will not be considered diagnostic test services covered under the GHP: 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 &	MMM Multi Health will provide the following medical and surgical

Covered Services	
Surgical Services	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

Covered Services	
	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 ant hemophilic factor (Factor VIII). • Monoclonal type antihemophilic factor with a certified hematologist's authorization. • Activated protrombine 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

Covered Services	
	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	Emergency Services will include the following without limitations: 1. Emergency room visits, including medical attention and routine and necessary services 2. Trauma services 3. Operating room use 4. Respiratory therapy 5. Specialist and sub-specialist treatment when required by the

Covered Services	
	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 ant 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.

Covered Services	
Maternity & Pre Natal Services	The GHP 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

Covered Services	
	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

Covered Services	
	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.

Covered 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 ant 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.

Covered Services	
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

Covered Services	
	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

Covered Services	
	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. Exclusions: The following services are excluded 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 aesthetic 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

Covered Services	
	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;

Covered Services	
	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.,

Covered Services	
	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 GHP 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 GHP. 6. The following drugs are excluded 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 GHP). • 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

Covered Services	
	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

Covered Services	
	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

Covered Services	
	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 GHP. 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.

Covered Services	
	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.

Covered Services	
	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. F) 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.

Covered Services	
	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:

Covered Services	
	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 GHP 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.

Covered 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

Covered Services	
	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 GHP 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

Covered Services	
	within twelve (12) months. The GHP 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

Covered Services	
	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

Covered Services	
	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; and j. Process for referring Enrollees into Disease Management. These procedures must be designed to include consultation and coordination with Enrollee's PCP. 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;

Covered Services	
	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

Covered Services	
	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 GHP, including GHP 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

Covered Services	
	and adolescents, including vaccinations; and 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; and 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.

6. Pharmacy

MMM Multi Health Department will work in close coordination with the Pharmacy Benefit Manager (PBM) engaged by ASES to ensure that pharmacy services provided to the MMM Multi Health enrollees are based on high quality pharmacy standards, while maintaining operations in compliance with ASES. Requirements, CMS and any other applicable law or statute.

To facilitate Claims processing, MMM Multi Health will send to the PBM, on a Daily Basis, the Enrollee Data.

The PBM as the entity under contract with ASES for MMM Multi Health Program is responsible for the administration of pharmacy claims processing, formulary management, drug utilization review, pharmacy network management, and Enrollee Information Services relating to pharmacy services. MMM Multi Health will work with the PBM as well as the Pharmacy Program Administrator ("PPA") selected by ASES as needed, in order to ensure the successful provision of pharmacy services. MMM Multi Health will be obligated to accept the terms and conditions of the contract that ASES awards to a PBM and PPA.

MMM Multi Health Clinical Pharmacy Operations are carried out by a team comprised of experienced professionals in the Government Health Plan, doctors in pharmacy and certified pharmacy technicians that leverage clinical interventions and discussion with healthcare providers. MMM Multi Health Clinical Operations Team is composed of the Pharmacy Clinical Unit and Reject Monitoring Unit:

- Pharmacy Clinical Unit: responsible for the evaluation of all coverage determination requests received and for the determination of coverage.
- Reject Monitoring Unit: performs claims processing monitoring to ensure that they are not being inappropriately rejected at a point-of-service, based on the CMS approved Formulary and Protocols.

MMM Multi Health has a Pharmacy Utilization Specialist dedicated to continuous drug utilization review. The approach is to coordinate topics with the PBM's Academic Detailing Program to develop educational activities addressing: Management and implications of polypharmacy; Condition management; Management of prescriptions; and Working with patients with conditions of special concern, including autism, ADHD, depression, and diabetes among others. There is a communication process within to deal with under and over utilization, poly-pharmacy, outliers and opportunities for improvement.

6.1. 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 Preferred Drug List (PDL)

- Drugs included on the Master Formulary, but not in the PDL (through the exceptions process).

- In some instances, through the exceptions process, drugs that are not included on either the PDL or the Master Formulary.

- 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.

6.2. Drugs excluded from pharmacy benefit services

Rebetron or any other medication prescribed for the treatment of Hepatitis C (to be provided by the Health Department, upon Referral to the Health Department by a Network Provider. This medication is not provided through MMM Multi Health).

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.

6.3. 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 by the PBM or MMM Multi Health, according to policies and procedures established by the ASES Pharmacy and Therapeutic ("P&T") Committee and decided upon in consultation with MMM Multi Health, when applicable.

- MMM Multi Health ensures that Prior Authorization for pharmacy services is provided for the Enrollee in the following timeframes, including outside of normal business hours.
    - The decision whether to grant a Prior Authorization of a prescription must not exceed seventy-two (72) hours from the time of the Enrollee's Service Authorization Request for any Covered Service. An exception exists in circumstances 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. In such cases, Prior Authorization must be provided as expeditiously as the Enrollee's health requires, and no later than within twenty-four (24) hours following the Service Authorization Request.

    - Prescriptions written by a Provider who is outside the PPN may be filled only upon a Countersignature from the Enrollee's PCP, or another assigned PCP from the 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, unless the Provider notes a contra-indication in the prescription. 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.

MMM Multi Health observes 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 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.

- 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 CPTET 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).

- Contraceptive medications 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 separately by the Health Department.

- Directions for prescriptions for chronic use drugs for children with special health needs will cover therapy 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 at the time and date, as established by the Puerto Rico Pharmacy Law.

6.4. Formulary Management Program

6.4.1. What is the Preferred Drug List (PDL)?

The PDL is a list of prescription drugs, both generic and brand name covered by the MMM Multi Health.

MMM Multi Health will have representation in the Pharmacy and Therapeutic Committee for the clinical evaluation of Medications to be excluded or included in the Drugs Formulary and will also have representation in 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.

All PDL changes are published on our websites:

www.multihealthpsg.com

Or our Provider portal: www.innovamd.com

6.4.2. What is the Drug Formulary?

The Drug Formulary includes drugs on the PDL and other drugs evaluated and approved by the P&T Committee but not included on the PDL. These drugs will require an exception process to be approved.

6.4.3. Can the PDL change?

www.multihealthpsg.com

Or on our provider portal: www.innovamd.com

6.4. Exception Request process

Physicians are encouraged to prescribe drugs on the Preferred Drug List (PDL) whenever possible. In the following two categories of exceptional cases, however, the MMM Multi Health will cover drugs not included on the PDL, upon submission of acceptable written documentation of the medical justification for the drug from the Provider:

- MMM Multi Health cover drugs included on the Master Formulary in lieu of a PDL drug, only as a part of an exceptions process, upon a showing that no drug listed on the PDL is clinically effective for the Enrollee.

- MMM Multi Health will cover a drug that is not included on either the PDL or the Master Formulary, provided that the drug is not in an experimental stage and that the drug has been approved by the FDA for the treatment of the condition.

In addition to demonstrating that the drug prescribed has FDA approval and is not considered experimental, a Provider prescribing a drug not on the PDL must demonstrate that: The drug does not have any bioequivalent on the market; and the drug is clinically indicated because of Contra-indication with some drugs that are in

the PDL that the Enrollee is already taking, and scientific literature's indication of the possibility of serious adverse health effects related to taking the drug. Such as history of adverse reaction by the Enrollee to some drugs that are on the PDL therapeutic failure of all available alternatives on the PDL or other special circumstances.

6.5. Fraud Investigations

MMM Multi Health has tracking mechanisms for Fraud, Waste, and Abuse of pharmacy services issues, and will forward Fraud, Waste, and Abuse Complaints from Enrollees related to pharmacy services to the PBM and to ASES.

6.6. Pharmacy Department Contact Information

6.7.1. Pharmacy Clinical Unit

Pharmacy (PA Physical & Mental Medication)

(787) 545-0630 (Metro Area), 1-844-880-8820 (toll free)

Fax 787 447-6121 MMMH

6.7.2. Internet Websites:

MMM Multi Health: www.multihealthpsg.com

InnovaMD: www.innovamd.com

7. Quality Improvement Program

Provide 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. Seek input from, and work with: Enrollees, Providers, community resources, and agencies to actively improve the quality of care provided to Enrollees.

7.1. Performance Improvement Measures & Projects

Quality Assessment and Performance Improvement Program (QAPI) effectively monitors the program elements listed in 42 CFR 438.66. ASES, in strict compliance with 42 CFR 438.204 and other Federal and Puerto Rico regulations, will evaluate the delivery of healthcare by MMM Multi Health. Such quality monitoring will include monitoring of all MMM Multi Health's Quality Management/Quality Improvement ("QM/QI") programs. The QAPI convene and facilitate an Advisory Board. Performance Improvement Projects (PIPs) work plan and activities that are consistent with Federal and Puerto Rico statues, regulations, and QAPI requirements for pursuant to 42 C.F.R. 438.240. For more detailed information refer to the "External Quality Review (EQR) Managed Care Organization Protocol" available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. PIPs must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and administrative areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction.

PIPs in the following areas:

- One (1) clinical care project in the area of increasing fistula use for Enrollees at-risk for dialysis.
- One (1) clinical care project in the area of Behavioral Health.
- One (1) administrative project in the area of reverse co-location and co-location of physical and Behavioral Health and their integration.
- Conduct additional PIPs as specified as need or requested.

In designing Performance Improvement Program:

- Show that the selected area of study is based on a demonstration of need and is expected to achieve measurable benefit to Enrollee (rationale).

- Establish clear, defined and measurable goals and objectives that MMM Multi Health will achieve in each year of the project.
- Measure performance using quality indicators that are objective, measurable, clearly defined and that allow tracking of performance and improvement over time.
- Implement interventions designed to achieve quality improvements.
- Evaluate the effectiveness of the interventions.
- Establish standardized performance measures (such as HEDIS or another similarly standardized product).
- Plan and initiate activities for increasing or sustaining improvement.
- Document the data collection methodology used (including sources) and steps taken to assure data is valid and reliable.

7.2. Advisory Board

The Advisory Board will consist of representatives from all MMM Multi Health populations, family members, and Providers. Advisory Board's members will serve to advise MMM Multi Health on issues concerning service delivery and quality of all Covered Services (e.g., behavioral health, physical health), enrollee rights and responsibilities, resolution of enrollee's grievances and appeals and the needs of groups represented by the Advisory Board's members as they pertain to Medicaid. MMM Multi Health will have an equitable representation of its representatives in terms of race, gender, special populations, and Puerto Rico's geographic region areas. The Advisory Board will keep a written record of all attempts to invite and include its representatives in its meetings. All Advisory Board representatives need to participate actively in deliberations and that no one board representative dominates proceedings in order to foster an inclusive meeting environment.

7.3. Quality Assessment Performance Improvement ("QAPI") Programs

Establish a QAPI that specifies quality measurement and performance improvement activities using clinically sound, nationally developed and accepted criteria. For

Medicaid and Children's Health Insurance Program (CHIP) Eligible, the QAPI program will be in compliance with Federal requirements specified at 42 CFR 438.240.

The QAPI program will be based on the latest available research in the area of quality assurance and at a minimum will include:

- Method of monitoring, analyzing, evaluating, and improving the delivery, quality and appropriateness of healthcare furnished to all Enrollees (including over, under, and inappropriate utilization of services) and including those with special healthcare needs.
- Written policies and procedures for quality assessment, Utilization Management, and continuous quality improvement that is periodically assessed for efficacy and reflects Enrollee and Network Provider input.
- Include an Information System sufficient to support the collection, integration, tracking, analysis, and reporting of data, in compliance with 42 CFR 438.242.
- Designated staff with expertise in quality assessment, Utilization Management, and continuous quality improvement.
- A review of outcome data at least quarterly for performance improvement recommendations and interventions.
- A mechanism to detect over, under, and inappropriate utilization of services.
- Reports that have been evaluated indicated recommendations that are implemented, and provided feedback to Providers and Enrollees.
- A methodology and process for conducting Provider Credentialing and Re-Credentialing.
- Procedures for validating completeness and quality of encounter data.

- Annual PIPs as specified by ASES.
- Development of an Emergency Room (ER) quality initiative program.
- Development of a Quality Incentive Program.
- Reporting on specified performance measures, including specified performance measures.
- Conducting Provider and Enrollee satisfaction surveys.
- Quarterly reports on program results, conclusions, recommendations, and implemented system changes, as specified by ASES.
- Process for evaluating the impact and effectiveness of QAPI program at least annually.

7.3.1. ER Quality Initiative Program

To monitor the Emergency Room (ER) Quality Initiative Program, it's necessary to implement efficient and timely monitoring of Enrollees' use of the Emergency Room, including whether a legitimate Emergency Medical Condition or Psychiatric Emergency justified such use. The ER Quality Initiative Program will be designed to identify high users of Emergency Services for non-emergency situations and to allow for early interventions in order to ensure appropriate Utilization of services and resources. The ER Quality Initiative Program will specify all strategies to be used by MMM Multi Health to address high users of inappropriate Emergency Services and include, at a minimum, the following components:

- Description of system(s) for tracking, monitoring, and reporting high users of ER services for non-emergency situations.
- Criteria for defining non-emergency situations.

- Educational component to inform (i) Enrollees about the proper use of ER services and how to access ER services and (ii) PCPs about identifying high users or potential high users of ER services.

- Protocols for identifying high users of inappropriate ER services and referring them to Care Management for needs assessment and identification of other more appropriate services and resources.

- Process for ensuring the provision of physical and Behavioral Health Services in an appropriate setting upon identification of the need.

- Quarterly reporting on ER services utilization.
- Process for monitoring and evaluating program effectiveness, identifying issues, and modifying the ER Quality Initiative Program as necessary to improve service utilization.

7.3.2. Quality Incentive Program

The Quality Incentive Program will consist of three (3) categories of performance indicators: Performance measures, Preventive clinical program measures, and ER utilization measures. The following is a description of each of the three (3) categories of performance indicators and the associated reimbursement level for each.

Performance Measures	1. Breast cancer screening; 2. Cervical cancer screening; 3. Cholesterol management; 4. Diabetes care management; 5. Access to preventive care visits; 6. Access to dental preventive care visits;

	7. Timeliness in pre-natal care; 8. Asthma management; 9. Antidepressant medication management; 10. Follow-up care for children with prescribed ADHD medication; 11. Follow-up after hospitalization for mental illness and engagement of alcohol and other drug dependence treatment; 12. Identification of alcohol and other drug treatment services; 13. Behavioral health utilization.
Preventive Clinical Programs Measure	1. Care Management; 2. Disease Management; 3. Wellness Program; 4. Pre-natal and Maternal Program; 5. Provider continuing education curriculum program; 6. Physician Incentive Plan.
ER Utilization Measure	1. ER Quality Incentive Program to reduce the inappropriate use of ER services for non-emergency situations.

7.4. Wellness Plan

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. 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. The Wellness Plan reaches, at a minimum, eighty-five percent (85%) of MMM Multi Health Enrollees. To achieve the goal of 85%, 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.

The Wellness Plan will present strategies for encouraging Enrollees to:

- Seek an annual health checkup.
- Appropriately use the services of MMM Multi Health, including MMM Multi Health Service Line.
- Seek women's health screenings including mammograms, pap smears, cervical screenings, and tests for sexually transmitted infections.
- Maintain a healthy body weight, through good nutrition and exercise.
- Seek an annual dental exam.
- Seek behavioral health screening;
- Attend to the medical and developmental needs of children and adolescents, including vaccinations.

Receive education regarding the diagnosis and treatment of high-risk diagnoses including:

- Depression
- Schizophrenia
- Bipolar disorders

- Attention Deficit Disorder and Attention Deficit (ADD)
- Hyperactivity Disorder
- Substance abuse
- Anxiety disorders.

7.5. Provider and Enrollee Satisfaction Surveys

An annual satisfaction survey for Providers and Enrollees must be performed. The survey for Enrollees will be the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Experience of Care and Health Outcomes (ECHO) survey instruments. The results of the surveys will be submitted to ASES and to the Puerto Rico Medicaid Program. A process will be established to notifying Providers and Enrollees about the availability of survey findings and making survey findings available upon request. The results of the Provider and Enrollee surveys will be used for monitoring service delivery and quality of services and for making program enhancements.

7.6. External Quality Reviews

In compliance with Federal requirements at 42 CFR 438.358(b)(3), 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 services covered. Analytics' activities to assess the quality of care and services provided to Enrollees and to identify opportunities for program must be established and developed.

8. Administrative & Clinical Function

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

8.1.1. EPSDT Purpose and Scope

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 by contractual agreement between GHP, MMM Multi Health.

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

8.1.2. Definitions

Bright Futures - Bright Futures is a national healthcare promotion and disease prevention initiative that uses a developmentally based approach to address children's healthcare needs within families and the community. The AAP has adopted the Bright Futures periodicity schedule to help guide healthcare providers for pediatric preventive care. The Government Health Plan (GHP) of Puerto Rico has also adopted these guidelines for use with GHP enrollees. (Please see attached schedule).

EPSDT - The EPSDT Program is the child health component of Medicaid. EPSDT is designed to address physical, mental, and developmental health needs. Screening services "to detect physical and mental conditions" must be provided at periodic intervals. EPSDT is a mandatory set of services and benefits for all individuals under the age of 21 who are enrolled in Medicaid.

The EPSDT acronym stands for:

- Early: Identifying problems early, starting at birth
- Periodic: Checking children's health at periodic, age-appropriate intervals.
- Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems.
- Diagnosis: Performing diagnostic tests to follow up when a risk is identified,
- Treatment: Control, correct or reduce health problems found.

8.1.3. Provider Contractual Requirements

Healthcare Provider responsibilities for EPSDT per CMS and ASES requirements are stipulated in Network Providers and Medical Group contracts.

The Bright Futures periodicity schedules along with required follow-up for appointments and or missed appointments are shared accordingly.

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 to beneficiaries

Each Municipality in Puerto Rico has a variety of free transportation services available to assist enrollees in getting to their medical appointments. The Provider office can assist enrollees contacting the local Municipal office. If such service is unavailable, PCPs may refer these enrollees to the Care Management Program for evaluation and coordination, as needed.

Following EPSDT and Bright Future requirements, checkups must include:

- Initial newborn Healthy Child hospital checkup
- A comprehensive health and developmental history
- Developmental assessment, including mental, emotional, and Behavioral Health development
- Measurements, including head circumference for infants
- An assessment of nutritional status
- A comprehensive unclothed physical exam
- Immunizations according to the guidelines issued by the Advisory Committee on Immunization Practices (ACIP) (the vaccines are provided and paid for by the Health Department for Medicaid and CHIP Eligible enrollees. The vaccine is provided and paid for by MMM Multi Health for Other Eligible Persons in the GHP)

- Certain laboratory tests
- Anticipatory guidance and health education
- Vision screening
- Tuberculosis
- Hearing screening
- Dental services that may be preventive or corrective services for children under age 21, mandated by the EPSDT requirements
- Lead screening for the detection of the presence of lead toxicity. The screening shall consist of two (2) components: verbal risk assessment (from thirty-six (36) to seventy-two (72) months of age), and blood screening for lead. Regardless of risk, the PCP shall order blood screening testing for lead for all EPSDT-Eligible children at twelve (12) and twenty-four (24) months of age. Children between twenty-four (24) months of age and seventy-two (72) months of age should receive a blood lead screening testing for lead if there is no record of a previous test.
- If a suspected problem is detected by a screening examination as described above, the child shall be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

Physicians should comply with inter-periodic or partial screenings in outpatient physician encounters to bring up to date a child that is not in compliance with the EPSDT recommended schedule.

After screening and diagnostic services are provided, physicians must assess if a referral for a specific medically necessary Medicaid covered service is warranted and proceed to provide all documentation and facilitate the coordination process to refer the child to the necessary service.

Individualized healthcare, diagnostic services, and "treatment" as listed in the Federal Medicaid statute, must be provided when medically necessary to correct and improve physical and mental conditions discovered during screening services, whether or not included in the state plan.

The medical justification for a service must accompany the request for EPSDT treatment services. These services must be considered either mandated or optional services by CMS.

Providers have the responsibility to provide EPSDT diagnostic and treatment services according to American Academy of Pediatrics (AAP) guidelines and use the specific coding for each service provided.

An EPSDT screening is complete when codes from each service area required for that age, including the appropriate evaluation and management codes, are documented.

Physicians should provide these services in a culturally and linguistically competent manner, taking into account cultural beliefs, language barriers or limitations, and ethnically diverse groups.

8.1.4. Provider Outreach and Education Regarding EPSDT

8.1.4.1. Providers will be oriented on the following:

- The importance of preventive care
- The periodicity schedule and depth and breadth of services
- That EPSDT services are provided without cost
- That transportation will be coordinated if needed

8.1.4.2. 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 enrollees

- GHP Provider Manual

- GHP 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 enrollees and their families.

8.1.5. Appointment Scheduling and Tracking

- Utilizing their current appointment system, providers are responsible for providing timely access to EPSDT services. Monthly reports provided by MMM Multi Health will supplement the provider's efforts in identifying enrollees 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.

8.1.6. Provider Compliance

Provider compliance will be monitored through:

- PCP reports on enrollees needing or past due for EPSDT Services
- Random EPSDT Claims Audits
- Physicians that successfully comply may participate in the EPSDT Provider Recognition Program

8.2. Prenatal Program

8.2.1. 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.

8.2.2 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 referred case 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 GHP 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.

8.2.3. Prenatal and Postpartum Services

All enrollees enrolled in the Special OB Coverage are guaranteed access to contracted Ob/Gyns for their pre and postnatal healthcare services. Physician 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.

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

- *Comprehensive assessment* - An initial comprehensive assessment including history, review of systems, and physical examination.

- *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.

Given the correlation between poor oral health and pregnancy outcomes, the OB/Gyn 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.

8.2.3.2 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.

8.2.4. Prenatal Wellness & Care Management Program

The Prenatal Wellness & Care Management Program will provide an array of strategies and interventions for pregnant GHP 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

- PHQ-9

- 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 management within the practice (co-location) or through referral to MMM Multi Health Mental Health 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.

8.2.5. 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 GHP by trimester and age.
- Number of pregnant women enrolled in the GHP 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.

8.2.5.2. Strategies may include:

- Mailing of 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 GHP Service Line or the Triage Line

8.3. Wellness Plan

Wellness and prevention are fundamental parts of the company's approach to coordinated and integrated healthcare, especially after considering the impact of chronic health conditions among different demographic groups on the Island. Given the impact of non-communicable diseases such as diabetes, cancer, asthma and heart disease in Puerto Rico, MMM Multi Health will establish an integrated healthcare delivery system based on a prevention and wellness platform. The latter would allow enrollees to be educated regarding:

- Risk factors for chronic health conditions; obesity, lack of physical activity, smoking, family history of illness and disease, and nutritional choices
- EPSDT measures

- Status of existing chronic health conditions
- Mental health status
- Oral health
- Appropriate pharmacy use
- A clear road map on how to initiate and maintain the pathway towards health and wellness

The benefits of the aforementioned approach are well known, especially within an integrated system of care: improved clinical outcomes, better utilization of resources, increase in enrollee satisfaction, and affordable healthcare for more individuals. Wellness activities and events will be developed according to the age group and the health needs of participants.

MMM Multi Health prevention, health education, and wellness programs have been developed after an integrated model which has promoted the inclusion of the company's mental and behavioral health. It is a standard operation procedure to integrate mental and behavioral health in the discussion of, and education about, chronic health conditions such as: diabetes, congestive heart failure, hypertension, chronic kidney disease, obesity and others. On a monthly basis the Wellness team will provide seminars, workshops, educational sessions and face to face interventions on those subject matters as well as on risk behaviors.

8.3.1. Wellness Initiatives for the GHP Target Population

A key element for the success of wellness initiatives will be the establishment of a multidisciplinary team. This team will provide targeted interventions based on population needs (children, adolescents, adults, and older adults). Interventions have been designed to support and promote the integration of physical and behavioral health in a variety of settings and outreach events.

8.3.1.1 These outreach initiatives will be offered using diverse educational strategies, such as:

- Group health classes
- Workshops
- Health fairs
- Health clinics
- Population health campaigns or events
- Social Media, traditional media outlets

The following table describes some of the components to be included as part of the Wellness interventions for the GHP population. MMM Multi Health recognize that as more population data and epidemiological need profiles become available, additional topics will be included as needed. An important part of these interventions is to work in collaboration with government agencies to maximize our mutual efforts effort and to support each other for the benefit of the enrollees in the Region. This collaboration will be focused on the establishment of intervention strategies that would support the integration of mental and physical health. Specifically, the wellness program will coordinate joint efforts with the following agencies:

- Puerto Rico Department of Health
- Vice Secretariat for Health Promotion
- Department of Family Services
- Department of Education
- ASES
- Medical Assistance Program (Medicaid)

- Municipalities
- Community Based Organizations

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

Topic/Interventions	Population Group	Government Agency Collaboration	Scenarios
Annual health checkup (including EPSDT for child care)	Adult Adolescents Children	PR Department of Health Department of the Family Department of Education Non-Profit organizations such as: American Heart Association	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	PR Department of Health Department of the Family ASSMCA	Medical Provider Offices (Co-location Facility) Government agencies (Medicaid office, WIC, etc.) Community-based and faith-based organizations
*Physical Health: Asthma Diabetes Hypertension Non intentional injuries Flu Dengue *Among others	Adult Adolescents Children	PR Department of Health Department of the Family Department of Education Non-Profit organizations such as: American Heart Association	Medical Provider Offices (Co-location Facility) Government agencies (School, Head Start, Medicaid office, etc.) Community-based and faith-based organizations
Women's health			Medical Provider Offices

(mammograms, pap smears, cervical screenings)	Women	PR Department of Health Department of the Family Non Profit Organizations (Ex. Susan G. Komen, American Heart Association)	(Co-location Facility) Government agencies (Medicaid office, WIC, etc.) Community-based and faith-based organizations
Sexually Transmitted Diseases	Adults Adolescents	PR Department of Health Department of the Family Department of Education WIC Colleges and Universities	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	PR Department of Health Department of the Family Department of Education Department of Sports and Recreations	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 Children	PR Department of Health Department of the Family Department of Education Colleges and Universities PR Department of Health Department of the Family Department of Education	Medical Provider Offices (Co-location Facility) Government agencies (School, Head Start, Medicaid office, WIC, etc.) Community-based and faith-based organizations 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	PR Department of Health Department of the Family Department of Education ASSMCA	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	PR Department of Health Department of the Family Department of Education ASSMCA Non Profit Organizations; La Alianza de Autismo de PR	Medical Provider Offices (Co-location Facilities) Reverse Co-location Facility Community-based and faith-based organizations

On a monthly basis ASES will receive a calendar with the events scheduled for the contract year period. Additionally, MMM Multi Health will be submitting Quarterly Case Management Reports to ASES, which will include the Wellness Program Report. These quarterly reports will indicate:

- Number of events per region/per municipality
- Type of events
- Topics offered
- Number of participants per event

Percentage of participants who are enrolled in the GHP (this yearly percentage is cumulative and will count towards the goal of reaching 85% of enrollees in the program).

- Amount of government agency meetings in which the plan has participated

- Number of collaborative efforts carried out in conjunction with government agencies

In order to reach 85% of enrollees as requested by ASES, each enrollee will be additionally provided with the following action-steps at enrollment:

- Information about how to coordinate an initial visit with their designated Primary Care Provider or Pediatrician

- Information with suggested tests and preventive exams according to age-group and gender

- For enrollees with children and adolescents (0-21 years); a list containing the mandatory visits, tests, exams and screenings according to EPSDT Tables (including a vaccination schedule according to age)

- For women in reproductive age: a) recommended screenings for women including: pap smears, mammography's, and check-ups with gynecologist, b) description of Ob-Gyn services which are provided and information about the enrollment process for prenatal and post-partum services and c) family planning information and education on contraceptive use

Once enrolled in the GHP, the enrollee will receive a welcome package with information about the MMM Multi Health prevention and wellness program. Lastly, our MMM Multi Health Wellness team will be available to collaborate and participate in mass events organized by ASES or by government agencies.

MMM Multi Health will develop specific strategies with the Vice Secretariat of Health Promotion, the Department of Family Services, and the Department of Education that will concentrate on the following areas:

- Use of Guidelines for Disease Prevention developed by the Department of Health for chronic health conditions.

- Integrate efforts with community events, health fairs, and health risk appraisals carried out by the Department of Health within each of the communities served by MMM Multi Health.

- Establish a coordinated plan with the "Programa de Salud Escolar" of the Education Department to bring workshops, educational sessions, and information to the different schools within the designated region. Specific topics covered will include:

    - Physical activity
    - Nutrition
    - Disease Prevention
    - Smoking Prevention
    - Depression and anxiety
    - Reproductive Health
    - Vaccines

MMM Multi Health will establish a collaboration with the ACUDEN and TANF programs of the Department of Family Services to bring outreach, health promotion, and disease prevention information to their beneficiaries. Specifically, our Wellness Program will focus on:

- Collaborating with the Mayor's office of the municipalities in the region to identify communities in remote areas. Coordinate a quarterly health event by region in which the community can receive a health educational intervention. This collaboration will include the Mayor's office support in the coordination of transportation to enrollees living in remote areas, if necessary.

- Using regional media (Radio & News Paper) to announce health events, promote available services to enrollees in the municipality or to communicate important health educational topics to the community.

- Coordinate interventions with the Department of Education and the Department of Health as they develop their event calendars in the community.

- Identify PMGs in the municipality and encourage them to call and invite their patients to attend events coordinated and planned by the Wellness Program

8.4. Care Management

8.4.1. Assessment Process

8.4.1.1. Purpose

To establish the process for Care Management Assessment (which includes Case Management, Prenatal, and Disease Management Programs) used by MMM Multi Health to identify, plan, implement, monitor and review care for enrollees with chronic conditions or high acuity levels. Care Management programs strengthen outcomes for enrollees through individual care assessments and the development of care plans which are focused on integrated and coordinated service delivery. After initial assessment, these programs provide a contact person, who performs tasks to guide and direct the enrollee's needs) in order to provide the highest level of quality care and cost containment. Programs also provide

enhanced opportunities for enrollees and physicians to increase access to care and help enrollees improve their self-management skills.

8.4.1.2. Scope

This document applies to all Health Services Departments for MMM Multi Health. Complex Case Management Program or CCM (Case Management, Disease Management and Prenatal Program) provides multiple alternatives to care for enrollees with identified high-risk factors once enrollee's needs, preferences and limitations are assessed by a Case Manager. The Case Manager assesses plans, performs interventions and measures individual outcomes acting as a liaison and point of contact between members, providers and other health professionals and relatives to improve an enrollee's health, to ensure better management and optimal health outcomes. The Case Manager provides assistance in navigating the system, and helps promote coordination of care and appropriate delivery of services for enrollees that have experienced a critical health event or disease diagnosis. Enrollees have the right to accept or decline participation in the appropriate Program.

8.5. Special Coverage Protocol

8.5.1. Goals of the Special Coverage Program

Enrollees may qualify to be enrolled in the Special Coverage Case Management if they meet the criteria described by ASES in contractual requirement 7.7, or if the degree and complexity of their illness or condition is typically severe, needing intensive management, and requiring multiple resources working collaboratively to help them regain optimal health status. The Special Coverage Program Goals are as follows:

Identify and serve enrollees with high risk, chronic illness and high cost impact by performing a comprehensive needs assessment and Individualized Care Plan.

Perform coordination of care and to promote linkages to appropriate specialty providers, tests, treatments, and care facilities.

Establish cost effective outcomes by promoting quality of services, by reducing ER visits, hospitalizations and inappropriate ambulatory services, all in direct coordination with a Primary Care Physician.

Promote enrollees' clinical improvement and condition management/control by engaging them, their significant other/s and their providers to follow and adhere to the care plan designed

Empower enrollees through self-management, education, service coordination and orientation, medication review, monitoring and integration of available clinical, behavioral and pharmacological resources.

8.5.2. Identification of Eligible Enrollees

Eligible enrollees will be identified through various mechanisms: Referral to the Special Coverage Registry by the PCP, Case Manager, other program, or self-referral, and or:

Diagnosis with one or more of the following Health Conditions:

- Aplastic Anemia
- Rheumatoid Arthritis
- Autism
- Cancer
- Children with Special Needs
- Chronic Kidney Disease (Levels 3, 4 & 5)

- Cystic Fibrosis
- Hemophilia
- HIV-AIDS
- Leprosy
- Multiple Sclerosis & ALS (In Attachment 7 but not in Contract)
- Obstetrics
- Scleroderma
- Systemic Lupus Erythematous
- Tuberculosis

The Special Coverage Program for the GHP will provide effective management for those who may require intensive clinical services and ongoing care management. The PCP may refer an eligible enrollee by utilizing the appropriate electronic tools applying Special Coverage criteria. Received referrals will be routed to the clinical management software platform for review. Additionally, cases can also be identified when an enrollee are required to obtain 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. The Case Management nurse assigned to the Special Coverage Program will conduct an eligibility criteria review to confirm if the referred case meets clinical criteria for admission to the program. In the event the referral does not meet criteria, a denial letter will be sent to the enrollee and to the PCP indicating reasons for denial. If the referral does meet clinical admission 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. Special Coverage eligibility will be retroactive to the date of the Provider diagnosis. If the approved referral is submitted after determining diagnosis, coverage may be provided up to 60 days retroactive to the date in which the Provider submitted the registration request. If the enrollee is in the Special Coverage Program due to Pregnancy, coverage will be provided retroactively to the Estimated Date of Conception, as determined by the Physician.

8.5.3. Individualized Care and Treatment Plan

The Case Management Nurse will conduct a comprehensive needs assessment to establish an individualized care plan with the enrollee, provider(s), and support system, as well as coordinate care and promote access to the appropriate level of care. The Individual Care Plan will be developed collaboratively with the enrollee's physician taking into account the stage of the disease and severity, course of treatment and health goals.

8.5.4. Special Coverage Case

Management enrollees will be flagged to designate admittance in the special coverage condition and will be notified to the enrollment area for appropriate processes and procedures. Flagged cases will also have an open preauthorization in the enrollee's record for automatic approval of:

- Medical Treatments and procedures for qualifying conditions
- Visits to specialists for related conditions without need for referrals
- Approval of covered pharmacological treatments, outside of the Preferred Drug List. The preauthorization for related special coverage will generally be valid for a 12 month period, or as determined by ASES due to the state of the disease. As indicated by ASES (Section 7.7.11.9), preauthorizations will still be required for the following:

- Computerized Tomography
- Magnetic Resonance Test
- Cardiac Catheters
- Holster Test
- Doppler Test
- Stress Tests
- Lithotripsy
- Electromyography
- Single-photon Emission Computed Topography (SPECT)
- Orthopantogram (OPG) Test
- Impedance Plethysmography
- Other neurological, cerebrovascular, and cardiovascular procedures (invasive and noninvasive)
- Nuclear Imaging
- Diagnostic endoscopies
- Genetic Studies
- Pathological and clinical laboratory tests that require processing outside of Puerto Rico

Special Coverage Eligibility will be reviewed annually by the CM Nurse in communication with the PCP and the Specialist seeing the enrollee. Specific clinical goals and objectives identified in the Individual Care Plan will also be reviewed to ensure a seamless system of care. For enrollees in Special Coverage due to Pregnancy, benefit eligibility will be up to 56 days postpartum, if delivery occurs at 20 weeks or later. If pregnancy ends in abortion prior to week 20, coverage duration will be provided for 30 days from occurrence.

Care Management Program interventions for Special Coverage enrollees include:

- Comprehensive Initial Assessment
- Follow up to enrollees to ensure appropriate self-management activities
- Individual interventions
- Individualized Care Plan
- Telephonic and mailing education
- Coordination of services including visits to Specialists
- Community Agency Referrals, as applicable
- Home Visits when needed
- Interdisciplinary Care Team Discussions and Consultations

Our Care Management philosophy pursues a collaborative multi-disciplinary approach that involves office staff, social workers, psychologists and specialists, as needed, in order to optimize enrollee participation in the Special Coverage Program. The organization's health information technology platform is a critical part of this process in order to

document, coordinate and measure the impact of these care coordination interventions and to facilitate follow-ups and enhanced utilization of services and programs for enrollees.

8.6. Disease Management Program

8.6.1. Intervention Process:

The Health Services Department has established a process which defines how eligible enrollees can participate in the DM program and the materials that are provided to enrollees regarding program eligibility, use of services, and procedures for opting out of program participation.

8.6.2. Definitions:

- Eligible enrollees: those enrollees the organization identified as qualifying for program participation and whose program and stratification level call for any type of intervention.

- Opt in: process whereby eligible enrollees choose to receive DM services and participate in the program.
- Opt out: process whereby eligible enrollees elect not to receive disease management services to decline participation in the program.

- Care Manager: healthcare professional who is in charge of the process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and needs.

- Wellness Program: Program responsible for developing and implementing population health strategies for enrollees identified in moderate and low severity levels, to understand and manage the diagnosed conditions.

- Disease Management: program responsible for care management of eligible enrollees with one or more of the following conditions: Asthma, Chronic Kidney Disease (Levels 1

& 2), Congestive Heart Failure, Diabetes, Depression, Hypertension, and Obesity. The program supports the practitioners/patient relationship and Care Plan, emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and facilitates patient empowerment strategies for improved self-management.

- Participant: An Eligible Enrollee that has Opted-In (Consented) to participate in the DM program.

- Practitioner: Eligible Enrollee's Primary Cary Physician or Physician responsible for their care.

8.6.3. Procedures of Core Disease Management

- Enrollees are initially contacted through an outbound call, and invited to participate in the management program. Enrollees must formally consent (opt in) to participate in the program. Eligible enrollees who chose to participate in the program will be administered an Individual Care Assessment as well as the PHQ9 assessment. Eligible enrollees lacking an active telephone number will be notified of their eligibility for participation through a letter sent by mail.

- Participants are categorized into 3 sub-stratification levels using an algorithm that is incorporated in the assessment, as well as available medical documentation of disease conditions.

- Stratification levels represented estimate disease severity, which range from 1 (low) to 3 (high). These are used to determine the type and intensity of interactions with each participant. Intervention modalities may include phone calls and mailed educational materials.

- Levels 1 and 2 will be managed through diverse population health strategies which may include: educational courses, targeted mailings, targeted automated reminder calls, educational materials, among others

- Level 3 will be managed by the DM Care Manager

Care Managers will use the electronic clinical management software to document the care call interactions and enrollee medical information.

- The content of the care call interactions will be tailored to the needs of the enrollee, based on the Individual Care Plan determined by triggers identified during assessment.

- The goal is to support appropriate care choices, provide advice on better self-management practices, and encourage positive health behaviors and adherence to care standards including regular physician visits, disease-appropriate testing, and medication adherence.

Care Managers are given the discretion to re-categorize an enrollee's risk stratification (and associated frequency of phone call support) based on their assessment and clinical judgment of the enrollee's support needs, thus providing the flexibility to adapt the program to unique enrollee needs at the time of interaction.

8.6.4. Co-morbidity Management:

- The Care Manager will utilize the individual care assessment (ICA) to estimate other conditions that can affect the participant's health, such as Renal Disease, Asthma, Hypertension, among others.
- The tool will assist in developing an individual care plan for participants based on a holistic, mutually agreed approach, and may include interventions for specific co-morbidities.
- As a result of the assessment, the participant may also receive educational materials of other conditions through enrollee

educational materials, educational campaigns or massive educational campaigns.

8.6.5. Depression Screening and Behavioral Health Integration:

All participants will be screened for depression using the PHQ-9 (depression assessment tool). Screening will be administered during the first assessment in order to identify signs and symptoms related to depression.

If the PHQ-9 score determines that the participant has minimal or mild depression, they will be referred to the DM resource specialized in mental health conditions. If PHQ-9 scores reflect moderate, moderately severe, or severe depression, the participant will be referred to the Case Management Team within the Integrated Behavioral Health Department for the appropriate management.

8.6.6 Encouraging patients to communicate with their practitioners about their health conditions and treatment

The Care Manager is the liaison between the participant and their practitioner to promote adherence to the recommended treatment plan, as well as to ensure proper communication between both parties. Wellness and Care Management strategies encourage proper communication between the enrollee and their physician, to promote health literacy and encourage dialogue. Practitioners are advised that the DM program will provide the following services to the participant:

8.6.6.1. Monitoring:

- Enrollee's self-management of the condition
- Preventive health issues
- Relevant medical test results

8.6.6.2. Managing:

- Co morbidities
- Lifestyle issues

- Medication adherence
- Health behaviors
- Psychological issues

The Care Manager may contact the Practitioner to discuss enrollee barriers to success, non-compliance to treatment, among others in order to jointly assist the participant in improving his or her health and support the Physicians' clinical treatment goals.

8.7. 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.

8.8. Organizational Structure

The Care Management professional staff is composed of physicians, registered nurses, social workers, nutritionists, health educators, and others. Enrollees of the administrative staff support all functions.

8.8.1. Roles and Responsibilities:

Medical Director

To oversee clinical guideline development, resolution of clinical issues and implementation of physician education related to the program.

Social Worker

To assist in the implementation of outreach services, community referrals and home assessments as needed.

Nutritionist

Evaluates the nutritional requirements and creates individualized nutritional plans for enrollees.

Health Educator

To develop, implement and evaluate enrollee education activities and identify community resources and organizations as related to comorbidities such as Diabetes, CHF, Cardiovascular Disorders, etc.

Care Manager

To assess, facilitate, plan and advocate for health needs on an individual basis, including identifying and providing alternative care management solutions, resource coordination and enrollee / enrollee referrals.

Data Analyst

Identifies and tracks disease specific clinical indicators. Monitors and evaluates results of program activities and determines outcomes. Assists in the production of reports, evaluates claims data, tracks and monitors cost-containment.

Outcome Measures

The Care Management Program uses indicators to determine the success of the interventions for enrollees and practitioners. Through an annual review process, benchmarks are identified and goals are established for the following year. The indicators are measured against goals on an annual basis. Indicators for the program include cost and quality.

8.8.2. Health Support Programs:

The following table represents the additional support programs for Care Management:

Health Support Programs	General Description

Tobacco Cessation Program	Designed to help enrollees who wish to stop using tobacco products, as well as those who have quit using tobacco products to prevent a relapse.
Educational Campaigns	Geared to promote healthy lifestyles, preventive services and treatment adherences. Main interventions are focused on decreasing incidences and prevalence of chronic conditions among enrolleess.
Home Visits	Aimed at helping enrolleess and their caregivers or significant other, to understand and manage chronic conditions through individualized interventions.
Tele Health	Clinicians can remotely monitor patients' vital signs and send them short surveys about their health status. This combination of objective data and subjective responses enables a clinician to make more timely care decisions and helps prevent unnecessary hospitalizations.
Nurse Triage Line	To determine the severity of the caller's complaint using a series of algorithms developed by a coordinated effort of physicians and nurses, direct the caller to the appropriate emergency services if necessary, recommend the suggested medical follow-up based on their assessments and established triage protocols, and provide health information.
Wound Care	Helps improve chronic wound healing rates, reducing amputations and disabilities, thus greatly improving the quality of life for those served.

9. Coding and Clinical Documentation Practice

9.1. General concepts in clinical documentation

"If it isn't documented, it hasn't been done" is a principle in the healthcare setting. Clear and concise medical record documentation is critical when providing healthcare services to patients and is required in order for providers to receive accurate and timely payment for services rendered. The following general principles assist to ensure that medical record documentation for most medical services is appropriate:

- Documentation must be: clear, concise, consistent, complete, legible, reliable and specific.
- The provider must use standard abbreviations and terms.
- Any correction must include one-line strikes, initials and date of the correction; use of corrective tape is not acceptable.
- Do not use codes in clinical documents; write instead the diagnosis and service in medical terminology and standard abbreviations.
- Provider's name, enrollees's name and date of service must be present in each page of the medical record.
- Provider's signature and their credentials along with the license number must also be included in each clinical note.
- A standard format such as S.O.A.P. is recommended for most encounters in any practice.
- Include the reason for the encounter or procedure (medical necessity).
- Do not copy and paste medical information from one encounter to another.

- Patient's care must be verified individually to ensure accuracy avoiding medical errors and overpayment.

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

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 or evaluated.

IMPORTANT: The implementation date for ICD-10 is October 1, 2015; any claim with date of service or discharge date of October 1 and after must include ICD-10 codes. Any date of service or discharge date before the implementation date must include ICD-9 codes.

Healthcare Common Procedure Coding System (HCPCS) has been selected as the approved coding set for entities covered under HIPAA, for reporting outpatient procedures.

The first HCPCS's level is Current Procedure Terminology, Fourth Edition (CPT-4). It includes three levels of codes and modifiers. Level I contains the most commonly used codes for medical services and procedures. Level II (commonly referred to 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. 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 for the specific enrollees 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.

9.3. Integration of Physical and Behavioral Health

It's necessary to implement an integrated model of service delivery, and MMM Multi Health will observe all the protections of the Mental Health Code (Act No. 408) and the Puerto Rico Patient's Bill of Rights Act, as well as other applicable Federal and Puerto Rico legislation. The Behavioral Health Provider will be present and available to provide assessment, consultation, and Behavioral Health Services to Enrollees. The standard minimum criteria for weekly access will be 4 hours per week for every 5,000 enrollees assigned to a PMG Setting. The Behavioral Health Provider housed within the PMG will 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 will ensure that the services provided are compliant with Act No. 408.

9.4. Information Sharing

Establish a process for monitoring exchange of Information, documenting receipt of Information and following up on Information not submitted in a timely manner. To be on compliance providers implement a certified EHR and a HIE platform with the capacity of centralizing the management of the referred EHR by all the PMG Providers including all Behavioral Health Providers. PMGs needs immediately refer Enrollees to the Behavioral Health Provider located within the PMG (or, if the Provider is not available, to the emergency room) when an Enrollee displays suicidal behavior. ASSMCA and SAMHSA will be consulted where appropriate and will acknowledge that these entities participate, as appropriate, in the regulation of Behavioral Health Services under MMM Multi Health.

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 in MMM Multi Health's PPN. A written Referral from the PCP will be required:

- For the Enrollee to access specialty care and services within the MMM Multi Health's General Network but outside the PPN.
- For the Enrollee to access an Out-of-Network Provider (with the exception of Emergency Services).
- A Referral for either the General Network or out-of-network services will be provided during the same visit with the PCP but no later than twenty-four (24) hours of the Enrollee's request.
- When a Provider does not make the Referral in the required timeframe specified, or refuses to make a Referral, MMM Multi Health will issue an Administrative Referral.
- 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.
- 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.

- 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.

- If the Referral system that is developed by MMM Multi Health requires the use of electronic media, such equipment will be installed in Network Providers' offices at MMM Multi Health's expense.

10.1.1. 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:

- 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.

- 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.

- 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.

- 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.

- 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.
- 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 GHP 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).

- 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.

- 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.

- 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.

- 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.

10.1.2. Develop electronic, web-based referral

ASES strongly encourages MMM Multi Health to develop electronic, web-based Referral processes and systems. In the event that a Referral is made via the telephone, MMM Multi Health will ensure that Referral Data is maintained in a Data file that can be accessed electronically by MMM Multi Health, the Provider, and ASES.

11. Provider Network & Contracting Process

11.1. 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 Provider Network Operations Department verifies excluded providers and the Medicare/Medicaid Opt-Out list, on the 15th day of the month, prints and files copy of the reports available in the following links:

1. http://oig.hhs.gov/fraud/exclusions/supplement_archive.asp

2. http://medicare.fcso.com/Opt_out/

If a Network Operations Departments 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 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

- Reference Sections

- 42 CFR §422.204(b)(2); Manual Ch.6 – Section 60.3

- 42 CFR §422.204(b)(2)(iii); Manual Ch.6 – Section 20.2

- 42 CFR §422.204(b)(1); Manual Ch.6 – Section 70

- 42 CFR §422.205: Manual Ch. 6 – Section 50

11.2 Provider Qualifications

A group of Network Providers that GHP Enrollees may access without any requirement of a Referral or Prior Authorization; provides services to GHP Enrollees without imposing any Copayments; and meets the Network requirements described in Article 9 of this Contract. The GHP 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.

11.2.1 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 (FQHC) • 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 needed to offer Covered Services, except pharmacies, considering the specific health needs of the Service Region.
Non- Medical Practicing Provider	• Physician Assistant • Nurse

Specialist	• Podiatrists • Optometrists • Ophthalmologists • Radiologists • Endocrinologists • Nephrologists • Pulmonologist • Otolaryngologists (ENTs) • Cardiologists • Urologists • Gastroenterologists • Rheumatologists • Dermatologists • 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

11.3 Preferred Provider Network ("PPN") Standards

A group of Network Providers that GHP Enrollees may access without any requirement of a Referral or Prior Authorization; provides services to GHP Enrollees without imposing any Co-Payments; and meets the Network requirements described in Article 9 of this Contract. Preferred Provider Network ("PPN"), this will be composed of physician specialists, clinical laboratories, radiology facilities, hospitals, and Ancillary Service Providers that will render Covered Services to

persons enrolled in the GHP ("Enrollees"). The objectives of the PPN model are to increase access to Providers and needed services, 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 is established utilizing a PMG to deliver services to the Enrollees who select a PCP that is a member of an individual PMG. Each provider in the PPN will be associated with an individual PMG whose group includes PCPs, clinical laboratories, X-ray facilities, specialists and other providers that meet network requirements. Enrollees will be allowed to receive services from all Providers within their PMG's PPN without Referral or restriction. Enrollees who receive a prescription from a Network Provider within the PPN/PMG will be allowed to fill the prescription without the requirement of a Countersignature from their PCP. GHP 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 preferred providers and those Providers who are not associated with a PMG.

11.4 Provider Credentialing

11.4.1 Standard for Credentialing and Re-credentialing

11.4.1.1 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.

11.4.1.2 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.

- Practitioners/Providers, who are invited to form part of MSO provider network will complete, sign and date a practitioner/provider application. This application will include work history covering at least five years and/or a curriculum vitae as well as a statement by the applicant stating any limitations in the ability to perform with or without accommodations, any history of loss of license and/or any felony convictions, any history of loss or limitation of privileges or disciplinary activity, lack of present illegal drug use, and current malpractice insurance coverage.

- The application packet includes an attestation, signed by the applicant, to the correctness and completeness of the application. The application and attestation must be signed and dated within 45 calendar days for initial practitioners/providers, and 180 calendar days for re-credentialing practitioners, prior to review and assessment by the Credentials Committee and the rendering of the credentialing decision.

- Practitioners/Providers will not be included in the network until the credentialing process is completed.

Selection will be based on a number of factors including but not limited to: (1) enrollee needs, including accessibility and availability (2) network needs and (3) 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:

- The requesting PCP will become part of an MSO Group, and all his contracting documentation has been approved by the MSO.
- Non-Contracted PCP provides services in an underserved area where his specialty is required (Applies only to IM and FP providers).

- Non-Contracted IM or FP is a Board certified provider; that accepts participation in the Plan Educational Program for Admitting Physicians (CHAMMP); when applicable.

- In instances when provider receives, inherits or buys a practice from a retiring physician who is currently a member of MSO.

MSO 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 will not apply for Practitioners. Only the Medicare number will be established as requirement for Institutional provider.

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 every three (3) years through a process that updates information obtained during initial credentialing and considers

performance indicators collected by MSO and the Plan's Quality Improvement department (QI activities & enrollee complaints) during those three (3) years.

When primary source verification have not been received after 30 days of the receipt of application, the provider will be notified in an attempt that she/he can assist in the process of obtaining the required document. 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 Credentialing Department helpdesk, as stated on the credentialing application.

11.5 Credentialing Committee Review and Decision Process

All of the time sensitive credentialing factors are up to date and within the required 180 day time requirements 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 CMO, and a list of those providers reviewed is presented to 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.

11.6. Delegation

In certain circumstances MSO of PR may delegate all or part of the provider credentialing process to a PHO, IPA or other qualifying credentialing entity. This may involve delegation of information gathering, verification of some or all of the credentialing elements, or it can include delegation of the entire credentialing process, including decision-making.

Prior to entering into a delegated credentialing agreement, MSO of PR evaluates the capability of the delegated entity to perform the credentialing functions according to MSO of PR standards, applicable state and federal standards.

MSO of Puerto Rico conducts an audit (at least annually) of delegated credentialing and re-credentialing functions. Oversight of delegated credentialing and re-credentialing functions will include review of delegates:

- Written credentialing/re-credentialing plan and policies
- Credentialing/re-credentialing committee structure
- Primary Verification process
- Provider initial and re-credentialing applications
- Termination, peer review and appeal process
- Credentialing and Re-credentialing file audit in a manner consistent with the NCQA file review process

11.7. 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.

11.8. Reinstallation Process

MSO does not have a reinstallation process. Once a sanction is removed or expired, if the provider wants to participate in the network has to send a written request to the Providers Relations Department. The provider request needs to be presented and approved in the Evaluation Committee. If the Committee accepts the provider, then the contracting and credentialing process will start.

11.9. Regulatory References:

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

11.10. Definitions:

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.

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.

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.

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

Podiatrists - Doctors of Podiatric Medicine (DPM) who diagnose and treat, both mechanically and 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.

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.

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

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.

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.

11.11. Procedure

The Credentialing Coordinator contacts practitioner approved in Evaluation Committee

The PNO Coordinator verifies that the credentialing has been accomplished within forty five (45) calendar days. If the provider application is not complete by the 45th day the provider will be sent a letter by mail of not being able to complete the Credentialing Process due to not being able to complete the process required.

If any changes in specialty occur within the 45 days of turnaround time of the Credentialing process, the Credentialing Coordinator contacts the provider to acquire the following, for changes of specialty:

- New Practitioner Application
- Copy of Certificate-Diploma of higher level of education (Specialty)
- Malpractice, if expired
- DEA, if expired
- AMSSCA, certificate

If all documentation is complete as per CMS requirements and all primary source verification as per policy MSO-PNO-POL-156-080911-E, and no adverse findings, the Credentialing Coordinator submits the credentialing application with Acceptance/Rejection form to the Credentialing Chairman for approval.

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 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 AND query from Mediregs, 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:

- Conviction relating to program or healthcare fraud
- Conviction relating to obstruction of an investigation

- Conviction relating to controlled substances
- License revocation or suspension
- Exclusion or suspension under a Federal or State healthcare program
- Excessive claims or furnishing of unnecessary or substandard items and services
- Failure of HMOs and CMPs to furnish medically necessary items and services
- False or improper claims.
- Fraud and kickbacks and other prohibited activities.
- Exclusion of entities owned or controlled by a sanctioned person.
- Exclusion of individuals with ownership or control interest in sanctioned entities.
- Failure to provide payment information.
- Failure to grant immediate access.
- Violations of PPS corrective action.
- Default of health education loan or scholarship obligations.
- Violations of the limitations on physician charges.
- Billing for services of assistant at surgery during cataract operations.

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

Once all PSV is complete for the applicant and all relevant documentation is in the file, the file is presented to the Credentialing Committee for denial or approval.

All applicants receive notification of the credentialing committee's decision within 2 calendar days, from the date of the committee. Approvals are sent only to initial

credentialing applicants. Denials are sent within 2 days of the Credentialing Committee's decision for initial credentialing and re-credentialing applicants.

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 PNO Coordinator 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 accepts provider, the FEO prepares and sends a Welcome Letter (Attachment E) within 10 days after committee determination and hand delivers the welcome letter to the Contracting Coordinator for Contracting Representative provider orientation.

The list of accepted providers/practitioner in credentialing will be notifying by email to contracting department within 10 days after credentialing committee determination for contract.

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 Peer Review Committee for reconsideration and final determination.

11.12. 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 Plans for the corresponding process.

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

- Conviction relating to program or healthcare fraud
- Conviction relating to obstruction of an investigation
- Conviction relating to controlled substances
- License revocation or suspension
- Exclusion or suspension under a Federal or State healthcare program
- Excessive claims or furnishing of unnecessary or substandard items and services
- Failure of HMOs and CMPs to furnish medically necessary items and services
- False or improper claims
- Fraud and kickbacks and other prohibited activities.
- Exclusion of entities owned or controlled by a sanctioned person.
- Exclusion of individuals with ownership or control interest in sanctioned entities.
- Failure to provide payment information.
- Failure to grant immediate access.

- Violations of PPS corrective action.
- Default of health education loan or scholarship obligations.
- Violations of the limitations on physician charges
  .
- 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.

11.13. Regulatory References:

- 42 CFR §55.104
- 42 CFR §55.105
- 42 CFR §55.10

12. PCP's Responsibilities, duties and obligations

12.1. Provider'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)

Provider Type	Explanation
	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 GHP 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 GHP Enrollees. 12) Is prohibit denied medically necessary services to GHP enrollees as established in the contract 13) It's prohibited to deny any medically necessary services to GHP 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.

Provider Type	Explanation
	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 GHP 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 GHP 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 GHP 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 GHP Enrollees. 7) It's prohibited to deny medically necessary services to GHP enrollees as established in the contract.

Provider Type	Explanation
	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 GHP 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 GHP 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 GHP Enrollees than what is offered to commercial Enrollees. 6) It's prohibited to deny medically necessary services to GHP 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

Provider Type	Explanation
	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 GHP Enrollees than on other patients, and from referring GHP 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 GHP 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 GHP 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 GHP Enrollees than what is offered to commercial Enrollees. 3) It's prohibited to deny medically necessary services to GHP

Provider Type	Explanation
	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 GHP Enrollees than what is offered to commercial Enrollees. 5) It's prohibited to deny medically necessary services to GHP 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

Provider Type	Explanation
	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 GHP 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 GHP 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 GHP 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 GHP 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.

13. Compliance

13.1. Confidentially and Privacy

MMM Multi Health (MMMH), has implemented a confidentiality policy that requires all employees, 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 Services Agreement also includes provisions, which stipulate that each provider will comply with HIPAA privacy, and confidentiality and security matters. 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 require 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, in regards to the handling of protected health information and confidential information. Contracted provider offices are reviewed for confidentiality, privacy and security policies, procedures, and practices during credentialing site visits. A broad summary of applicable rules and provisions related to confidentiality is outlined below.

13.2. 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 (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.

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.

13.3. 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 State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. Organizations must safeguard the privacy of any information that identifies a particular enrollee. Health Information is defined as any information, whether oral or recorded in any form or medium, that:

- It's created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse.

- 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).

13.4. State Law

In Puerto Rico, the Patient's Bill of Rights (Article 11) establishes that a patient has the right to have the peace of mind that their medical records will be kept under strict confidentiality and that all providers and health insurers will take necessary measures to protect a patient's privacy when managing all related documents and information.

13.5. Contractual Arrangements

MMM Multi Health agreements with ASES request compliance with federal regulations in regards to 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 Multi Health 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.

Similar to 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.

13.6. Fraud, Waste & Abuse

What is Fraud?

Fraud affects adversely insured enrollees, health plans and professionals and entities that render health services. Fraud refers to any intentional and deliberate act to deprive another of property or money through deception or any other unfair action. It is done with the purpose of deceiving or making false misrepresentation with the purpose of obtaining a personal benefit or to benefit another person.

Some examples of fraud are:

- Billing for medical services or procedures not actually performed.
- Billing for supplies or medications not dispensed.
- Lending an ID card to someone who is not entitled to it (misrepresentation) to obtain clinical services or medications.
- Billing for a more costly payment than the one actually performed to obtain a higher payment.
- Submitting false documents to obtain reimbursements.
- Billing for the same service more than once.
- Providing false information in a health enrollment form.
- Billing for the dispensing of full Prescription when the Prescription was actually filled partially.

- Receiving services rendered by a provider that has been excluded from the Medicaid Program.
- Receiving reimbursement for services that are not medically necessary or that do not comply with the healthcare professional standards.

It is important that any illegal or fraudulent action be reported immediately to your Health Plan's Complaint Unit, the Patient's Advocate Office or to ASES at:

ASES

787-774-6060

13.6.1 What is Abuse?

Abuse is the excessive and improper use of a product, service or benefit, which results in unnecessary or excessive costs for the healthcare system.

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.

13.6.2. What is Waste?

Waste is the overutilization of services, misuse of resources or other practices 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.

For more guidance on this matter you can access the orientation on Fraud, Waste and Abuse section on the ASES website at www.ases.pr.org

Eliminating fraud, waste, and abuse (FWA) is the shared responsibility of everyone involved in providing healthcare and coverage. Below, please find our expectations for delivering excellent care and service to patients while minimizing risks to you and us:

- Accurately and correctly document patient medical records. A claim for services must be supported by proper documentation in medical records.
- Do not falsify or misrepresent information on a prescription.
- Know and abide by all applicable laws and regulations.
- Address FWA in your practice with appropriate internal policies and procedures.
- Protect patient information.
- Retain adequate records of employee training for 10 years.
- Strive for accuracy and excellence in service, coding, and billing:
    - Do not up-code.
    - Do not unbundle services.
    - Provide medically necessary services.
    - Do not bill for services not rendered.
    - Do not submit duplicate billing.
- Watch for suspicious activity and red flags.
- Do not retaliate against your own employees who report FWA concerns.

13.7. The Physician Self-Referral Law (Stark Law) / Anti-Kickback Statute

13.7.1. The Physician Self-Referral Law (Stark Law)

Prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or an immediate member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies. Penalties for physicians who violate the Physician Self- Referral Law (Stark Law) include fines as well as exclusion from participation in all Federal healthcare programs.

13.7.2. 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. Where remuneration is paid, received, offered, or solicited purposefully to induce or reward referrals of items or services payable by a Federal healthcare program, the Anti-Kickback Statute is violated.

FWA Compliance Unit is responsible of detecting, preventing and conducting preliminary and full investigation of situations that raise suspicions or allegations of potential fraud, waste or abuse when MMM Multi Health, delegated entities, enrollees, agents, and employees offer, pay, solicit or receive remuneration to induce referral of business reimbursable under a federal healthcare program.

The Company must not offer incentives to enrollees that influence the enrollee's decision to order or receive items or services from a particular provider, practitioner or supplier reimbursable by Medicare and should investigate any suspicious activity and report any Kickback or Stark Law Statue violation according to the law enforcement requirements.

It is important to report FWA concerns in a timely manner. To report a concern or ask a question, please contact:

Special Investigation Unit

1-(844) 256-3953

13.8. Training

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

14. 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. The Grievance System policies and procedures are submitted to ASES for review and prior written approval.

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

- Process for filing a Complaint, Grievance, or Appeal, or seeking an Administrative Law Hearing.
- Process for receiving, recording, tracking, reviewing, reporting, and resolving Grievances filed verbally, in writing, or in-person.
- Process for receiving, recording, tracking, reviewing, reporting, and resolving Appeals filed verbally or in writing.
- Process for requesting an expedited review of an Appeal.
- Process and timeframe for a Provider to file a Complaint, Grievance or Appeal on behalf of an Enrollee.

- 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.
- Procedures for the exchange of Information with Providers, ASES, and the Enrollees regarding Complaints, Grievances, and Appeals.
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- 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.
-
- 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.

- MMM Multi Health processes each Complaint, Grievance, or Appeal in accordance with applicable Puerto Rico and Federal statutory and regulatory requirements.

14.1. Complaint

The Complaint process is the procedure for addressing Enrollee 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 within fifteen (15) Calendar Days after the date of occurrence that initiated the Complaint. MMM Multi Health will have procedures in place to provide Notice of Dispositions of Complaints to all Enrollees in their primary language. 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 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.

14.2. 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 written 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) 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.

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.

14.3. 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, or its delegated representatives. MMM Multi Health may delegate this authority to an Appeal committee, but the delegation will be in writing. 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 forty-five (45) 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 three (3) Business Days 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 extend the prescribed timeframe, he or she has the right to file a Grievance and the Grievance 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:

- The results and date of the Appeal resolution
- For decisions not wholly in the Enrollee's favor
- The right to request an Administrative Law Hearing
- How to request an Administrative Law Hearing
- The right to continue to receive Benefits pending an Administrative Law Hearing;
- How to request the continuation of Benefits
- Notification if MMM Multi Health Action is upheld in a hearing.

14.4. 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.

15. Claims coding and processing

15.1. 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 Encounter Data to MSO on a monthly basis.

15.1.1. Definitions:

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.

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.

Referrals: The Primary Care Provider (PCP) must submit an electronic referral request to the Specialty Contracted Providers. MSO will offer to the PCP the alternative of generating the electronic referral through our InnovaMD web page and IVR, at no expense to the provider.

- A Referral for the PCP will not be required or restricted neither when the patient accesses care specialties and services under the Patient's Preferred Network (PPN), nor in the Out of Network Provider during Emergency Services.

- A Referral from the PCP will be required when the patient accesses care specialties and services within the Network (with the exception of Emergency Services), but outside the Preferred Network (PPN), or when they access services from an Out-of-Network Provider.

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

- The PCP should provide a copy of the referral to the patient (generated by InnovaMD or IVR), including the authorization number. A referral for either the general network or out-of-network services will be provided during the same visit with the PCP, but no later than twenty-four (24) hours after the Enrollee's request.

- The Provider Care Provider (PCP) cannot: limit the Enrollee's access to the specialist, nor force them to change the PMG, impose limit quotas or restrain services to subcontracted providers for medically necessary services (e.g. Laboratory, Pharmacies, or other services). Furthermore, any denial, unreasonable delay, or rationing of services to patients is expressly prohibited.

Adjustments: In the event a claim for compensation 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.

15.2. 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.

15.3. Timely Filling

The provider shall submit claims within 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 addresses:

MMM Multi Health
PO Box 71307
San Juan PR. 00936

15.4. Denial of Claims and Resolution of Contractual and Claims Disputes

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 denial letter will be sent requesting all outstanding Information so that the claim can be deemed clean.

The provider submits the claim with the information requested, no more than thirty (30) 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 thirty (30) Calendar Days.

In denied claims, if the provider does not agree with the resolution, they must follow the Adjustment process defined in the Claims Processing Section.

15.5. Dispute Resolution System

MSO has established a procedure to resolve billing, payment, and other administrative disputes between Providers and MMM Multi Health arising under Provider Contracts including a Provider Complaint resolution process implemented by MSO.

MSO has implemented an internal dispute resolution system, which includes the opportunity for a Provider to submit a timely written complaint to MSO. MSO will issue a written decision in regard to the Provider's complaint within fifteen (15) Calendar Days of receipt of the Provider's written complaint. MSO's written decision that is in any way adverse to the Provider will include an explanation of the grounds for the decision and a notice of the Provider's right to and procedures for an Administrative Law Hearing within ASES.

If the Provider is not satisfied with the decision in regards to their complaint within MSO's dispute resolution system, the Provider may pursue an Administrative Law Hearing. The parties to the Administrative Law Hearing will be MSO and the Provider. ASES will grant a Provider request for an Administrative Law Hearing, provided that the Provider submits a written Appeal, accompanied by supporting documentation, no later than thirty (30) Calendar Days following the Provider's receipt of MSO's written decision.

A Provider Dispute may be submitted by electronic mail or fax. It's important that the provider submit the Provider Dispute Form with all necessary supporting documents for case review to the following address: providerdisputeresolution@mso-pr.com or send by fax to 787-300-4885. The Provider must have undergone the adjustment process with the Claims Department and have obtained response from adjustment, before engaging the dispute resolution process.

15.6. Financial Recovery

MMM Multi Health have a process to handle audits to determine whether it has paid a Claim incorrectly. It identify potential overpayments and request 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.

16. Administration & Management

16.1. Business & Hours Operations

The GHP will be responsible for the administration and management of all requirements and consistent with the Medicaid Managed Care regulations of 42 CFR Part 438. Given that Enrollment occurs chiefly on site in the GHP's administrative offices, the GHP will ensure that its administrative offices are physically accessible to all Enrollees and fully equipped to perform all functions related to carrying out this Contract. The GHP will maintain administrative offices in each Service Region. The GHP will accommodate any request by ASES to visit the GHP's administrative offices to ensure that the offices are compliant with the Americans with Disabilities Act's ("ADA") requirements for public buildings, and with all other applicable Federal and Puerto Rico rules and regulations. The GHP must maintain one (1) central administrative office and an additional administrative office in each Service Region covered under this Contract. The GHP's office will be centrally located and in a location accessible by foot and by vehicle traffic.

The GHP may establish more than one (1) administrative office within each of its Service Regions, but must designate one (1) of the offices as the central administrative office. All of the GHP's written communications to Enrollees must contain the address of the location identified as the legal, duly- licensed central administrative office. This administrative office must be open at least between the hours of 9:00 a.m. and 5:00 p.m. (Atlantic Time), Monday through Friday; In addition, pursuant to the GHP's Enrollment Outreach plan (see Section 6.12), the GHP's administrative office must have extended open hours (until 7:00 p.m. (Atlantic Time) at least one (1) Business Day per Week; and must be open (to the extent necessary to permit Enrollment activities) one Saturday per month, from 9:00 a.m. to 5:00 p.m. (Atlantic Time). The GHP will ensure that the office(s) are adequately staffed,

throughout the Contract Term, to ensure that Potential Enrollees may visit the office to enroll at any time during GHP's hours of operation. This provision will ensure that Enrollees and Providers receive prompt and accurate responses to inquiries.

MMM Multi Health has a process to handle audit to determine after the fact it has paid a Claim incorrectly. Identify potential overpayment and request the reimbursement from the Provider or recoupment through the payment system.

The Provider will have a period of ninety (90) Calendar Days to appeals the recovery determination made by MSO.

16. 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
QIP	Quality Improvement Procedure
RFP	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
UM	Utilization Management
US	United States of America
USC	United States Code

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