



ESTADO LIBRE ASOCIADO DE
PUERTO RICO

Administración de Seguros
de Salud de Puerto Rico (ASES)



PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (10)

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GUIDELINES FOR CO-LOCATION OF BH PROVIDERS IN PMG SETTINGS

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ASES GUIDELINES FOR CO-LOCATION OF BEHAVIORAL HEALTH PROVIDER IN PMG SETTINGS*



In accordance with the provisions of the Puerto Rico Mental Health Code, Law No. 408 of October 2, 2000, as amended, and the Puerto Rico Patient's Bill of Rights and Responsibilities, the Government Health Plan (GHP) is committed to promoting mental and physical health integration, in order to improve program effectiveness and quality of life for enrollees.

Historically, physical and behavioral health services have had limited information and communication interchange, which suggests that patients were not being treated in a holistic approach. Our goal is to achieve better access to care and cost containment, while considering people's health as a whole. The GHP health care coordination integration strategy for physical and behavioral health services, specifically through its Co-Location Integration Model, provides a mean to open communication channels so that better access, more targeted services and cost containment is achieved.

A Primary Medical Group (PMG) can actually operate out of one or multiple service locations such, for example, as medical offices or clinics. These locations can offer different kinds or levels of services and attend different volumes of beneficiaries. Some PMGs actually operate one or more full service clinics, with a complete array of multidisciplinary services such as primary care services, physician specialists' services, laboratory, pharmacy and others. Other PMGs have a central clinic or office and then several smaller offices or clinics that offer different specific services. And there are still other PMGs, often referred to as "virtual PMGs," that do not have a central office and have multiple providers in separate, stand-alone offices, operating as the pure concept of an independent practice association or IPA.

Accordingly, it is necessary to clarify which PMG service locations will be considered as PMG Settings for purposes of the Co-Location requirements. Specifically, it is necessary to provide guidance as to which PMG service locations must include the placement of a behavioral health provider and the amount of time per week that the provider must be available at each covered PMG service location.

The following guidelines are presented in order to clarify and adequately monitor compliance with the Co-Location requirements. These guidelines seek to ensure access to services and adequate communication between professionals without affecting the financial stability of the Co-Location Integrated Model.

Definition of PMG Setting: The following key elements are considered when defining "PMG Setting":

1. **Volume:** A PMG setting is the physical service location (clinic or office) where the population accesses most of the services within the PMG. These service locations can vary in size, kinds of services offered and number of beneficiaries attended. ASES has determined to define the term "PMG Setting" on the basis of the volume of beneficiaries served. ASES will consider as a "PMG Setting" any PMG service location that serves at least 5,000 beneficiaries. This setting must have available a behavioral health provider in the weekly timeframes detailed in these guidelines. Any PMG service location that services less than 5,000 beneficiaries must follow the "Virtual Co-Location Model" also set forth in these guidelines.
2. **Comprehensiveness:** The PMG setting where multidisciplinary services are rendered, among these, primary care services, physician specialists services, laboratory, pharmacy, behavioral provider, etc.
3. **Substitution:** Location with the capability of keeping services in case that the PCP is not available.

Required Co-Location of Staff per PMG Setting. In view of the different kinds of PMG Settings and particularly, the different number of beneficiaries served, ASES has decided that the most reasonable course is to establish a table with the required weekly access to behavioral health providers according to the number of beneficiaries assigned to each PMG Setting. The standard minimum criteria for weekly access will be 4 hours per week for every 5,000 beneficiaries assigned to a PMG Setting. The following table details the minimum required weekly hours of mental health professional availability according to the number of beneficiaries served in each PMG Setting.

Covered Beneficiaries per PMG Setting	Minimum Behavioral Health Colocation Hours Required
5,000 – 9,999	4 hrs.
10,000 – 14,999	8 hrs.
15,000 – 19,999	12 hrs.
20,000 – 24,999	16 hrs.
25,000 – 29,999	20 hrs.
30,000 – 34,999	24 hrs.
35,000 – 39,999	28 hrs.
40,000 – 44,999	32 hrs.
45,000 – 49,999	36 hrs.
50,000 – 54,999	40 hrs.



Virtual Co-Location. In the case of those PMG service locations that have less than 5,000 beneficiaries assigned, such PMG service locations shall not be required to have a behavioral health provider available on site. In these instances, the PMG service location may refer the beneficiary to another service location within the same PMG that actually has a behavioral health provider available or consult with this behavioral health provider. This model aims to provide mental health treatment and coordinate the levels of services needed by patients referred by the PMG service location in question. Behavioral health providers will be available to address consults and discussions of cases.

A corrective action plan ("CAP") will be required of every PMG Setting that does not comply with the required co-location level. The PMG must present the CAP to the corresponding Entity within seven (7) calendar days from the receipt of the notice of the need for corrective action. The Entity will evaluate and approve or deny the CAP within seven (7) calendar days from the day such CAP is received. All PMGs with an approved CAP must comply with the terms of the CAP and achieve the required co-location within the timeframes established in the CAP.

Penalty Matrix. In the event that a PMG does not comply with the required co-location levels in any of its PMG settings, the PMG may be subjected to penalties according to the following matrix:

Sanction Level	Sanction Type	Timeframe to cure	Comments
0	Notice of Non Compliance with Colocation Level	30 days (Day 1-30)	A Corrective Action Plan is required
1	New members subscription Hold	30 days (Day 31-60)	If within the first 30 day period, the PMG continues non-compliant.
2	PM/PM payment withhold and new member subscription	30 days (Day 61-90)	A Standard \$1.50 PM/PM payment withhold (in addition to sanction 1) if after the previous two 30day periods, the GMP is still non-compliant.
3	Fine	15 days (Day 91-105)	Fines to be defined in accordance to contract
4	PMG Contract Cancellation	Day 106	

*This document is under review and pending approval of CMS

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PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (11)

PER MEMBER PER MONTH PAYMENTS

ATTACHMENT 11

Per Member Per Month Payments per Region

Region	Contracted PMPM
East	\$191.67
Southwest	\$164.86





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**PUERTO RICO GOVERNMENT HEALTH
PLAN MCO CONTRACT**

APPENDIX (12)

DELIVERABLES

ATTACHMENT 12 - DELIVERABLES

All deliverables and documents submitted in accordance with this Attachment 12 must be submitted to ASES in English. Deliverables included in this list (as well as other documents that are subject to ASES review in accordance with this Contract) will be due to ASES in accordance with the deadlines established in the request for information and the readiness schedule established by ASES.

	Deliverable Name	Contract Cite
1.	Newborn Notification Form	5.2.6.5
2.	Enrollee Handbook	6.2.1
3.	Provider Directory	6.2.1
4.	Enrollee ID Card	6.2.1
5.	Notice of Enrollment	6.2.4.3
6.	Notice of Redetermination	6.2.4.3
7.	Notice of Disenrollment	6.2.4.3
8.	Development and Distribution of Written Materials Policies and Procedures	6.3.1
9.	Tele GHP Policies and Procedures	6.8.10
10.	Tele GHP Quality Criteria and Protocols	6.8.16.2
11.	Tele GHP Outreach Program	6.8.16.3
12.	Scripts and Training Materials for Tele GHP Call Center Employees	6.8.16.4
13.	FAQs for Information Service and Medical Advice Service	6.8.15
14.	Website Screenshots	6.9.5
15.	Cultural Competency Plan	6.10.2
16.	Marketing Plan and copies of all Marketing Materials	6.14.5.1
17.	Special Coverage Registration form	7.7.3
18.	Special Coverage Registration Procedures	7.7.6.1
19.	Special Coverage Notification Forms	7.7.6.2
20.	Protocols for the Development of a Treatment Plan	7.7.6.4
21.	Special Coverage Provisions for Immediate Access to Specialists	7.7.6.5
22.	Strategy for Identification of Populations with Special Health Care Needs	7.7.6.6
23.	Needs Assessment Tool	7.8.2.3.4
24.	Care Management Policies and Procedures	7.8.2.6
25.	Disease Management Policies and Procedures	7.8.3.5
26.	EPSDT Outreach and Education Plan	7.9.1.4
27.	Integration Plan	8.7
28.	Timely Access to Behavioral Health Services Policies and Procedures	9.1.5.4
29.	Provider Licensing and Certification Policies and Procedures	9.2.3.6.1.18
30.	Enrollee Selection of PCP	9.3.1.5.2
31.	PPN Participation Policies and Procedures	9.3.3.5.1
32.	Enrollee Access to Specialists Policies and Procedures	9.4.5
33.	Protocol to Screen Enrollees for Special Coverage	9.5.2.2



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ATTACHMENT 12- DELIVERABLES
Page 2

34.	Provider Hours and Operational Monitoring Policies and Procedures	9.5.5
35.	Model Provider Contracts	10.1.6.1
36.	Provider Guidelines	10.2.1.3
37.	Programmatic Changes Policies and Procedures	10.2.1.6
38.	Provider Continuing Education Curriculum	10.2.2.1
39.	Payment System to State Health Facilities	10.5.9
40.	Utilization Management Policies and Procedures (including referrals)	11.2.2
41.	Utilization Management Clinical Criteria	11.4.3
42.	QAPI Program (including ER quality)	12.2.4
43.	Wellness Plan	12.5.8.4
44.	Fraud, Waste, and Abuse Policies and Procedures	13.1.6
45.	Fraud, Waste and Abuse Compliance Plan	13.2.1
46.	Network Provider Investigations, Suspensions and Debarment Policies and Procedures	13.1.11
47.	Provider Disclosure Form	13.5.13.3
48.	Grievance System Policies and Procedures	14.1.4
49.	Grievance System forms	14.1.2
50.	Staff Training Plan	15.3.2
51.	Current MCO Organization Chart	15.3.2
52.	Implementation Plan	15.5.2
53.	Provider Payment Schedule	16.5.1
54.	Business Continuity and Disaster Recovery (BC-DR)	18.2.8.3
55.	Protection of Enrollee Health Records Policies and Procedures	34.1.6

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APPENDIX (13)

NL_MARKETING MATERIALS





ESTADO LIBRE ASOCIADO DE
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Administración de Seguros
de Salud de Puerto Rico (ASES)

Cartas Normativas 13-1212 y 13-1216 Enmendadas

21 de enero de 2014

Compañías contratadas por ASES para proveer servicios de salud física, mental y farmacia

Ricardo A. Rivera Cardona
Director Ejecutivo



MATERIALES DE MERCADEO

Reciba un cordial saludo de parte de todo el equipo de trabajo que labora en la Administración de Seguros de Salud (ASES). Como resultado de la evaluación de los materiales promocionales y comunicaciones escritas, efectivo el 1 de enero de 2014 es mandatorio lo siguiente:

1. El contenido de charlas, presentaciones, auspicios, ferias de salud, materiales educativos, esfuerzos en medios masivos, anuncios impresos, radio y televisión, plan de medios, carteles y/o cruza calles, etc. que incluya información de beneficios y servicios del Plan de Salud de Gobierno y que sea financiada total o parcial con fondos de ASES, tiene que ser aprobado por ASES. Es requisito que se incluya el estimado detallado de gastos para la actividad junto a los materiales a ser evaluados por la ASES.
2. Toda presentación, exposición pública y/o participación de cualquier empleado de la compañía en cualquier medio de publicidad, prensa y/o radio con el objetivo de exponer beneficios y servicios del Plan de Salud de Gobierno a todo tipo de audiencias como beneficiarios, proveedores, oficiales de gobierno municipal y estatal y la comunidad, tiene que ser aprobada por ASES.

3. El contenido de todo material de mercadeo deberá cumplir con las siguientes guías:
- El logo de ASES a utilizarse es el color verde y gris (Se incluye logo y guía de manejo de logo).
 - El logo de ASES se ubicará en el encabezado y en la portada de todas las piezas.
 - El logo de la compañía se colocará en la parte inferior y/o posterior de cada pieza, según aplique en tamaño menor al logo de ASES.
 - Se referirán a MI Salud como Plan de Salud de Gobierno.
 - Todo encabezado deberá tener: Plan de Salud de Gobierno, logo de ASES y título de la pieza.
 - Toda pieza incluirá en la parte inferior o posterior, según aplique, el sello con el número de servicio al cliente de ASES (se incluye imagen).
 - Banners y carpas tienen que incluir el nombre de Plan de Salud del Gobierno y el logo de ASES en primer plano. El logo de la compañía se puede colocar en segundo plano y en tamaño menor al de ASES.
4. Todo material de mercadeo tendrá que ser enviado al Departamento de Cumplimiento de ASES para aprobación. Al mismo se le asignará un número de aprobación el cual deberá ser colocado en la parte inferior o posterior de cada material promocional en un tamaño no menor de 8. Sin ese número de aprobación, el material de mercadeo no podrá ser publicado. El tiempo de revisión por cada material de mercadeo será de 15 días laborables.

El contrato 14-050 permite a ASES imponer sanciones y penalidades monetarias, entre otros, cuando la compañía incumpla con las directrices que ésta le haya notificado, por lo que la distribución directa o indirecta de cualquier material de mercadeo sin la debida aprobación de ASES, constituirá un evento sujeto a sanciones monetarias y distribución del cese y desista de inmediato de ese material de mercadeo. De tener dudas o preguntas sobre este particular pueden comunicarse con el Sr. Jorge Mas o el Sr. William Ruiz al teléfono 787-474-3300 ext. 2308 o 2220 respectivamente o vía correo electrónico: jmas@asespr.org o wruiz@asespr.org.

Cc. William Ruiz
Jorge L. Mas





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APPENDIX (13)

NL_ER CLAIMS PAYMENT





22 de octubre de 2014

CARTA NORMATIVA #14-10-22-B

PAGO DE RECLAMACIONES EN SALAS DE EMERGENCIAS POR SERVICIOS DE SALUD FÍSICA Y MENTAL EN HOSPITALES MÉDICO- QUIRÚRGICOS

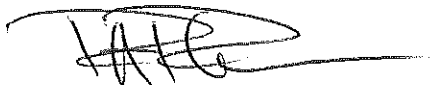
Re: Para derogar la Carta Normativa 04-01-30 sobre la separación de prestación y facturación de servicios de salud física y mental.

A partir del 1ro de abril del 2015*, el modelo de servicios del Plan de Salud del Gobierno establece que cada aseguradora responsable de administrar los servicios de salud para una determinada región, será a su vez responsable de pagar los servicios médicos de salud física y mental bajo el mismo sistema de facturación. El modelo de integración procura la integración de datos y de responsabilidad de pago bajo una sola entidad. De acuerdo con esta política, cada aseguradora establecerá los contratos con todo servicio de sala de emergencia y será el pagador único independientemente de si el servicio es un diagnóstico de salud física o de salud mental. Siendo el modelo de servicio y riesgo financiero uno integrado, queda sin efecto la carta normativa Núm. 04-01-30 enviada el 13 de Febrero del 2004 que disponía la separación de prestación y facturación de servicios de salud física y mental.

De existir un modelo de servicios donde entidades de salud mental funjan como entidades subcontratadas para dar servicios de salud mental, el arreglo tiene que ajustarse a que sea solo la entidad responsable del riesgo financiero quien procese el pago de las reclamaciones de dichos servicios. Será responsabilidad de la entidad contratada por ASES, realizar la contratación de las facilidades y proveedores de salud mental y de salud física. También será responsable de la configuración y credencialización de ambos tipos de proveedores en su sistema de adjudicación de reclamaciones, con las tarifas acordadas para los servicios según la cubierta de beneficios.

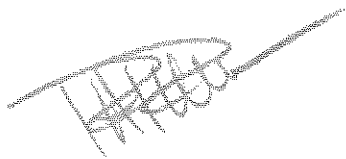
A partir del 1 de abril del 2015* queda sin efecto la carta normativa Núm. 04-01-30 y se sustituirá la misma por esta normativa.

Cordialmente,



Ricardo A. Rivera Cardona
Director Ejecutivo

*Fecha final dependerá de la efectividad del contrato.





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SPECIAL NEEDS CHILDREN DIAGNOSTIC CODES

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Special Needs Children Diagnostic Codes

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21 JAN 2009

23 de diciembre de 2008

Lcda. Minerva Rivera
Directora Ejecutiva ASES

Johnny V. Rullán, MD., FACPM
Secretario de Salud

LISTADO DE DIAGNÓSTICO DE NIÑOS CON NECESIDADES
ESPECIALES DE SALUD (NNES)

El listado de Diagnósticos de Niños con Necesidades Especiales de Salud fue revisado respondiendo a su petición.

Es necesario señalar que en principio este listado fue provisto a ASES como una guía; por tanto, es importante que no se excluya de los beneficios de la cubierta de la Tarjeta de Salud del Gobierno de Puerto Rico a un niño que presente alguna condición que no esté en el listado. Si el niño cumple con la definición de Niños con Necesidades Especiales de Salud del Negociado para la Salud Materno Infantil, deberá recibir los servicios aún antes de que se establezca un diagnóstico.

Sometemos además nuestras recomendaciones para la identificación, diagnóstico y tratamiento de los niños y jóvenes con necesidades especiales de salud a manera de asegurar el acceso a los servicios que esta población necesita. Éstas tienen el propósito de asegurar unos servicios uniformes para todos los niños con necesidades especiales de salud sin importar la aseguradora.

Gracias por su atención a este asunto.

Listado de Diagnóstico de NNEs
d/ varios 2008-08



RECIBIDO
OFICINA DIRECTORA EJECUTIVA
ASES
21 JAN 2009 P 2:44

NIÑOS CON NECESIDADES ESPECIALES DE SALUD

DEFINICIÓN:

Niños que tienen o se encuentran en mayor riesgo de desarrollar una condición crónica física, de conducta, emocional o del desarrollo, que también necesitan servicios de salud y otros servicios relacionados de un tipo o en una cantidad que va más allá de lo que los niños necesitan por lo general.

ESTANDAR DE NECESIDAD MÉDICA ESPECÍFICO PARA NIÑOS

- Servicios médicamente necesarios son aquellos necesarios para la prevención y el mantenimiento de la salud o para el diagnóstico y tratamiento de una condición física o mental, o si fueran necesarios para prevenir el deterioro de esa condición o para promover el desarrollo o el mantenimiento del funcionamiento apropiado para la edad.

CUBIERTA ESPECIAL NNES

En la "Cubierta Especial" las Aseguradoras, con quien ASES contrata los servicios, asumen el riesgo de los servicios para las condiciones clasificadas con Diagnósticos de Condiciones de Niños con Necesidades Especiales. (Ver lista diagnósticos ASES)

En esta lista de condiciones se incluyen los diagnósticos más frecuentes, pero no limita o excluye otras condiciones que cumplan con la definición. Con este propósito se debe utilizar un instrumento de cribamiento (ver "Screener") para determinar su aplicabilidad.

Es responsabilidad del médico primario solicitar la cubierta, y registrar al asegurado utilizando el formulario correspondiente para Niños con Necesidades Especiales de Salud que se encuentra en el Manual del Proveedor. También el proceso de certificación puede ser iniciado por uno de los Centros Pediátricos del Departamento de Salud.

Para poder evaluar y certificar estos casos es necesario que se incluya junto al formulario la información necesaria: E)

- Resumen de caso: Historial y físico actualizado
- Evaluaciones y consultas de especialistas.
- Resultados de procedimientos y pruebas diagnósticas
- Resultados de pruebas de laboratorio diagnósticas.
- Plan de seguimiento necesario.
- Plan de tratamiento



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Esta información y el formulario de registro deben ser enviadas al Programa de Manejo de Casos (PMC) de la Aseguradora. El PMC evaluará la solicitud de certificación y la información documental incluida. Cada caso se evalúa individualmente por el Manejador de casos y consultando al equipo asesor del Programa. Esto dependerá de la cubierta negociada. El acuerdo con las aseguradoras debe ser uniforme y que obligue igual a todas las compañías.

Se le notifica directamente por carta a la familia y al médico primario si la solicitud para la inclusión de su paciente en el registro NNE ha sido aceptada o denegada; o si falta información para la consideración del caso. El médico y/o la familia podrá apelar por escrito cualquier decisión de denegación, con la información adicional necesaria.

4



Desórdenes Metabólicos

- 270 Desórdenes de metabolismo de amino-ácidos aromáticos
- 270.0 Desórdenes de transporte de amino-ácidos
- 270.0 Cistinosis
- 270.0 Cistinuria
- 270.0 Fanconi
- 270.0 Hartnup's
- 270.0 Lowe's
- 270.1 Fenilcetonuria (PKU)
- 270.2 Desórdenes de metabolismo de tirosina
- 270.2 Alcaptonuria
- 270.2 Hipertirosinemia
- 270.2 Oronosis
- 270.2 Tirosinosis
- 270.2 Tirosinuria
- 270.2 Albinismo
- 270.3 Enfermedad de Maple-Syrup
- 270.3 Otros desórdenes de metabolismo de amino-ácidos en cadena
- 270.3 Hiperleucina-isoleucinemia
- 270.3 Hipervalinemia
- 270.3 Acidemia isovalérica
- 270.3 Acidemia metilmalónica
- 270.3 Acidemia propiónica
- 270.4 Desórdenes de metabolismo de amino-ácidos con sulfuro
- 270.4 Homocistinuria
- 270.4 Methionina
- 270.4 Deficiencia de oxidasa de sulfito
- 270.4 Homocistina cistationina
- 270.5 Otros desórdenes de metabolismo de amino-ácidos aromáticos.
- 270.5 Desorden de:
- 270.5 Metabolismo de histidina
- 270.5 Metabolismo de Triptófano
- 270.5 Desórdenes de metabolismo de amino-ácidos en cadena y ácido graso
- 270.6 Desórdenes de metabolismo del ciclo de urea Citrulinemia
- 270.6 Hiperamonemia
- 270.6 Ácido arginosuccínico
- 270.7 Desórdenes de metabolismo de lisina e hidroxilisina
- 270.7 Aciduria glutárica
- 270.7 Hidroxilisina
- 270.7 Hiperilisina
- 270.7 Desórdenes de metabolismo de glicina
- 270.7 Hiperiglicinemia no cetósica
- 270.8 Desórdenes de metabolismo de ornitina
- 270.8 Ornitinemia tipo I, II
- 270.8 Hiperhidroxiprolinemia
- 270.8 Hiperprolinemia tipos I, II
- 270.8 Sarcosinemia
- 270.8 Otros desórdenes específicos de metabolismo de amino-ácido
- 270.9 Otros desórdenes no específicos del metabolismo y transporte de amino-ácidos
- 271 Desórdenes del transporte y metabolismo de carbohidratos
- 271.0 Glicogenosis
- 271.0 Amilopectinosis
- 271.0 Deficiencia de glucosa-6-fosfatasa
- 271.0 Glicogenosis cardíaca



Índice por Diagnóstico y Condición

ICD 9

271.0	Enfermedad:
271.0	Andersen
271.0	Cori
271.0	Forbes
271.0	Hers
271.0	McArdle
271.0	Pompe
271.0	Taui
271.0	Von Gierke
271.0	Deficiencia de fosforilasa hepática
271.1	Desorden de metabolismo de galactosa Galactosemia
271.2	Desorden de metabolismo de fructosa, Fructosemia
271.3	Intolerancia a lactosa
271.3	Otros desórdenes de absorción intestinal de carbohidratos
271.4	Otros desórdenes específicos de metabolismo de carbohidratos Pentosuria, Glicosuria renal
271.8	Desorden de metabolismo de piruvato y gluconeogénesis
271.8	Defectos en degradación de glicoproteína
271.9	Desorden no específico del transporte y metabolismo de carbohidratos
272	Desórdenes del metabolismo de lípidos
272.0	Hipercolesterolemia
272	Gangliosidosis
272.0	Hipercolesterolemia
272.1	Hiperglicerinemia
272.4	Otras hiperlipidemias no específicas
272.7	Otras gangliosidosis
272.7	Lipidos
272.7	Anderson's
272.7	Fabry's
272.7	Gaucher's
272.7	Krabbe
272.7	Niemann-Pick
272.7	Fabry's
272.7	Leukodistrofia metacromática
272.7	Mucopolisacaridosis, tipo I
272.7	Hurler's
272.7	Hurler-Scheie
272.7	Scheie
272.7	Mucopolisacaridosis, tipo II
272.7	Hunter's
272.7	Otros mucopolisacaridosis
272.7	Maroteaux-Lamy
272.7	Morquio's
272.7	Sanfilippo
273	Desórdenes de metabolismo de proteína de plasma
274.9	Gota inespecífica
275	Desórdenes del metabolismo de minerales
275.0	Desórdenes de metabolismo de hierro
275.1	Desórdenes de metabolismo de cobre
275.1	Wilson's
275.2	Desórdenes de metabolismo de magnesio
275.3	Desórdenes de metabolismo de fósforo
275.4	Desórdenes de metabolismo de calcio
275.9	otros Desórdenes del metabolismo de minerales
276.2	Acidosis Láctica
277	Otros desórdenes del metabolismo
277.00	Fibrosis Quística



ICD 9Índice por Diagnóstico y Condición

277.1	Desórdenes de metabolismo de purina y pirimidina
277.1	Porfiria eritropoética hereditaria
277.2	Otros desórdenes de metabolismo de purina y pirimidina
277.2	Lesch-Nyhan
277.2	Xantínuria hereditaria
277.3	Amiloidosis
277.4	Gilbert's
277.4	Crigler-Najjar
277.4	Otros desórdenes de metabolismo de bilirubina
277.4	Dubin-Johnson
277.4	Rotor's
277.6	Deficiencia antitripsina alpha-1
277.8	Otros desórdenes específicos del metabolismo
277.81	Deficiencia primaria de carnitina
277.82	Deficiencia de carnitina
277.85	Desórdenes de la oxidación de ácidos grasos
277.85	CPT1, CPT2, LCHAD, VLHAD, MCAD, SCAD
277.87	Desórdenes del metabolismo mitocondrial
277.89	Otros desórdenes específicos del metabolismo
277.89	Hans Schuller Christian, Histiocitosis, Histiocitosis
277.9	Otros desórdenes del metabolismo no específicos
	Enfermedades Hereditarias y degenerativas del Sistema Nervioso
330	Degeneración cerebral
330.0	Esfingolipidosis (Leucodistrofia)
330.1	Lipidosis cerebral
330.8	Otras degeneraciones cerebrales
330.8	Alper's
330.8	Leigh's
330.8	Encefalopatía necrotizante sub-aguda
331.4	Hidrocefalia obstructiva, adquirida
333.1	Temblores esenciales
333.2	Myoclonus
333.4	Huntington's chorea
334.0	Enfermedad espinocerebelar
334.0	Ataxia Hereditaria
334.0	Ataxia de Friedreich's
334.1	Paraplegia espástica hereditaria
334.2	Degeneración cerebelar primaria
334.2	Marie's
334.2	Sanger's-Brown
334.8	Ataxia-telangiectasia
335	Atrofia muscular espinal y síndromes afines
335.0	Atrofia muscular espinal infantil, tipo I (Werdnig-Hoffman)
335.1	Otras atrofas musculares espinales hereditarias
335.10	Atrofia muscular espinal:
335.10	Infantil, tipo II
335.11	Juvenil, tipo II (Kugelberg-Welander)
340	Esclerosis múltiple
341	Otras enfermedades demielinizantes del sistema nervioso central
341.0	Neuromielitis óptica
341.1	Esclerosis difusa
341.1	Encefalitis periaxial
341.1	Enfermedad de Schilder
341.8	Otras enfermedades demielinizantes del sistema nervioso central
341.8	Demielinización central del cuerpo calloso
341.8	Mielinólisis central pontina



ICD 9Índice por Diagnóstico y Condición

341.8	Mielitis transversa aguda en enfermedad desmielinizante del sistema nervioso central
341.8	Mielitis necrotizante subaguda
341.9	Enfermedades desmielinizantes no específicas del sistema nervioso central
345	Epilepsia
345	Epilepsia generalizada sin convulsiones
345.1	Epilepsia generalizada con convulsiones
345.1	• clónicos
345.1	• mioclónicos
345.1	• tónicos
345.1	• tónico-clónicos
345.1	Síndrome de Lennox-Gastaut
345.2	Estado de pequeño mal epiléptico
345.3	Estado de gran mal epiléptico
345.3	Estado epiléptico tónico-clónico
345.4	Epilepsia parcial, con pérdida de conocimiento
345.4	Estado de ausencia epiléptica
345.4	Estado de mal epiléptico parcial complejo
345.5	Epilepsia parcial, sin pérdida conocimiento
345.6	Ataques de Salaam
345.6	Espasmos infantiles
345.7	Epilepsia parcial continua [Kozhevnikov]
345.8	Otros estados epilépticos
345.9	Estado de mal epiléptico de tipo no especificado
342.0	Hemiplejía flácida
342.1	Hemiplejía espástica
342.3	Monoplejía infantil
342.9	Hemiplejía, no especificada
343	Parálisis cerebral infantil
343.0	Diplejía espástica
343.1	Hemiplejía, congénita
343.2	Cuadriplejía, no especificada
343.4	Hemiplejía infantil
343.8	Parálisis (cerebral) espástica congénita
343.9	Parálisis cerebral infantil no específica
344	Otros síndromes de parálisis espástica infantil, no congénita
356	Neuropatía hereditaria motora y sensorial
356.0	Neuropatías hereditarias idiopáticas
356.0	Enfermedad de Dejerine-Sottas
356.1	Atrofia muscular peroneal, enfermedad de Charcot-Marie-Tooth
356.2	Neuropatía hereditaria sensorial, tipos I-IV
356.8	Síndrome de Roussy Levy
348	Otras condiciones del cerebro
348.0	Quistes cerebrales
348.30	Encefalopatía sin especificar
356.3	Enfermedad de Refsum
356.3	Neuropatía asociada con ataxia hereditaria
356.4	Neuropatía progresiva idiopática
356.6	Otras neuropatías hereditarias e idiopáticas
356.9	Neuropatía hereditaria e idiopática, sin otra especificación
357	Polineuropatía inflamatoria
357.0	Síndrome de Guillain-Barre
357.0	Polineuritis (post) infecciosa aguda
359	Distrofia muscular y otras miopatías
359.0	Distrofia muscular congénita hereditaria
359.1	Distrofia muscular hereditaria progresiva
359.1	• autosómica recesiva, tipo infantil, semejante a Duchenne o Becker



Índice por Diagnóstico y Condición

ICD 9

359.1	• benigna [Becker]
359.1	• cintura-pélvica
359.1	• distal
359.1	• escapuloperoneal
359.1	• escapuloperoneal benigna con contracciones precoces [Emery-Drehtuss]
359.1	• fascioescapulohumeral
359.1	• grave [Duchenne]
359.1	• ocular
359.1	• oculofaríngea
359.2	Desórdenes motóricos
359.2	Distrofia miotónica [Steinert]
359.2	Miotonia congénita:
359.2	• dominante [Thomsen]
359.2	• recesiva [Becker]
359.9	Miopatías, sin especificar

Desórdenes Músculo Esqueléticos

723.5	Torticollis, no específica
732.1	Osteocondritis juvenil de pelvis y cadera
732.1	Coxa plana
732.1	Legg-Calve-Perthes
732.1	Enfermedad de Scheuermann
732.4	Osteocondritis juvenil de la tibia y del peroné
732.4	Proximal de la tibia (Blount)
732.4	Tuberosidad de la tibia (Osgood-Schlatter)
732.4	Tibia vara
736.7	Otras deformidades adquiridas de los miembros
736.71	Deformidad "equinovarus" adquirida
736.79	Otras deformidades equinas del pie, adquirida
737	Curvatura de espina
737.1	Cifosis adquirida
737.2	Lordosis adquirida
737.3	Escoliosis, idiopática
754.1	Torticollis del músculo esternocleidomastoideo

Anomalías Congénitas

Anomalías congénitas del sistema nervioso

740.0	Anencefalia
740.1	Craneorraquisquis
740.2	Encefalocele
741	Espina bífida
741.00	Espina bífida con hidrocefalia, región no específica
741.01	Espina bífida con hidrocefalia, región cervical
741.02	Espina bífida con hidrocefalia, dorsal (torácico)
741.03	Espina bífida con hidrocefalia, región lumbar
741.9	Espina bífida, no especificado
741.91	Espina bífida sin mencionar hidrocefalia, región cervical
741.92	Espina bífida sin hidrocefalia, región dorsal (torácico)
741.93	Espina bífida sin hidrocefalia, región lumbar
742.0	Encefalocele
742.1	Microcefalia
742.2	Malformaciones congénitas del cuerpo calloso
742.2	Agnesia del cuerpo calloso
742.2	Arnencefalia
742.2	Holoprosencefalia
742.2	Otras anomalías hipoplásicas del encéfalo: Agnesia, hipoplasia, Lisencefalia



ICD 9**Índice por Diagnóstico y Condición**

742.3	Hidrocefalia congénita
742.3	Malformaciones del acueducto de Silvio: Anomalia, estenosis, obstrucción
742.4	Otras malformaciones congénitas del encéfalo
742.4	Megalencefalia
742.4	Quistes cerebrales congénitos:
742.4	Esquicefalia
742.4	Porencefalia
742.4	Macrografía
742.51	Diastematomielia
742.53	Hydromielia
742.59	Otras anomalías congénitas del cordón espinal
742.8	Otras anomalías congénitas del cordón espinal, específicas
742.8	Otras anomalías congénitas del sistema nervioso
742.8	Síndrome de Arnold-Chiari
742.9	Anomalías congénitas del cerebro, cordón espinal y sistema nervioso, no específicas
743	Malformaciones congénitas del ojo, del oído, de la cara y del cuello
743	Anoftalmia, microftalmia y macroftalmia
743.03	Globo ocular quístico
743.1	Microftalmia
743.2	Bufalmos, glaucoma congénito
743.2	Glaucoma congénito
743.3	Malformaciones congénitas del cristalino
743.3	Catarata congénita
743.35	Afaquia congénita
743.36	Otras malformaciones congénitas del cristalino
743.37	Desplazamiento congénito del cristalino
743.39	Coloboma del cristalino
743.4	Malformaciones congénitas del segmento anterior del ojo
743.41	Anomalia del tamaño y forma de la cornea
743.42	Opacidad corneal congénita
743.43	Otras malformaciones congénitas de la cornea
743.44	Otras malformaciones congénitas del segmento anterior del ojo
743.44	Anomalia de Rieger
743.45	Ausencia del iris, Aniridia
743.46	Coloboma del iris
743.46	Otras malformaciones congénitas del iris
743.47	Esclerótica azul
743.48	Malformación congénita del segmento anterior del ojo, no especificada
743.51	Malformaciones congénitas del segmento posterior del ojo
743.51	Malformación congénita del humor vítreo
743.52	Otras malformaciones congénitas del segmento posterior del ojo
743.52	Coloboma del fondo del ojo
743.53	Malformación congénita de la coroides
743.55	Malformación congénita de la retina
743.57	Malformación congénita del disco óptico
743.57	Coloboma del disco óptico
743.59	Malformación congénita del segmento posterior del ojo, no especificada
743.6	Malformaciones congénitas de los párpados, del aparato lagrimal y de la órbita
743.61	Entropión congénito
743.62	Entropión congénito
743.62	Otras malformaciones congénitas de los párpados
743.64	Ausencia y agenesia del aparato lagrimal
743.65	Estenosis y estrechez congénitas del conducto lagrimal
743.65	Otras malformaciones congénitas del aparato lagrimal
743.66	Malformación congénita de la órbita



ICD 9

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Índice por Diagnóstico y Condición

Otras malformaciones congénitas del ojo, especificadas

Malformaciones congénitas del ojo, no especificadas

Malformaciones congénitas del oído que causan alteración de la audición

Ausencia congénita del pabellón (de la oreja)

Ausencia congénita, atresia o estrechez del conducto auditivo (externo)

Otras malformaciones congénitas del oído medio

Malformación congénita de los huesecillos del oído

Fusión de los huesecillos del oído

Malformación congénita del oído interno

Ausencia congénita del oído SAI

Ausencia congénita de lóbulo auricular

Aurícula accesoria

Otras malformaciones congénitas del oído

Otras malformaciones congénitas del oído, especificadas

Macrotia

Microtia

Ausencia de la trompa de Eustaquio

Malformación congénita del oído, no especificada

Seno, fístula o quiste de la hendidura branquial

Oreja cervical

Seno y quiste preauricular. Fístula:

Otras malformaciones de las hendiduras branquiales

Pterigion del cuello

Otras malformaciones congénitas especificadas de cara y cuello

Macroquelia

Microquelia

Macrostomia

Microstomia

Malformación congénita de la cara y del cuello, no especificada

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Malformaciones congénitas del sistema circulatorio

Malformaciones congénitas de las cámaras cardíacas y sus conexiones

Tronco arterioso común

Persistencia del tronco arterioso

Transposición (completa) de los grandes vasos

Transposición de los grandes vasos en ventrículo derecho

Síndrome de Taussig-Bing

Transposición de los grandes vasos en ventrículo izquierdo

Transposición corregida

Tetralogía de Fallot

Ventrículo común

Ventrículo único

Defecto del tabique ventricular

Síndrome de Eisenmenger

Defecto del tabique auricular

Agujero Oval

Ostium secundum (tipo II)

Defecto del tabique aurículoventricular

Defecto de la almohadilla endocárdica

Defecto del tabique auricular ostium primum (tipo I)

Canal aurículoventricular común

Corazón trilobular biauricular

Otras malformaciones congénitas de los tabiques cardíacos

Malformación congénita del tabique cardíaco, no especificada

Malformaciones congénitas de las válvulas pulmonar y tricúspide

Angustia de la válvula pulmonar, sin especificar



ICD 9

Índice por Diagnóstico y Condición

746.01	Atresia de la válvula pulmonar
746.02	Estenosis congénita de la válvula pulmonar
746.09	Insuficiencia congénita de la válvula pulmonar
746.1	Estenosis, atresia congénita de la válvula tricúspide
746.2	Anomalia de Ebstein
746.3	Estenosis congénita de la válvula aórtica
746.4	Insuficiencia congénita de la válvula aórtica
746.5	Estenosis mitral congénita
746.6	Insuficiencia mitral congénita
746.7	Síndrome de hipoplasia del corazón izquierdo
746.7	Síndrome de hipoplasia del corazón izquierdo
746.81	Estenosis aórtica congénita
746.82	Corazón triauricular
746.83	Estenosis del infundíbulo pulmonar
746.84	Otras malformaciones congénitas del corazón, especificadas
746.85	Malformación de los vasos coronarios
746.86	Bloqueo cardíaco congénito
746.87	Otras malformaciones congénitas del corazón
746.87	Dextrocardia
746.87	Levocardia
746.89	Divertículo congénito del ventrículo izquierdo
746.9	Malformación congénita del corazón, no especificada
747	Malformaciones congénitas de las grandes arterias
747.0	Conducto arterioso permeable
747.0	Conducto [agujero] de Botalli abierto
747.0	Persistencia del conducto arterioso
747.1	Coartación de la aorta
747.2	Otras anomalías de la aorta
747.21	Anomalia del arco aórtico
747.22	Atresia y estenosis de la aorta
747.22	Ausencia de la aorta
747.22	Aplicación de la aorta
747.29	Otras malformaciones congénitas de la aorta
747.29	Aneurisma del seno de Valsalva (con ruptura)
747.29	Aneurisma congénito
747.3	Anomalías de la arteria pulmonar
747.40	Malformaciones congénitas de las grandes venas
747.41	Conexión anómala total de las venas pulmonares
747.42	Conexión anómala parcial de las venas pulmonares
747.49	Conexión anómala de las venas pulmonares, sin otra especificación
747.5	Ausencia e hipoplasia congénita de la arteria umbilical
747.5	Arteria umbilical única
747.60	Otras malformaciones congénitas del sistema vascular periférico
747.6	Malformación arteriovenosa periférica
747.62	Estenosis congénita de la arteria renal
747.62	Otras malformaciones congénitas de la arteria renal
747.8	Otras malformaciones congénitas del sistema vascular, especificadas
747.81	Anomalías del sistema cerebrovascular
747.82	Anomalia vascular espinal
747.83	Circulación fetal persistente
747.9	Malformación congénita del sistema vascular, no especificada
748	Malformaciones congénitas del sistema respiratorio
748	Malformaciones congénitas de la nariz
748.0	Atresia de las narinas
748.1	Agenesia o hipoplasia y otras malformaciones de la nariz
748.2	Pterigion de la laringe



ICD 9

Índice por Diagnóstico y Condición

748.3	Malformaciones congénitas de la laringe, traquea y bronquios
748.3	Broncomalacia congénita
748.4	Malformaciones congénitas del pulmón
748.4	Quiste pulmonar congénito
748.5	Agenesia, hipoplasia y displasia del pulmón
748.5	Secuestro del pulmón
748.5	Hipoplasia y displasia pulmonar
748.6	Otras malformaciones congénitas del pulmón
748.01	Bronquiectasia congénita
748.8	Otras Anomalías específicas del sistema respiratorio
749	Fisura del paladar y labio leporino
749.00	Fisura del paladar
749.01	Fisura del paladar, unilateral completo
749.02	Fisura del paladar unilateral, incompleto
749.03	Fisura del paladar bilateral completo
749.04	Fisura del paladar bilateral, incompleto
749.10	Labio leporino
749.11	Labio leporino unilateral completo
749.12	Labio leporino unilateral, incompleto
749.13	Labio leporino bilateral completo
749.14	Labio leporino bilateral, incompleto
749.20	Fisura del paladar con labio leporino
749.21	Fisura del paladar duro con labio leporino, unilateral
749.22	Fisura del paladar duro y del paladar blando con labio leporino, unilateral
749.23	Fisura del paladar duro con labio leporino, bilateral
749.24	Fisura del paladar duro y del paladar blando con labio leporino, bilateral
749.25	Fisura del paladar blando con labio leporino, unilateral
749.26	Fisura del paladar con labio leporino, sin otra especificación
750	Otras malformaciones congénitas del sistema digestivo
750.0	Anomalia Frenillo lingual corto
750.1	Otras malformaciones congénitas de la lengua.
750.15	Macroglosia
750.2	Otras malformaciones congénitas de la boca y de la faringe
750.2	Malformaciones congénitas de las glándulas y de las conductos salivales
750.26	Otras malformaciones congénitas de la boca
750.27	Displasia faríngea
750.29	Otras malformaciones congénitas de la faringe
750.3	Atresia del esófago sin menbrón de fistula
750.3	Atresia del esófago con fistula traqueoesofágica
750.3	Fistula traqueoesofágica congénita sin menbrón de atresia
750.3	Estrechamiento o estenosis congénita del esófago
750.4	Malformaciones congénitas del esófago
750.4	Pteron del esófago, dilatación congénita del esófago, divertículo, duplicación.
750.5	Esófago pilórico, hernia pilórica, anomalía
750.5	Hernia hiatal congénita
750.7	Otras malformaciones congénitas del estómago, específicamente
750.8	Otras malformaciones congénitas de la parte superior del tubo digestivo
751.0	Divertículo cecal, divertículo del ciego
751.1	Ausencia, atresia y estenosis congénita del intestino delgado
751.1	Ausencia, atresia y estenosis congénita del duodeno
751.1	Ausencia, atresia y estenosis congénita del vevuno
751.2	Ausencia, atresia y estenosis congénita del intestino grueso, parte no especificada
751.2	Ausencia, atresia y estenosis congénita del recto y ano
751.3	Enfermedad de Hirschsprung, Agangliosis, megacolon congénito (agangliosis)
751.4	Otras malformaciones congénitas del intestino



ICD 9

Índice por Diagnóstico y Condición

- 751.0 Malformaciones congénitas de la vesícula biliar, de los conductos biliares y del hígado
751.01 Agenesia, aplasia e hipoplasia de la vesícula biliar
751.01 Atresia de los conductos biliares
751.02 Enfermedad quística del hígado
751.09 Quiste del colédoco
751.1 Agenesia, aplasia e hipoplasia del páncreas
751.7 Páncreas anular
751.7 Quiste congénito del páncreas
751.9 Otras malformaciones congénitas del sistema digestivo
- 752 Malformaciones congénitas de los órganos genitales
752.0 Anomalías y ausencia congénita de ovario
752.1 Malformaciones congénitas de las trompas de Falopio y de los ligamentos anchos
752.2 Malformaciones congénitas del útero
752.2 Duplicación del útero con duplicación del cuello uterino y de la vagina
752.3 Agenesia y aplasia del útero y Otras anomalías del útero
752.3 Otras malformaciones congénitas del útero
752.40 Anomalías del cuello uterino, vagina y genitalia externa femenina
752.41 Quiste embrionario del cuello uterino
752.42 Himen imperforado
752.49 Agenesia y aplasia del cuello uterino
752.49 Otras malformaciones congénitas de los órganos genitales femeninos
752.49 Ausencia congénita de la vagina
752.6 Hipospadias, epispadias y otras anomalías del pene
752.64 Aplasia y ausencia congénita del pene
752.69 Otras malformaciones congénitas del pene
752.7 Sexo indeterminado y pseudohermafroditismo
752.7 Sexo indeterminado, sin otra especificación. Genitales ambiguos
752.8 Otras malformaciones congénitas de los órganos genitales masculinos
752.8 De las malformaciones congénitas de los conductos deferentes, de
- 753 Malformaciones congénitas del sistema urinario
753.0 Agenesia renal y otras malformaciones hipoplásicas del riñón
753.0 Agenesia renal, unilateral
753.0 Agenesia renal, bilateral
753.0 Agenesia renal, sin otra especificación
753.0 Hiperplasia renal, unilateral
753.0 Hipoplasia renal, bilateral
753.0 Hiperplasia renal, sin especificación
753.0 Síndrome de Potter
753.1 Pene rudimentario o sin pene
753.11 Quiste renal solitario congénito
753.12 Riñón rudimentario o sin pene
753.15 Displasia renal
753.16 Riñón quístico o quistes
753.17 Riñón espongiado SAI
753.19 Otras enfermedades renales quísticas
753.2 Defectos obstructivos congénitos de la pelvis, renal y malformaciones congénitas del uréter
753.23 Otros defectos obstructivos de la pelvis renal y del uréter
753.23 Ureteroceles congénitos
753.29 Hidronefrosis congénita
753.29 Atresia y estenosis del uréter
753.29 Megalouréter congénito
753.29 Agenesia del uréter
753.29 Duplicación del uréter
753.29 Mala posición del uréter



ICD 9

Índice por Diagnóstico y Condición

753.29	Reflujo vésico-urétero-renal congénito
753.3	Otras malformaciones congénitas del riñón
753.3	Riñón supernumerario
753.3	Riñón lobulado, fusionado y en herradura
753.3	Riñón ectópico
753.3	Hiperplasia renal y riñón gigante
753.4	Otras anomalías específicas del uréter
753.5	Exstrofia de la vejiga urinaria
753.6	Válvulas uretrales posteriores congénitas
753.6	Otras atresias y estenosis de la uretra y del cuello de la vejiga
753.7	Anomalías del uracho
753.8	Ausencia congénita de la vejiga y de la uretra
753.8	Divertículo congénito de la vejiga
753.8	Otras malformaciones congénitas de la vejiga y de la uretra
754	Malformaciones y deformidades congénitas del sistema osteomuscular
754.0	Deformidades osteomusculares congénitas de la cabeza, de la cara
754.0	Asimetría facial
754.0	Facies comprimida
754.0	Dolicocefalia
754.0	Plagiocefalia
754.0	Otras deformidades congénitas del cráneo, de la cara y de la mandíbula
754.0	Aplastamiento congénito de la nariz
754.0	Atrofia o hipertrofia hemifacial
754.0	Depresiones en el cráneo
754.0	Desviación congénita del tabique nasal
754.0	754.10 Tortícolis Congénita
754.2	Deformidad congénita de la columna vertebral
754.2	Escoliosis congénita:
754.3	Deformidades congénitas de la cadera
754.30	Luxación congénita de la cadera, unilateral
754.3	Dísplosia acetabular congénita
754.31	Luxación congénita de la cadera, bilateral
754.32	Subluxación congénita de la cadera, unilateral
754.33	Subluxación congénita de la cadera, bilateral
754.35	Cadera inestable
754.4	Deformidad congénita de la rodilla
754.4	Genu recurvatum congénito
754.41	Luxación congénita de la rodilla
754.42	Curvatura congénita del fémur
754.43	Curvatura congénita de la tibia y del peroné
754.44	Curvatura congénita de hueso(s) largo(s) del miembro inferior, sin otra especificación
754.5	Deformidades congénitas de los pies
754.51	Talipes equinovarus
754.53	Metatarsus varus
754.59	Otras deformidades varus congénitas de los pies
754.61	Pie plano congénito
754.62	Talipes calcaneovalgus
754.69	Otras deformidades valgus congénitas de los pies
754.69	Metatarsus valgus
754.71	Pie cavus
754.79	Talipes calcaneovarus
754.79	Hallux varus congénito
754.79	Otras deformidades congénitas de los pies
754.81	Tórax excavado
754.81	Tórax en embudo, congénito
754.82	Tórax en quilla



ICD 9**Índice por Diagnóstico y Condición**

754.82	Tórax de paloma, congénito
754.89	Otras deformidades congénitas de las extremidades
754.89	Artrogriposis múltiple congénita
754.89	Dedo deforme congénito
754.89	Mano en pala (congénita)
755.0	Polidactilia
755.02	Dedo(s) supernumerario(s) del pie
755.1	Sindactilia
755.13	Membrana interdigital del pie
755.14	Fusión de los dedos del pie
755.2	Defectos por reducción del miembro superior
755.21	Ausencia congénita completa del (de los) miembro(s)
755.23	Ausencia congénita del antebrazo y de la mano
755.26	Defecto por reducción longitudinal del radio
755.27	Defecto por reducción longitudinal del cubito
755.29	Ausencia congénita de la mano y el (los) dedo(s)
755.3	Defectos por reducción del miembro inferior
755.3	Otros defectos por reducción del (de los) miembro(s) inferiores
755.31	Ausencia congénita completa del (de los) miembro(s) inferior(es)
755.34	Defecto por reducción longitudinal del fémur
755.35	Defecto por reducción longitudinal de la tibia
755.37	Defecto por reducción longitudinal del peroné
755.4	Otros defectos por reducción del (de los) miembro(s) superiores
755.4	Ausencia completa de miembro(s) no especificado(s)
755.4	Acromelia, miembro(s) no especificado(s)
755.5	Otras malformaciones congénitas del (de los) miembro(s) superiores, incluida la cintura escapular
755.54	Deformidad de.
755.55	Huesos del carpo supernumerarios
755.57	Macroductilia (dedos de la mano)
755.58	Mano en pinza de langosta, lobster claw
755.59	Disostosis cleidocraneal
755.59	Polidactilia
755.6	Otras malformaciones congénitas del (de los) miembro(s) inferior(es), incluida la cintura pelviana
755.64	Malformación congénita de la rodilla
756.0	Malformaciones congénitas de los huesos del cráneo y de la cara
756.0	Craneosinostosis
756.0	Acrocefalia
756.0	Fusión imperfecta del cráneo
756.0	Oxicefalia
756.0	Trigonocefalia
756.0	Disostosis craneofacial
756.0	Enfermedad de Crouzon
756.0	Hipertelorismo
756.0	Macrocefalia
756.0	Disostosis maxilofacial
756.0	Disostosis oculomaxilar
756.0	Ausencia de huesos del cráneo, congénita
756.0	Deformidad congénita de la frente
756.0	Platibasia
756.1	Malformaciones congénitas de la columna vertebral y tórax óseo
756.10	Anomalías de la columna vertebral, sin especificar
756.11	Espondilolisis, L-S
756.12	Espondilolistesis congénita
756.14	Hemivertebra, lordosis congénita
756.15	Síndrome de fusión cervical
756.16	Síndrome de Klippel-Feil



Índice por Diagnóstico y Condición

ICD 9

756.17	Espina bífida oculta
756.2	Costilla cervical
756.3	Malformación congénita del esternón
756.4	Osteocondrodistrofia con defecto del crecimiento
756.4	Acondrogenesis
756.4	Enanismo tanatofórico
756.4	Acondroplasia
756.51	Osteogénesis imperfecta
756.52	Osteopetrosis
756.53	Otras osteocondrodistrofias especificadas. Osteoosteodistrofia
756.54	Displasia polioestótica fibrosa
756.55	Displasia condroectodérmica. Síndrome de Ellis-van Creveld
756.56	Displasia diafisaria progresiva
756.57	Displasia metáfisaria
756.59	Otras osteocondrodistrofias
756.59	Síndrome de Albright-McCune-Albright
756.6	Malformaciones congénitas del diafragma
756.6	Absencia
756.8	Eventración
756.74	Síndrome del abdomen en cordón
756.79	Exófalos
756.79	Ortoquiasis
756.79	Gastrosquisis
756.79	Otras malformaciones congénitas de la pared abdominal
756.83	Síndrome de Ehlers-Danlos
757	Malformaciones congénitas de la piel, pelo y uñas
757.0	Infedema hereditario
757.1	Ictiosis congénita
757.1	Ictiosis vulgar
757.1	Ictiosis ligada al cromosoma X
757.1	Ictiosis lamelar
757.1	Niño de colodión
757.1	Eritrodermia icctiosiforme vesicular congénita
757.1	Feto anequino
757.2	Otras malformaciones congénitas de la piel, especificadas
757.31	Displasia ectodérmica (anidróica)
757.32	Hamartomas vasculares. Nevo no neoplásico, congénito
757.33	Otras malformaciones congénitas de la piel
757.33	Anomalías congénitas pigmentarias. Xeroderma pigmentosa
757.33	Mastocitosis. Urticaria pigmentosa
757.39	Enfermedades hísticas
757.39	Apéndices cutáneos supernumerarios
757.4	Alonidia paroníquia. Otras malformaciones congénitas del pelo
757.5	Anoniquia, otras malformaciones congénitas de las uñas
757.6	Malformaciones congénitas de la mama
759	Otras anomalías congénitas no específicas
759.0	Malformaciones congénitas del bazo
759.0	Asplenia (congénita)
759.0	Esplenomegalia congénita
759.1	Malformaciones congénitas de la glándula adrenal
759.2	Malformaciones congénitas de otras glándulas endocrinas
759.2	Conducto tirogloso persistente
759.2	Malformación congénita de glándula tiroidea o paratiroidea
759.2	Quiste tirogloso
759.3	Síndrome de Turner



Índice por Diagnóstico y Condición

ICD 9

759.3	Dextrocardia con situs inversus
759.3	Disposición auricular en imagen en espejo con situs inversus
759.3	Situs inversus o transversus:
759.3	Transposición de vísceras:
759.4	Gemelos siameses
759.5	Esclerosis Tuberosa
759.6	Otras hamartosis congénitas, sin clasificar
759.6	Peutz-Jeghers
759.6	Sturge-Weber
759.7	Anomalias congénitas múltiples, según descritas
759.81	Síndrome Prader Willi
759.82	Síndrome Marfan's
759.83	Síndrome Frágil X
759.89	Otros síndromes de malformaciones congénitas
758.89	Síndrome de Russell-Silver
759.89	Síndrome de Alport
759.89	Síndrome de Laurence-Moon(-Bardet)-Biedl
759.89	Síndrome de Zellweger
759.89	Síndrome de Carpenter's
759.89	Síndrome de Angelman's
758	Anomalías cromosómicas, no clasificadas en otra parte
758.0	Síndrome de Down
758.0	Trisomía 21, por falta de disyunción meiótica
758.0	Trisomía 21, mosaico (por falta de disyunción mitótica)
758.0	Trisomía 21, por translocación
758.0	Síndrome de Down, no especificado
758.1	Síndrome de Edwards
758.1	Trisomía 18, por falta de disyunción meiótica
758.1	Trisomía 18, mosaico (por falta de disyunción mitótica)
758.1	Trisomía 18, por translocación
758.2	Síndrome de Patau
758.2	Trisomía 13, por falta de disyunción meiótica
758.2	Trisomía 13, mosaico (por falta de disyunción mitótica)
758.2	Trisomía 13, por translocación
758.3	Otras supresiones de parte de un cromosoma autosómico
758.3	Supresión del brazo corto del cromosoma 4
758.3	Síndrome de Wiedemann
758.3	Supresión del brazo corto del cromosoma 5
758.3	Síndrome del grito de gato
758.3	Síndrome velo-cardio-facial
758.5	Otras condiciones debidas a anomalías en cromosomas autosómicos
758.6	Supresión de los autosomas, no especificada
758.0	Síndrome de Turner
758.1	Síndrome Klinefelter's
758.1	Cariotipo 40,X
758.81	Otras condiciones resultado de anomalías en cromosomas sexuales
758.89	Otras condiciones resultado de anomalías en cromosomas no específicos
769	Condiciones en el periodo perinatal
769.71	Síndrome fetal por ingestión de meconio
769.72	Prematuridad
769.6	Lesión del plexo braquial
769.8	Hipoxia, Asfixia o Anoxia perinatal
772.1	Hemorragia intraventricular (Grado III-IV)
774.1	Kernicterus



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NNES II ICD9 rev dic 23 2008

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779.7

Índice por Diagnóstico y Condición

Leucomalacia periventricular quística

360 Desórdenes en los Órganos Sensoriales
362.2 Desórdenes del ojo y anexos
369 Retinopatía del Prematuro
369 Ceguera y pérdida de visión
369.2 Ceguera moderada a severa, ambos ojos
369.4 Ceguera legal
369.5 Ceguera un ojo (otro normal)
372.0 Estrabismo (alternante, congénito, no paralítico)
372.00 Estrabismo, no especificado
372.10 Exotropía
372.20 Endotropía
372.80 Paralítico
372.81 Separación del eje (síndrome de Duane)
389 Pérdida de audición
389.00 Sordera conductiva bilateral
389.10 Sordera neurosensorial, no específica
389.2 Sordera conductiva y neurosensorial, mixta
476.4 Pólipos en las cuerdas vocales
476.40 Ausencia de la voz
784.41 Alergia
784.49 Disfonía

Quemaduras y Traumas
709.2 Cicatrices y fibrosis de la piel
709.2 Cicatriz desfigurante
709.2 Cicatriz incapacitante
908.9 Defectos tardíos de quemaduras
949.0 Quemaduras y Corrosiones
952.9 Daño al cordón espinal

Falta del desarrollo fisiológico normal
783.4 Retrasos en el desarrollo fisiológico, no específico
783.41 Failure to thrive, fallo en ganar peso
783.42 Retraso en el Desarrollo, general (área no específica)
783.43 Estatura corta, fallo en crecimiento

Asma Bronquial
493.00 Asma
493.0 Asma predominantemente alérgica extrínseca
493.1 Asma no alérgica
493.9 Asma, no especificado

Desórdenes de Conducta y Mentales
296.00 Esquizofrenia
296.0 Depresión
298.9 Psicosis
298.9 Depresión
300.9 Neurosis
300.9 Conducta dañina a sí mismo (Conducta suicida)
312.0 Trastornos de la Conducta (Desórdenes de conducta en niños y adolescentes)
312.0 Trastorno de la conducta insoportable (Conducta agresiva)
313.81 Trastorno opositor desafiante
314.00 Desorden de actividad y atención (ADHD)



ICD 9
314.01

Índice por Diagnóstico y Condición

Déficit de atención con hiperactividad

315
315.3
315.6
315.9

Retraso y Desórdenes del Desarrollo
Desorden en el desarrollo del lenguaje
Retraso en el desarrollo, mixto
Retraso en el desarrollo, no específico

Retardación Mental

317.00
318 0
318.1
318.2
319.0
319 0

Leve, coeficiente intelectual de 50 a 70
Moderado, coeficiente intelectual de 35 a 49
Severo, coeficiente intelectual de 20 a 34
Profundo, coeficiente intelectual bajo 20
Retraso mental, no especificado
Síndrome de William

Desórdenes endocrinos y nutricionales

243 0
243 0
240.01
240.02
252.0-252.08
252 0
253.0
253 0
255.2
255 0
259.1
259 0
278 01
278 0-278 9

Hipotiroidismo congénito 244 0 244 9 Hipotiroidismo Adquirido
Diabetes Mellitus insulino Dependiente, tipo I Juvenil
Hipertiroidismo 252.1 Hipoparatiroidismo
Acromegalia y gigantismo
Hiperplasia congénita adrenal
Desarrollo precoz sexual, pubertad precoz
Obesidad morbosa
Hiperfisiología

Desórdenes inmunológicos y Hematológicos

279
279.0
279.1
279.3
279 0
282.4
283 9
283 0
286 0
279 2

Enfermedad del virus de inmunodeficiencia humana (VIH)
Deficiencia de inmunidad humoral
Deficiencia de inmunidad celular
Deficiencia de inmunidad no específica
Anemia Mayor
Anemia Hemolítica
Hemofilia
Deficiencia de inmunidad combinada

Enfermedades del tejido conectivo y colágeno

710
710
710.1
710.2
710 3
710 4
714

Lupus eritematoso sistémico
Esclerosis, esclerodrema
Sicca Syndrome
Dermatomiositis
Polimiositis
Artritis reumatoidea juvenil

Cáncer y Tumores

140-239
200 9

Neoplasmas
Tumores malignos
Tumores invasivos
Leucemia





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APPENDIX (13)

NL_AUTO-ENROLLMENT

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de Salud de Puerto Rico (ASES)



22 de octubre de 2014

CARTA NORMATIVA #14-10-22

A TODAS LAS ENTIDADES CONTRATADAS Y PROVEEDORES QUE OFRECEN SERVICIOS DE SALUD BAJO EL PLAN MI SALUD

**Re: Para derogar la Carta Normativa #11-06-29 sobre Suscripción Automática
(Auto-Enrollment)**

Mediante la presente Normativa se sustituye la Normativa 11-06-29 de 29 de junio de 2011. Esta nueva Normativa establece que toda persona que resulte ser elegible al Plan MI Salud del Gobierno de Puerto Rico quedará automáticamente asegurada y suscrita al Plan según la Región de residencia. Su tarjeta del Plan de Salud del Gobierno será enviada través de correo en un término no mayor de cinco (5) días laborables luego de haber resultado elegible.

El asegurado podrá comenzar a recibir servicios de salud desde el mismo día en que la Oficina de Medicaid, del Departamento de Salud de Puerto Rico, le haga entrega de la Notificación de Acción Tomada mediante la forma MA-10. La fecha para determinar desde cuando la persona está asegurada es la que se indica en la sección titulada "Fecha de Certificación" de la forma MA-10 (parte superior derecha). A partir de dicha fecha usted puede acceder servicios médicos a través de su Grupo Médico y Médico Primario, aun cuando no hubiera recibido su tarjeta de identificación del Plan. De no haber recibido su tarjeta podrá presentar la forma MA-10 para recibir los servicios medicamente necesarios.

Debido a que las tarjetas no son emitidas por el Programa Medicaid al momento de ser elegibles, se requiere toda la colaboración de parte de la Aseguradora para la emisión de las mismas en un término no mayor de dos (2) días laborables. No se podrán denegar servicios por parte de los proveedores porque el paciente no tenga su tarjeta, siempre que presente la MA-10 y una identificación con foto.

Es responsabilidad del proveedor comunicarse con la Aseguradora para asegurarse de que el beneficiario esté debidamente suscrito en el Plan y tenga un Grupo Médico y Médico Primario asignado. De no contar con un médico primario aun así, el proveedor podrá prestar los servicios de salud física, mental o dental, según aplique. Las entidades de salud contratadas por ASES tendrán la responsabilidad de pagar por los servicios brindados según los términos y las condiciones del contrato.

Para facilitar la facturación y pago por los servicios que el proveedor prestó, la forma MA-10 incluye una sección que indica "MPI/SS" que provee el número de identificación del asegurado. El proveedor deberá acompañar con su factura una copia de la forma MA-10, para el envío a la Aseguradora. La forma MA-10 indica el período de vigencia de elegibilidad del beneficiario.

Lo dispuesto en esta Carta Normativa no aplica a los beneficiarios suscritos en un Plan Medicare Platino.

ASES requiere a las entidades contratadas que en un término improrrogable de cinco (5) días calendario se envíe a cada uno de sus proveedores participantes del Plan Mi Salud copia fiel y exacta de esta Carta Normativa. Las entidades deberán enviar a la atención del Director Ejecutivo de ASES una Declaración Jurada suscrita por su Presidente Corporativo haciendo constar que han dado fiel cumplimiento a lo aquí requerido.

Solicitamos el fiel cumplimiento con esta normativa para que se mantengan brindando los servicios de excelencia y calidad conforme al Plan MI Salud del Gobierno de Puerto Rico.

Como siempre, estamos seguros que contaremos con el apoyo de todos nuestros proveedores.

Cordialmente,


Ricardo A. Rivera Cardona
Director Ejecutivo





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PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (13)

NL_REFERRALS

4

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22 de octubre de 2014

CARTA NORMATIVA # 14-10-22-A

A TODAS LAS ENTIDADES CONTRATADAS POR LA ADMINISTRACIÓN DE SEGUROS DE SALUD (ASES) Y PROVEEDORES DE SERVICIOS DE SALUD DEL PLAN DE SALUD DEL GOBIERNO

Re: REFERIDOS

Esta Carta Normativa se publica con el propósito de dejar sin efecto las Cartas Normativas #11-0501 de 1ro de mayo de 2011 y la 2013-11-14 del 14 de noviembre de 2013, a la luz de la legislación y de la normativa aplicable.

El Programa de Salud del Gobierno del Estado Libre Asociado de Puerto Rico ("el plan") es un modelo integrado de salud adoptado para ofrecer servicios a las personas beneficiarias cubiertas bajo lo dispuesto en la Ley Núm. 72 de 1993, conocida como la Ley de la Administración de Seguros de Salud, y a las personas médico indigentes cubiertas bajo el programa federal de Medicaid. La Ley Núm. 72 define a los proveedores de servicios de salud como los "médicos primarios, médicos de apoyo, servicios primarios, proveedores primarios y organizaciones de servicios de salud". Por su parte, la Ley Núm. 72 define al "médico primario" como el "profesional proveedor participante que evalúa y da tratamiento inicialmente a los beneficiarios" y quien "[e]s responsable de determinar los servicios que precisa el beneficiario, [de] proveer continuidad [y] de referir a los beneficiarios a servicios especializados". "Se consideran médicos primarios [los] médicos generalistas, médicos internistas, médicos de familia, pediatras, ginecólogos y obstetras". Para garantizar la calidad y libre selección de los beneficiarios a los servicios de salud cubiertos por el plan, la Ley Núm. 72 también dispone que los beneficiarios del plan tendrán derecho a escoger, e incluso a cambiar, su médico primario, derecho al libre acceso a los servicios médicos y a que no se les niegue los servicios bajo la cubierta.

Bajo lo dispuesto en la Ley Núm. 72, los beneficiarios del plan se suscriben a un Grupo Médico Primario (GMP), que es el custodio del manejo integrado de salud de los beneficiarios suscritos al plan y asignados a dicho GMP. Dentro de cada GMP se integran el número de médicos primarios y especialistas necesarios para el cuidado de la salud de la población bajo su atención, según exige el contrato entre la ASES y el asegurador seleccionado, las condiciones médicas prevalecientes y la demografía de esa población. Dichos GMP, como norma general, deben incluir médicos generalistas, médicos de familia, internistas, pediatras, ginecólogos y ginecólogos-obstetras.

El GMP es el responsable de velar y garantizar que los beneficiarios bajo su atención tengan acceso a los servicios especializados cubiertos y necesarios para sus condiciones de salud. Para viabilizar y facilitar el libre acceso a servicios especializados, el modelo del plan provee para que cada GMP cree su propia red preferida de proveedores de salud. Estas redes preferidas garantizan a los beneficiarios acceso directo a la cubierta de servicios especializados sin referido o autorización del médico primario.

El modelo integrado del plan también les brinda a los beneficiarios acceso a los especialistas que no forman parte del GMP y su red preferida a través de la red general del asegurador contratado por la ASES. Esta red general complementa la red preferida del GMP y ofrece otras opciones al beneficiario en caso de que las alternativas disponibles dentro de la red preferida no sean viables o se necesite de otros proveedores. Sin embargo, para que el GMP pueda ofrecer a los pacientes un cuidado de salud administrado de forma ordenada, coordinada y responsable en cumplimiento con la Ley Núm. 72, es preciso que antes de utilizar un especialista fuera del GMP y su red preferida, el beneficiario obtenga un referido de su médico primario y pague, de ser aplicable, el correspondiente co-pago cuando visite al especialista de la red general.

La emisión de referidos es responsabilidad exclusiva del médico primario seleccionado por el asegurado. El asegurado bajo ninguna circunstancia podrá ser dirigido a otra facilidad o grupo médico para la obtención de referido o autorizaciones de servicios. Ninguna Junta, Comité, Administrador de Grupo Médico, etc. podrá emitir referidos. Tampoco podrá pasar juicio sobre la determinación del médico primario el emitir el referido.

En el caso particular del acceso a los ginecólogos y ginecólogos-obstetras, es preciso reconocer que la Ley Núm. 194 de 25 de agosto de 2000, según enmendada, mejor conocida como la "Carta de Derechos y Responsabilidades del Paciente", también de aplicación al Plan de Salud del Gobierno del Estado Libre Asociado, dispone en lo concerniente a la selección de planes de cuidado de salud y proveedores de servicios de salud médico-hospitalarios, que todo paciente, usuario o consumidor de tales planes y servicios en Puerto Rico tiene derecho a "que los planes de cuidado de salud individuales o grupales cubran los servicios de ginecología y obstetricia con acceso directo, sin requerir referido o autorización previa del plan, siempre que ese médico sea parte de la red de proveedores del plan de cuidado de salud".

En consideración a todo lo antes expuesto y de conformidad con la Ley Núm. 72 de la ASES y lo dispuesto en la Carta de Derechos y Responsabilidades del Paciente, el modelo del Plan de Salud del Gobierno reconoce el derecho de sus beneficiarias a seleccionar y acceder de forma directa al ginecólogo o ginecólogo-obstetra de su preferencia a través del GMP y su red preferida sin necesidad de un referido de su



médico primario. En caso de que las beneficiarias necesiten los servicios de un ginecólogo o ginecólogo-obstetra en la red general y fuera de la red preferida, deberá obtener el correspondiente referido del médico primario y pagar, de ser aplicable, el copago que corresponda en la visita a dicho especialista.

Le recordamos que los referidos deben proveerse en la misma visita al Médico Primario (PCP, por sus siglas en inglés) o en un término no mayor de veinticuatro (24) horas luego de dicha visita. En aquellos casos en que el especialista a ser referido no forme parte de la red preferida del GMP, el médico primario tendrá la responsabilidad de coordinar la cita y asegurarse de que el servicio sea provisto en un término no mayor de treinta (30) días, siempre tomado en consideración el estado de salud del paciente. En este caso, no se cobrarán los copagos aplicables a especialistas fuera de la red.

En cuanto a la región virtual existe el modelo de libre selección para los asegurados que pertenezcan a la misma. Como ha de ser de su conocimiento, dicha región está compuesta por niños bajo la custodia del Departamento de la Familia (ADFAN) y mujeres sobrevivientes de violencia doméstica (Oficina de la Procuradora de las Mujeres). Para esta región no aplica la selección de grupo ni médico primario por ser esta una población flotante, por lo que no es necesario la expedición de referidos para que dicha población accese sus servicios de salud.

Finalmente, reiteramos, que bajo las redes preferidas del plan no se requieren referidos para visitar a especialistas, ni contrafirmas del médico primario para servicios de cubierta física. Tampoco el asegurado tendrá que pagar copagos al utilizar las redes preferidas dentro del Grupo Médico Primario de su selección y la aseguradora no podrá denegar facturas por estos servicios por no contar con el referido del médico primario. Además, no se requiere referido para acceder los servicios dentales, con excepción de las cirugías maxilofaciales donde se requiere referido del médico primario para el cirujano maxilofacial.

Solicitamos el fiel cumplimiento con esta normativa para que se mantengan brindando los servicios de excelencia y calidad conforme al Programa de Salud del Gobierno del Estado Libre Asociado de Puerto Rico.

Cordialmente,


Ricardo Rivera Cardona
Director Ejecutivo





ESTADO LIBRE ASOCIADO DE
PUERTO RICO

Administración de Seguros
de Salud de Puerto Rico (ASES)

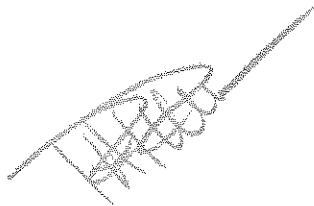
PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (14)

GUIDELINES FOR THE DEVELOPMENT OF PROGRAM INTEGRITY PLAN



Guidelines for the Development of Program Integrity Plan

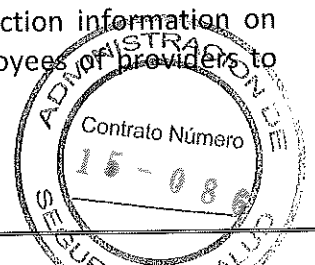


2014 – 2015

(This document is to be used by all contracted companies participating in the Government Health Plan of the Commonwealth of Puerto Rico. The purpose of sharing information with contracted companies is to provide them guidelines with minimum requirements to formulate their own Plan Integrity Program for the Health Care Delivery System sponsored by the Commonwealth of Puerto Rico)

The Insurer shall comply with the following Medicaid Integrity requirements:

- A. 60 days after the dated of the agreement the Company must submit to ASES Compliance Office copy of the policies and procedures for identifying and tracking potential provider fraud cases, for conducting preliminary and full investigation and for referring cases of suspected fraud to an appropriate law enforcement agency. The Compliance Plan should be developed in accordance with 42 CFR 438.608.
- B. Each company must submit to the Administration's Compliance Office on a quarterly basis a report with the following information: preliminary and full investigations, audits performed, administrative actions against providers, overpayments identified and providers referred to the Department of Justice (if not submit a certification signed by the Compliance Director and the President or CEO).
- C. Each company must submit to the Compliance Office on a quarterly basis a report with the following information: fraud investigations pending, fraud investigations in process, fraud investigations finished and referrals to the Department of Justice or U.S. Attorney's Field Office (if there were no investigations, submit a certifications signed by the Compliance Director and the President or CEO).
- D. Each Company has five (5) days to notify ASES about the referrals made to the US Attorney's Field Office and HHS-OIG.
- E. Each company must submit to the Compliance Office a certification signed by the Compliance Director and the President or CEO indicating that all full investigations were made in accordance with 42 CFR 455.15.
- F. Each Company has five (5) days to notify ASES about any adverse or negative action that the MCO has taken on provider application (upon initial application or application renewal) or actions which limit the ability of providers to participate in the program.
- G. Each Company must review the credentialing forms of all providers and any fiscal agents they may use to ensure that they are in accordance with federal regulation 42 CFR 455.104.
- H. Each Company must require all providers to fill out a complete ownership and control disclosures form. The Company is responsible to ensure compliance with regulation.
- I. Each Company must review providers agreement to incorporate appropriate business transaction language to ensure accordance with federal regulation 42 CFR 455.105.
- J. Each Company must request providers to fulfill a business transactions form and verify compliance with regulation.
- K. Each Company must establish a method to capture criminal conviction information on owners, persons with control interest, agents, and managing employees of providers to ensure that is in accordance with federal regulation 42 CFR 455.106.



- L. Each Company must review the enrollment packages for all provider types to request criminal conviction information as stated before.
- M. Each Company should develop and implement procedures to report to HHS-OIG and ASES within 20 working days any criminal conviction disclosures made during the MCO credentialing process. Copy of the policies should be submitted to ASES Compliance Office.
- N. Each Company must submit to the Compliance Office a certification signed by the Compliance Director and the President or CEO stating compliance with 42 CFR 455.106.
- O. Each Company must comply with requirement in 42 CFR 455.20 and must document in a quarterly report compliance with regulation.
- P. Each Company must comply with requirement in 42 CFR 455.101.
- Q. Each Company must review the enrollment form and credentialing packages for all provider types to capture the identity of agents and managing employees.

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TABLE OF CONTENTS

Integrity Program Basis and Scope

Definitions

Other applicable regulations

Guidelines for Sub-Parts A, B

Sub-Part A: Fraud Detection and Investigation Program

PI A001: State plan requirement. § 455.12

PI A002: Methods for identification, investigation, and referral. § 455.13

PI A003: Preliminary investigation. § 455.14

PI A004: Full investigation. § 455.15

PI A005: Resolution of full investigation. § 455.16

PI A006: Reporting requirements. § 455.17

PI A007: Provider's statements on claims forms. § 455.18

PI A008: Provider's statement on check. § 455.19

PI A009: Recipient verification procedure. § 455.20

PI A010: Cooperation with State Medicaid fraud control units. § 455.21

PI A011: Suspension of payments in cases of fraud (§ 455.23)

Sub-Part B: Disclosure of Information by Providers and Fiscal Agents

PI B001: Purpose § 455.100

PI B002: Definitions. § 455.101

PI B003: Determination of ownership or control percentages. § 455.102

PI B004: State Plan requirements § 455.103

PI B005: Disclosure of Information and Screen for Identity and Exclusions by Providers and Fiscal Agents. § 455.104 and 455.436.

PI B006: Disclosure by providers: Information related to business transactions. § 455.105

PI B007: Disclosure by providers: Information on persons convicted of crimes. § 455.106

Sub-Part E: Provider Screening and Enrollment

PI E001: Termination or denial of enrollment. § 455.416

PI E002: Reactivation of provider enrollment. § 455.420

PI E003: Appeals rights. § 455.422

PI E004: Criminal background checks. § 455.434

Other

State Medicaid Directors Letter (SMDL) #09-001



Introduction

Under the authority of Sec. 1102 of the Social Security Act (42 U.S.C. 1302); as detailed in the 43 FR 45262, Sept. 29, 1978, the Medicaid Program must have a program to detect and investigate fraud, waste and abuse.

The Commonwealth of Puerto Rico Department of Health and its Office for the Medically Indigent, acting as the single state agency are responsible for the management of the Medicaid and SCHIP grant funds. These funds are transferred to the Puerto Rico Health Insurance Administration (ASES), to be combined with state funds to provide health benefit coverage to the medically indigent population through contracts with health plans. Acting as a sub-grantee to the Office for the Medically Indigent Medicaid program, ASES establishes contracts with insurance companies and other organizations to facilitate the beneficiaries' access to the benefit coverage throughout their provider's networks.

Integrity Program Basis and Scope

This document sets forth guidelines with minimum criteria for the compliance with Program Integrity Policies and Procedures that each organization (grantee, sub-grantee, insurance companies) must have for the administration of the Commonwealth of Puerto Rico's Medicaid and State Health Plans. This document includes guidelines for the elaboration of the 3 main sections in the organizations Program Integrity Plan (PIP):

1. Fraud Detection and Investigation
2. Providers and Fiscal Agents Disclosure of Information on Ownership and Control
3. Integrity Program

Regulation Citation

Sections 1902(a)(4) [42 USC 1396(a)(4)1, (61)2, (64)3]; 1903(i)(2) [42 USC 1396(b)(i)(2)] 4-1936[42 USC 1396u-6]5) and regulations at 42 CFR Parts 438, 455, 1001 and 1002

Overall Requirement

All providers/contractors are required to comply with the federal regulation on federal database searches at 42 CFR 455.436 and the CMS State Medicaid Director Letter #09-001, which explains what types of ongoing exclusion searches providers should conduct among their employees.

Companies are also required to notify to the Department of Health and Human Services-Office of Inspector General (HHS-OIG) of any action it takes to limit the ability of an individual or entity to participate in its program as stated in 42 CFR 1002.3.

Each contracted company must report actions it takes when it denies a provider enrollment based on program integrity concerns. Companies should report on each provider whom it has disenrolled, suspended, terminated or otherwise restricted from participation in the Medicaid program based on program integrity concerns. Companies are required to report affected providers directly to HHS-OIG while copying ASES.



Definitions

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider

Conviction or Convicted means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

Disclosing Entity means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent

Exclusion means that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit for him/her or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Furnished refers to items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a provider, or other supplier of services. (For purposes of denial of reimbursement within this part, it does not refer to services ordered by one party but billed for and provided by or under the supervision of another.)

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Health insuring organization (HIO) has the meaning specified in §438.2.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.



Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

- (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
- (b) Any Medicare intermediary or carrier; and
- (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Person with an ownership or control interest means a person or corporation that—

- (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
- (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
- (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
- (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
- (e) Is an officer or director of a disclosing entity that is organized as a corporation; or
- (f) Is a partner in a disclosing entity that is organized as a partnership.

Practitioner means a physician or other individual licensed under State law to practice his or her profession.

Program Integrity Plan (PIP) means the program, process or policy that each contracted company has to comply with integrity requirements. The plan should be developed in accordance with federal regulation.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means—

- (a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or



(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Stakeholder means the single state agency, the sub-grantee and all organizations contracted to provide health care management and services to Medicaid beneficiaries

Suspension means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

Termination means—

(1) For a—

(i) Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and

(ii) Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.

(2)(i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary.

(ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.

(3) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to—

(i) Fraud;

(ii) Integrity; or

(iii) Quality.

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider



Section A

Fraud Detection and Investigation sub part represents each one of the elements that must be included as part of the integrity program activities, although they are not necessarily the only elements that come into play.

All contracted plans must have an integrity program with their own structure, policies and procedures. Among other areas, they should have written policies and procedures on methods for the identification, investigation and referral of suspected cases; procedure to perform preliminary investigations as well as full investigations; procedures to address resolution of full investigations; procedures to comply with reporting requirements; provider's statements on claims form (if applicable); provider's statement on checks; cooperation with the Commonwealth of Puerto Rico Office for the Medically Indigent fraud control unit and procedure to withhold payments in case of fraud or willful misrepresentation. Contracted companies are required to submit to ASES Compliance Office copy of their integrity programs for evaluation. The plan should be developed in accordance with 42 CFR 438.608.

Each one of the Guidelines under section A includes the name or title of the guideline, scope, purpose, process and general information to identify the creation date, creator, and revisions or updates. This document will be attached to the contract each organization holds with the Puerto Rico Insurance Administration; while each one of the contracted organization should have at least a minimum set of policies and procedures to address the guidelines included.

The Program Integrity Plan (PIP) of each organization is to be monitored by the sub-grantee on periodic basis. An annual report will be issued reporting data and findings.



Commonwealth of Puerto Rico
Program Integrity Plan 2014 - 2015

Title SA1.1	State Plan Requirements
Scope	Applies to Single State Agency and Sub-Grantee
Purpose	This guideline describes the commitment of the single state agency and the sub-grantee in adhering to the statute rules and regulations and the implementation of a Program Integrity Plan for the Medicaid Program
General	The grantee and the sub-grantee will abide by the following guidelines on how to manage the integrity program activities in the whole service delivery system.
Guidelines	<ol style="list-style-type: none">1. The single state agency and sub-grantee acknowledge the need to adhere to a Medicaid Integrity Program as defined in the state plan.2. The grantee and sub-grantee agree to establish a structure to manage Program Integrity Plan (PIP) activities.3. The organization structure to perform above mentioned activities is furnished with a Program Integrity Plan (PIP) of members representing the single state agency, the sub-grantee and each contracted organization.4. The PIP leads the efforts toward achieving compliance with state plan requirements regulation by establishing the minimum criteria of required PI program policies and procedures.5. The PIP monitors contracted companies plan compliance on regular basis.6. The PIP chairman develops the meeting calendar each year, develops the committee agenda, and keeps minutes of all meetings and call for meetings.7. Sub-grantee facilitates the development and update of the Program Integrity Plan guidelines, reports and notification to guarantees its distribution and final acceptance among contracted companies and regulatory agencies.8. Sub-grantee review performance of each organization, level of adherence to policies and recommend corrective action plan development for areas that must be improved.9. Sub-grantee develops an annual report that is to be submitted to the Medicaid Integrity Group and to the CMS region 2. The report will include the areas and companies reviewed during the period and the findings of each company, if any.10. The PIP provides guidance and guarantees that each contracted companies develop and implement policies and procedures in their organizations.11. The PIP guidelines are integrated into each contracted organization Program Integrity Plan Policies and Procedures; and are assumed as a standard operating procedure to prevent fraud, waste and abuse in the management of Medicaid funds and health plan benefit coverage for the indigent population.



Title SA02.1	Methods for identification, investigation, and referral
Scope	Grantee, Sub-grantee and Contracted Organizations
Purpose	This guide describes what the organization must include in their PIP to guarantee the use of methods for the identification, investigation, and referral of suspected fraud and abuse cases.
General	The organization must establish methods for the identification, investigation and referral of suspected cases, that guarantees the use of a consistent and objective approach to address fraud, waste and abuse when performing PIP activities.
Guidelines	<p>The PIP must include an explicit definition of methods to perform identification of cases suspected of fraud, waste and abuse</p> <ol style="list-style-type: none"> what is fraud, waste and abuse how is detected fraud, waste and abuse who performs the identification when preliminary, full investigation and resolutions are done <p>The PIP must have a detailed process to perform investigations on each suspected case guaranteeing objective methods to identify potential cases and perform investigations</p> <ol style="list-style-type: none"> open and documents the case initiate data gathering process follow a protocol to verify information issue a report of findings refer case to next level close the case <p>The PIP must include a variety of methods for the identification, investigation and referral of suspected cases, accepted in the industry and without infringing provider or beneficiary rights. Methods might include</p> <ol style="list-style-type: none"> electronic data exchanges data mining claims registries / reconciliation targeted procedures profiling <p>The PIP must include a systematic approach of data analysis by:</p> <ol style="list-style-type: none"> flagging the case identifying cause for flagging (i.e. over-under payment) establishing actions and sanctions <p>The PIP must have procedures in place for referring suspect fraud cases to law enforcement officials, at a minimum:</p>



Guidelines	<ul style="list-style-type: none"> a. an organizational structure to address the reports. b. a due process that includes but is not limited to: case identification, complete record with supporting materials, notification letter to suspect, notification letter to single state agency, documentation of entrance and exit interviews, and if necessary copy of referral letters and case resolution letter to and from legal authorities. c. a flowchart to work in cooperation with the grantee and sub-grantee as well as with the state legal authorities such as: Organization's Legal Affairs Department, ASES, Single State Agency – Department of Health Legal Department, State Department of Justice, and the Office of Inspector General. d. a follow up process to work with legal authorities each case of fraud, waste and abuse suspicion until final disposition and notification to the single state agency.
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Commonwealth of Puerto Rico
Program Integrity Plan 2014 - 2015

Title SA03	Preliminary Investigations
Scope	Grantee, Sub-grantee and Contracted Organizations
Purpose	To provide guidance on how to perform a preliminary investigation when the agency receives a complaint of fraud or abuse from any source or identifies any questionable practices.
General	The organization must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.
Guidelines	<p>The PIP defines a standard operating procedure to complete a preliminary investigation of all suspect cases of fraud, waste and abuse.</p> <p>The PIP identifies the requirements to complete the preliminary investigation when evaluating providers and beneficiaries. It should include at least:</p> <ul style="list-style-type: none">a. Source of informationb. Identification method (how the case is detected)c. Cause for investigationd. Case documentatione. Analysis of Data and documentsf. Report of Findingsg. Action Taken (Recommended Action) <p>The PIP includes a mechanism to keep tracking of all preliminary investigations and results.</p> <p>The PIP establishes a mechanism to report preliminary investigations activity to the sub-grantee (ASES) which will be in charge of reporting activity to the single state agency (Office for the Medically Indigent).</p>



Commonwealth of Puerto Rico
Program Integrity Plan 2014 - 2015

Title SA04	Full Investigations
Scope	Grantee, Sub-grantee and Contracted Organizations
Purpose	To provide guidance and minimum set of elements in the PIP to perform full investigations on incidents of fraud and abuse.
General	If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occur in the Medicaid program, the organization must take the appropriate actions.
Guidelines	<p>The PIP must define the process to conduct a full investigation and specify when a case requires the full investigation. Full investigations must be done in accordance with federal regulation and based in the company written policy. The company must submit copy of the written policies to ASES for review and approval.</p> <p>The PIP must define the process to refer the cases to the companies fraud liaison (i.e. companies compliance office), the appropriate law enforcement agency / sub-grantee when there is a reason:</p> <ul style="list-style-type: none">a. to suspect a provider has engaged in fraud or abuse of the program.b. to suspect a recipient is defrauding the program.c. to suspect a recipient has abused the Medicaid program. <p>The PIP must have a mechanism to keep tracking of all full investigations performed in progress and closed.</p> <p>The PIP must have a mechanism to report the sub-grantee (ASES) informed full investigations in progress, conducted and results.</p>



Commonwealth of Puerto Rico
Program Integrity Plan 2014 - 2015

Title SA05	Resolution of full investigation
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on minimum actions that must be taken in order to complete the process of a full investigation.
General	The full investigations must continue until the cases are referred, solved or closed.
Guidelines	<p>The PIP must include the process to guarantee that a full investigation must continue until:</p> <ul style="list-style-type: none">a. appropriate legal action is initiated.b. the case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse.c. the matter is resolved between the organization and the provider or recipient<ul style="list-style-type: none">✓ the resolution may include but is not limited to:<ul style="list-style-type: none">1) Sending a warning letter to the provider or recipient, giving notice that continuation of the activity in question will result in further action;2) Suspending or terminating the provider from participation in the Medicaid program;3) Seeking recovery of payments made to the provider; or4) Imposing other sanctions provided under the organization PIP plan. <p>The PIP must guarantee that there is a mechanism to keep tracking of all full investigations until resolution.</p>



Commonwealth of Puerto Rico
Program Integrity Plan 2014 - 2015

Title SA06	Reporting Requirements
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on how to adhere to a minimum set of elements that must be included in the process to report fraud and abuse information to the appropriate organizations officials.
General	The organization must submit a progress report the fraud and abuse information and statistics to the appropriate department / grantee / sub-grantee on quarterly basis.
Guidelines	<p>The PIP must describe the mechanism to report fraud and abuse data to the appropriate fraud liaison, organization structure, sub-grantee (ASES) and grantee (Office for the Medically Indigent).</p> <p>The PIP progress report must include at least the following information:</p> <ol style="list-style-type: none"> # of complaints on fraud and abuse received. # of complaints that warrant preliminary investigation. Detailed information for each case of suspected provider fraud and abuse that warrants a full investigation: <ul style="list-style-type: none"> ✓ Provider's name and id number ✓ Source of the complaint ✓ Type of the provider ✓ Nature of the complaint ✓ Estimate amount of money involved ✓ Legal and administrative disposition of the case and actions taken by the law enforcement officials to whom the case has been referred. <p>Suspected fraud cases must be reported immediately in a written format to ASES Compliance Office.</p> <p>The PIP reports must be submitted in electronic format to facilitate its inclusion in the Commonwealth of Puerto Rico Medicaid Program PI Annual Report.</p>



Commonwealth of Puerto Rico
Program Integrity Plan 2014 - 2015

Title SA07	Provider's statements on claims forms
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on how to comply with regulation on provider's statements on claims forms.
General	The organization may print that all provider claims forms be imprinted in boldface type with the following statement, or with alternate wording that is approved by the Regional CMS Administration.
Guidelines	<p>The PIP must include that providers are required to attest in the claim forms that they agree with the following statement:</p> <ul style="list-style-type: none">✓ "This is to certify that the foregoing information is true accurate and complete".✓ "I understand that payment of this claim will be from federal and state funds and that any falsification or concealment of a material fact maybe prosecutes under federal and state laws". <p>For electronic claims, providers must attest that they agree with the following statements:</p> <ul style="list-style-type: none">✓ "This is to certify the truthfulness of the foregoing information and certify that is true, accurate, complete and that the service was provided". <p>The statements may be printed above the claimant's signature or, if they are printed on the revenue of the form, a reference to the statements must appear immediately preceding the claimant's signature.</p>




Commonwealth of Puerto Rico
Program Integrity Plan 2014 - 2015

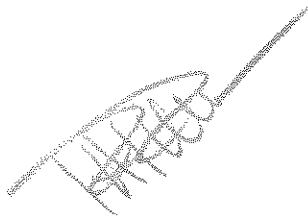
Title SA08	Provider's statements on check
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on how to comply with regulation on provider's statements on check.
General	The organization may print the following wording above the claimant's endorsement on the reverse of checks or warrants payable to each provider.
Guidelines	<p>The PIP must include that providers are required to attest (in addition to the statements required in providers claims form) that they agree with the following statement either by having it written on checks or temporarily in a legal document as an affidavit:</p> <p>✓ "I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws".</p> <p>The above attestation must be included in electronic and checks payment.</p> <p>The PIP must indicate frequency and responsible for conducting spot checks to guarantee the organization complies with the provider's statements and / or the provider signature appears on a legal document attesting compliance.</p>



Commonwealth of Puerto Rico
Program Integrity Plan 2014 - 2015

Title SA09	Recipient verification procedure
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To verify that the services listed on claims forms have been rendered.
General	The organization must have a method for verifying with recipients whether services billed by providers were received.
Guidelines	<p>The PIP must include a description of how the organization performs claims matches with medical records to guarantee adequacy of billing.</p> <p>The PIP must define the mechanism to monitor frequency of encounters and services rendered to patients billed by providers.</p> <p>The PIP will provide periodic updates on reconciliation findings report to the sub-grantee and grantee.</p> <p>The sub-grantee will select a sample to perform independent reviews to verify that recipient's services billed by providers (as well as encounters under capitated environment) were indeed rendered. This review will be performed through confirmations to beneficiaries.</p>

 Note: All contracted companies are required to comply with Law 114 which require that the beneficiaries must receive an Evidence of Medical Benefits with a detailed of the services and expenses incurred during a quarter. ASES compliance office will review the compliance with the Law.





Commonwealth of Puerto Rico
Program Integrity Plan 2014 - 2015

Title SA10	Cooperation with Medicaid Fraud Control Units
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on how to communicate findings and to cooperate with any Puerto Rico or federal law enforcement agency. To request that all contracted companies must communicate preliminary findings to ASES.
General	The organization must have a mechanism to provide information to the regulatory and legal authorities on cases, investigations, schemes and any other activity where intention to commit fraud, abuse and waste of services occur.
Guidelines	<p>The PIP must demonstrate it has an effective mechanism to cooperate with the Medicaid antifraud unit as well as with other program divisions in charge of preventing and prosecuting cases related to fraud, waste and abuse of services under the Medicaid program. To this end, ASES has established the Medicaid Integrity Group (MIG) with the participation of the OIG and the Medicaid office.</p> <p>The PIP must establish a process to guarantee the organization complies with the following:</p> <ul style="list-style-type: none">✓ All cases of suspected provider fraud are referred to the antifraud / integrity organization's unit.✓ If the antifraud / integrity unit determines that it may be useful in carrying out the unit's responsibilities, promptly comply with a request from the unit for --<ul style="list-style-type: none">i. Access to, and free copies of, any records or information kept by the organization or its contractors;ii. Computerized data stored by the organization or its contractors. These data must be supplied without charge and in the form requested by the unit;iii. Access to any information kept by providers to which the organization is authorized access. In using this information, the unit must protect the privacy rights of recipients;✓ Communicate to ASES preliminary findings; and✓ On referral from the unit, coordinate with ASES or appropriate law enforcement agency before initiating any available administrative or judicial action to recover improper payments to a provider. <p>The PIP must recommend the organization to have in the provider's contract a disclaimer that as a contracted provider any data related to services or payments provided must be available for review of the integrity staff.</p>



Commonwealth of Puerto Rico
Program Integrity Plan 2014 - 2015

Title SA11	Suspension of payments in cases of fraud
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on elements to be considered when suspending payments to providers who committed fraud.
General	The organization must suspend payments to providers as a mechanism to prevent wrong disbursement of payments when there is a credible allegation of fraud for which an investigation is pending unless the agency have a good cause to not suspend payments or to suspend payment only in part.
Guidelines	<p>The PIP will establish a mechanism and adhere to the following recommendations when considering suspension of payments:</p> <p>(a) <i>Basis for suspension.</i> The Organization must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part. The Organization may suspend payments without first notifying the provider of its intention to suspend such payments. A provider may request, and must be granted, administrative review where State law so requires.</p> <p>(b) <i>Notice of suspension.</i> The Organization must send notice of its suspension of program payments within:</p> <ul style="list-style-type: none">• 5 days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold such notice.• 30 days if requested by law enforcement in writing to delay sending such notice, which request for delay may be renew in writing up to twice and in no event may exceed 90 days.• The notice must include or address all of the following:<ul style="list-style-type: none">✓ State that payments are being suspended in accordance with this provision (CFR 42 CFR 455.23);✓ Set forth the general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation✓ State that the suspension is for a temporary period, as stated on paragraph (c) of this section and cite the circumstances under which suspension will be terminated;✓ Specify, when applicable, to which type or types of Medicaid claims (capitation or claims) or business units of a provider suspension is effective.✓ Inform the provider of the right to submit written evidence for consideration by the agency.✓ Set forth the applicable administrative appeals process and corresponding citations to State law. <p>(c) <i>Duration of suspension</i></p>



1) All suspension of payment actions under this section will be temporary and will not continue after either of the following:

- ✓ The agency or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider.
- ✓ Legal proceedings related to the provider's alleged fraud are completed.

2) It must be documented in writing the termination of a suspension including, where applicable and appropriate, any appeal rights available to a provider.

(d) *Referrals to the ASES, Medicaid and OIG.*

(1) Whenever the Organization investigation leads to the initiation of a payment suspension in whole or part, the Organization must make a fraud referral to ASES who will notify the OIG and the Medicaid Office.

(2) The fraud referral must meet all of the following requirements:

- Be made in writing and provided to ASES not later than the next business day after the suspension is enacted.
- Conform to fraud referral performance standards issued by the Secretary.

(3)(i) If the Medicaid fraud control unit or other law enforcement agency accepts the fraud referral for investigation, the payment suspension may be continued until such time as the investigation and any associated enforcement proceedings are completed.

(ii) On a quarterly basis, the Organization must request a certification from the Medicaid fraud control unit or other law enforcement agency that any matter accepted on the basis of a referral continues to be under investigation thus warranting continuation of the suspension.

(4) If the Medicaid fraud control unit or other law enforcement agency declines to accept the fraud referral for investigation the payment suspension must be discontinued unless the State Medicaid agency or ASES has alternative Federal or State authority by which it may impose a suspension or makes a fraud referral to another law enforcement agency. In that situation, the provisions of paragraph (d)(3) of this section apply equally to that referral as well.

(5) A decision to exercise the good cause exceptions in paragraphs (e) or (f) of this section not to suspend payments or to suspend payments only in part does not relieve the Organization of the obligation to refer any credible allegation of fraud as provided in paragraph (d)(1) of this section.

(e) *Good cause not to suspend payments.* The Organization may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

(1) Law enforcement officials have specifically requested that a payment suspension not be imposed because such a



payment suspension may compromise or jeopardize an investigation.

- (2) Other available remedies implemented by the Organization more effectively or quickly protect Medicaid funds.
- (3) The Organization determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed.

(4) Beneficiary access to items or services would be jeopardized by a payment suspension because of either of the following:

- (i) An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
- (ii) The individual or entity serves a large number of recipients within a HRSA-designated medically underserved area.

(5) Law enforcement declines to certify that a matter continues to be under investigation per the requirements of paragraph (d)(3) of this section.

(6) The State determines that payment suspension is not in the best interests of the Medicaid program.

(f) *Good cause to suspend payment only in part.* The Organization may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

(1) Recipient access to items or services would be jeopardized by a payment suspension in whole or part because of either of the following:

- (i) An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
- (ii) The individual or entity serves a large number of recipients within a HRSA-designated medically underserved area.

(2) The Organization determines, based upon the submission of written evidence by the individual or entity, that is the subject of a whole payment suspension, that such suspension should be imposed only in part.

(3)(i) The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and

(ii) The Organization determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.

(4) Law enforcement declines to certify that a matter continues to be under investigation per the requirements of paragraph (d)(3) of this section.

(5) The State determines that payment suspension only in part is in the best interests of the Medicaid program.



(g) *Documentation and record retention.* The Organization must meet the following requirements:

(1) Maintain for a minimum of 5 years from the date of issuance all materials documenting the life cycle of a payment suspension that was imposed in whole or part, including the following:

- (i) All notices of suspension of payment in whole or part.
- (ii) All fraud referrals to the Medicaid fraud control unit or other law enforcement agency.
- (iii) All quarterly certifications of continuing investigation status by law enforcement.
- (iv) All notices documenting the termination of a suspension.

(2)(i) Maintain for a minimum of 5 years from the date of issuance all materials documenting each instance where a payment suspension was not imposed, imposed only in part, or discontinued for good cause.

(ii) This type of documentation must include, at a minimum, detailed information on the basis for the existence of the good cause not to suspend payments, to suspend payments only in part, or to discontinue a payment suspension and, where applicable, must specify how long the Organization anticipates such good cause will exist.

(3) Annually report to the Secretary and ASES summary information on each of following:

(i) Suspension of payment, including the nature of the suspected fraud, the basis for suspension, and the outcome of the suspension.

(ii) Situation in which the Organization determined good cause existed to not suspend payments, to suspend payments only in part, or to discontinue a payment suspension as described in this section, including describing the nature of the suspected fraud and the nature of the good cause.



Title SA12	Disclosure of Information and Screen for Identity and Exclusions by Providers and Fiscal Agents
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide definition of concepts in order to fully adhere to the regulation on providers control and ownership of facilities and verification of employees for exclusions
General	The organization must adhere to standard definitions when dealing with disclosure of information by providers and fiscal agents when establishing mechanism to regulate providers control and ownership of facilities and verification of employees for identity and exclusions
Guidelines	<p>The PIP will adhere to the following <u>definitions</u> of concepts to keep consistency with federal regulation and application of law:</p> <p><i>Agent</i> means any person who has been delegated the authority to obligate or act on behalf of a provider.</p> <p><i>Disclosing entity</i> means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.</p> <p><i>Other disclosing entity</i> means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the federal programs (Medicaid, SCHIP, FQHC's). This includes:</p> <ul style="list-style-type: none"> (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII); (b) Any Medicare intermediary or carrier; and (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act. <p><i>Fiscal agent</i> means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.</p> <p><i>Group of practitioners</i> means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).</p> <p><i>Indirect ownership interest</i> means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.</p>
Guideline	<i>Managing employee</i> means a general manager, business manager, administrator, director, or other individual who exercises operational or



7

managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that –

- (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
- (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
- (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
- (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
- (e) Is an officer or director of a disclosing entity that is organized as a corporation; or
- (f) Is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means –

- (a) An individual, agency or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- (b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).



Guideline

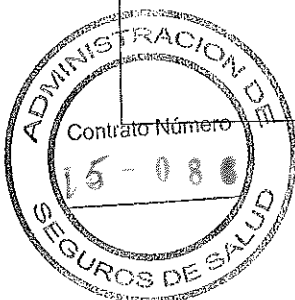
Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

The PIP must also ensure providers compliance with screening employees for identity and exclusions. To further protect against payments for items and services furnished or ordered by excluded parties, all current providers and providers applying to participate in the plan must be advised to take the following steps to confirm identities and to determine whether their employees and contractors are excluded individuals or entities:

- ✓ Providers have the obligation to screen all employees and contractors to confirm the identity and determine the exclusion status through routine checks of Federal databases. The Organization should communicate this obligation to providers upon enrollment and reenrollment.
- ✓ Providers should explicitly be required to agree to comply with this obligation as a condition of enrollment.
- ✓ Providers should be informed that they can search the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe.
- ✓ Providers should be required to search the LEIE and EPLS no less frequently than monthly to capture exclusions and reinstatements that have occurred since the last search.
- ✓ Providers should be required to immediately report to them any exclusion information discovered.

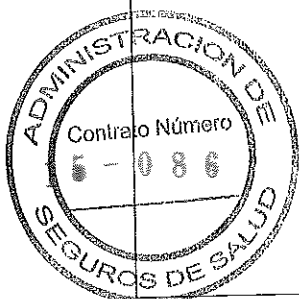
This line of defense in combating fraud and abuse must be conducted accurately, thoroughly, and routinely. The Organization must notify ASES and the HHS-OIG promptly of any administrative action taken against a provider for failure to comply with these screening and reporting obligations. See 42 CFR section 1002.3(b)(3). The Organization can satisfy this obligation by communicating the relevant information to ASES and the appropriate Regional Office of the OIG Office of Investigations.

The Organizations also should inform providers that civil monetary penalties may be imposed against Medicaid providers and entities contracted by ASES who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients. (Section 1128A(a)(6) of the Act; and 42 CFR section 1003.102(a)(2))



Commonwealth of Puerto Rico
Program Integrity Plan 2014 - 2015

Title SA13	Disclosure by disclosing entities: Information on ownership and control.
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidelines on what information must be disclosed by entities that have ownership and control over facilities.
General	The organization must have a mechanism to monitor on a timely manner the providers and fiscal agents that owns or control facilities where Medicaid beneficiaries receive services.
Guidelines	<p>The Organization must require each disclosing entity to disclose the following information in a timely manner:</p> <p>(a) <i>Type of Information that must be disclosed.</i></p> <p>(1) (i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or the entity contracted by ASES. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.</p> <p>(ii) Date of birth and Social Security Number (in the case of an individual).</p> <p>(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or the entity contracted by ASES) or in any subcontractor in which the disclosing entity (or fiscal agent or the entity contracted by ASES) has a 5 percent or more interest.</p> <p>(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or the entity contracted by ASES) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or the entity contracted by ASES) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.</p> <p>(3) The name of any other disclosing entity (or fiscal agent or the entity contracted by ASES) in which an owner of the disclosing entity (or fiscal agent or the entity contracted by ASES) has an ownership or control interest.</p> <p>(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or the entity contracted by ASES).</p> <p>(b) <i>When the disclosures must be provided.</i></p>



(1) Disclosures from providers or disclosing entities. Disclosure from any provider or disclosing entity is due at any of the following times:

- (i) Upon the provider or disclosing entity submitting the provider application.
- (ii) Upon the provider or disclosing entity executing the provider agreement.
- (iii) Upon request of the organization during the re-validation of enrollment process under § 455.414.
- (iv) Within 35 days after any change in ownership of the disclosing entity.

(2) Disclosures from fiscal agents or managed care entities - .Disclosures from fiscal agents are due at any of the following times:

- (i) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.
- (ii) Upon the fiscal agent executing the contract with the State.
- (iii) Upon renewal or extension of the contract.
- (iv) Within 35 days after any change in ownership of the fiscal agent.

Updated information must be furnished to the Secretary or the State survey or the Organization at intervals between recertification or contract renewals, within 35 days of a written request.

(c) Consequences for failure to provide required disclosures.

- ✓ Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.
- ✓ The Organization shall not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose ownership or control information as required by this section.

The PIP will include the process to provide an annual report to the grantee and sub-grantee on above information and data.



Commonwealth of Puerto Rico
Program Integrity Plan 2014 - 2015

Title SA14	Disclosure by providers: Information related to business transactions.
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	The organization must establish a mechanism to facilitate the providers disclose information related to their business transactions when own or control facilities where Medicaid beneficiaries received services.
Guidelines	<p>The PIP must describe the mechanism to allow providers owning or controlling facilities disclose information related to business transactions.</p> <p>The PIP must attest the organization abide by the following regulation:</p> <ul style="list-style-type: none">(a) <i>Provider agreements.</i> The organization must enter into an agreement with each provider or provider group under which the provider agrees to furnish to it or to the grantee / sub-grantee on request, information related to business transactions.(b) <i>Information that must be submitted.</i> A provider must submit, within 35 days of the date on a request by the organization full and complete information about –<ul style="list-style-type: none">✓ The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and✓ Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request. <p>The PIP must include withholding of payment processes and procedures to enforce above guideline.</p>



Commonwealth of Puerto Rico
Program Integrity Plan 2014 - 2015

Title SA15	Disclosure by providers: Information on persons convicted of crimes
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on type of information providers must report in compliance with integrity program.
General	The organization is obliged to request providers to report any conviction of crimes or any other in the program integrity regulation.
Guidelines	<p>The PIP must include a mechanism to confirm that information included below is considered as part of the integrity activities.</p> <p>(a) <i>Information that must be disclosed.</i> Before the organization enters into or renews a provider agreement, or at any time upon written request by the organization, the provider must disclose to the organization the identity of any person who:</p> <ol style="list-style-type: none">(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs. <p>(b) <i>Notification to Inspector General.</i></p> <ol style="list-style-type: none">(1) The organization must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.(2) The organization must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program. <p>(c) <i>Denial or termination of provider participation.</i></p> <ol style="list-style-type: none">(1) The organization may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.(2) The organization may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.



Commonwealth of Puerto Rico
Program Integrity Plan 2014 - 2015

Title SA16	Provider Screening and Enrollment
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on termination or denial of enrollment and criminal background checks.
General	The organization is obliged to establish procedures for termination or denial of enrollment and to obtain providers consent to criminal background checks.
Guidelines	<p>The PIP must include a process to confirm that the requirements included below are considered as part of the integrity activities.</p> <p>1. The Organization must:</p> <p>(a) terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under this subpart.</p> <p>(b) deny enrollment or terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years, unless ASES determines that denial or termination of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.</p> <p>(c) deny enrollment or terminate the enrollment of any provider that is terminated on or after January 1, 2011, under title XVIII of the Act or under the Medicaid program or CHIP of any other State.</p> <p>(d) terminate the provider's enrollment or deny enrollment of the provider if the provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information, unless ASES determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.</p> <p>(e) terminate or deny enrollment if the provider, or any person with a 5 percent or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the ASES within 30 days of a CMS or a ASES request, unless ASES determines that termination or denial of enrollment is not in the best interests of the Medicaid program and ASES documents that determination in writing.</p>



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(f) terminate or deny enrollment if the provider fails to permit access to provider locations for any site visits under § 455.432, unless ASES determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.

(g) May terminate or deny the provider's enrollment if CMS, ASES or the State Medicaid agency—

(1) Determines that the provider has falsified any information provided on the application; or

(2) Cannot verify the identity of any provider applicant.

1. Reactivation of provider enrollment

After deactivation of a provider enrollment number for any reason, before the provider's enrollment may be reactivated, the Organization must re-screen the provider.

2. Appeal rights

The State Medicaid agency must give providers terminated or denied under § 455.416 any appeal rights available under procedures established by State law or regulations.

3. Criminal background checks

As a condition of enrollment, the organization must require providers to consent to criminal background checks including fingerprinting when required by law enforcement agencies or State law.





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PUERTO RICO

Administración de Seguros
de Salud de Puerto Rico (ASES)

PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (15)

FORMULARY A-102 EVIDENCE OF LACK OF PROVIDERS AND PROVIDERS REFUSAL TO CONTRACT



Formulary A-102 - Evidence of Lack of Providers and Providers Refusal to Contract

Pursuant to section 9.4.3 of the Contract, the Contractor must use this Formulary to evidence the lack of providers in its Service Region or refusal to contract as part of the General Network or the PPN of its Service Region. The Contractor must carry out all efforts to contract with those specialists within contiguous Service Regions; provided that before recurring to contiguous regions Contractor must validate and submit all supporting documents evidencing the lack of Providers or refusal to contract required in this Formulary.

Provider Name _____

Specialty _____

Service Region _____



List of MCO's Recruitment Activities and dates of such activities:

Provide the Dates and Outcomes of Meetings with provider:

Explain the issues causing concerns or barriers to Contracting:

Provide description of contract offers to the provider including fees and any other incentives:

Provide reasons why the provider refused the contract:

Describe provider counter offers:

Describe remedies offered by MCO to address provider's concerns in order to come to terms with the contract

Please attach to this Formulary any relevant document in support of your responses.





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Administración de Seguros
de Salud de Puerto Rico (ASES)

PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (16)

LIST OF REQUIRED REPORT

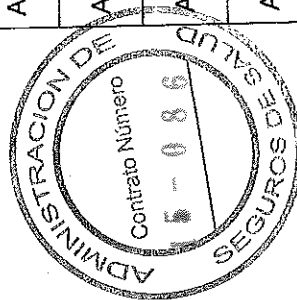
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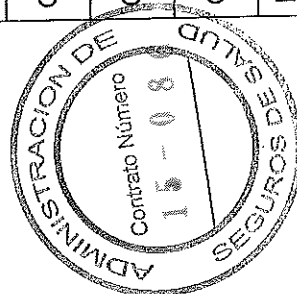


List of Required Reports

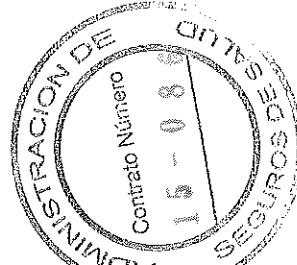
Program Area	ASES Dept.	Report Number	Report Reference	Frequency	Report Title
Administrative	Customer Service	1	6.8	Monthly	Call Center Report
Administrative	Systems and Compliance	2	17.7	Monthly	Privacy and Confidentiality Report
Administrative	Compliance	3	13.5	Quarterly	Fraud Waste Abuse Report
Administrative	Customer Service	4	6.2	Quarterly	Enrollee Enrollment Materials Report
Administrative	Compliance	5	13.1	Quarterly	Employee and Contractor Suspensions/Debarment Report
Administrative	Compliance	6	13.2	Annually	Compliance Plan
Administrative	Compliance	7	13.3	Annually	Program Integrity Plan
Administrative	Systems and Compliance	8	17.7	Annually or 10 Business Days following incident	Systems Incident Report
Administrative	Executive	9	12.2.7	10 days following each meeting	Activities of the Advisory Board



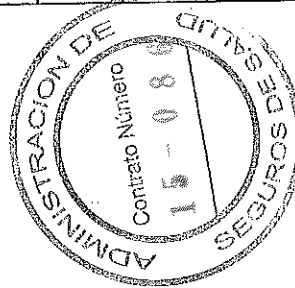
Program Area	ASES Dept.	Report Number	Report Reference	Frequency	Report Title
Claims	Finance	10	16.7	Monthly	Claims Activity Report
Claims	Finance	11	16.8	Monthly	Encounter Data
Covered Services	Quality	12	7.8.2	Quarterly	Care Management Report
Covered Services	Quality	13	7.8.3	Quarterly	Disease Management Report
Covered Services	Quality	14	7.5	Annually	Wellness Plan
Covered Services	Quality	15	7.5.8	Annually	Maternal and Pre-Natal Plan
Covered Services	Quality	16	7.9	Annually	EPSDT Plan
Covered Services	Quality	17	7.9	Annually	CMS-416 Report
Financial Management	Finance	18	22.1	Monthly	Per Member Per Month Disbursement Report
Financial Management	Systems	19	22.1	Monthly	Actuarial Data
Financial Management	Finance	20	23.4	Monthly	Enrollee TPL Health Insurance Report



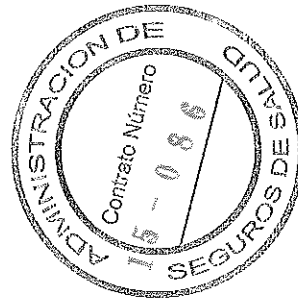
Program Area	ASES Dept.	Report Number	Report Reference	Frequency	Report Title
Financial Management	Finance	21	23.4	Quarterly	Retention Fund Report
Financial Management	Finance	22	23.1	Quarterly	Unaudited Financial Statement
Financial Management	Finance	23	23.4	Quarterly	Cost Avoidance Report
Financial Management	Compliance	24	23.7.4	Annually	Disclosure of Information on Annual Business Transactions
Financial Management	Finance	25	23.1	Annually	Report to Puerto Rico Insurance Commissioner's Office
Financial Management	Finance	26	23.1	Annually	Annual Corporate Report
Financial Management	Quality	27	23.6	Annually	Physician Incentive Plan Report
Financial Management	Finance	28	23.1	Annually	Audited Financial Statements
Financial Management	Finance	29	23.7.3	Annually	Report on Controls Placed in Operation and Tests of Operating Effectiveness
Provider	Compliance	30	9.2.3	Monthly	Provider Credentialing and Re-Credentialing Report
Provider	Quality	31	9.1	Monthly	National Provider List



Program Area	ASES Dept.	Report Number	Report Reference	Frequency	Report Title
Provider	Compliance	32	9.1	Quarterly	Provider Suspensions and Terminations Report
Provider	Quality	33	9.1	Quarterly	Geographic Access Report
Provider	Customer Service	34	12.7	Annually	Provider Satisfaction Survey Report
Provider	Quality	35	9.1	Annually	Provider Training and Outreach Plan/Evaluation Report
Quality	Customer Service	36	14.8	Quarterly	Grievances and Appeals Report
Quality	Quality	37	12.6	Quarterly	Quality Improvement Performance Report
Quality	Quality	38	12.6	Annually	Audited HEDIS Results Report
Quality	Customer Service	39	12.7	Annually	Enrollee Satisfaction Survey Report
Quality	Quality	40	12.3-12.5	Annually	QAPI Program Description
Systems	Systems	41	17.5	Monthly	Systems Availability and Performance Report
Systems	Systems	42	17.5	Quarterly	Business Continuity and Disaster Recovery (BC-DR) Test Report



Program Area	ASES Dept.	Report Number	Report Reference	Frequency	Report Title
Systems	Systems	43	17.5	Annually	Business Continuity and Disaster Recovery (BC-DR) Plan
Utilization Management	Quality	44	10.7	Quarterly	Admissions and Readmissions
Utilization Management	Clinical Affairs	45	8.7	Quarterly	Integration Report
Utilization Management	Clinical Affairs	46	7.5	Quarterly	Prior Authorization Report
Utilization Management	Clinical Affairs	47	11.1.3	Quarterly	Utilization Management Report
Utilization Management	Clinical Affairs	48	11.1.2	Annually	UM Program Description/Work Plan



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de Salud de Puerto Rico (ASES)

PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (17)

HIE ADOPTION STRATEGIC PLAN

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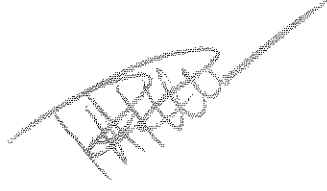
PLAN FOR THE ADOPTION OF ELECTRONIC HEALTH RECORDS BY THE GOVERNMENT HEALTH PLAN PROVIDER NETWORK

According to the public policy established by the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, that promotes the adoption and meaningful use of health information technology and the Act 40 of 2012, enacted by the Commonwealth of Puerto Rico, the *Administración de Seguros de Salud de Puerto Rico [ASES]* as the agency responsible for the implementing the government health plan (GHP) established a Plan for the adoption of electronic health records (EHRs) by the *GHP* health care provider network.

ASES recognizes that physicians are the gateway to organized and integrated healthcare delivery systems. The implementation of this Strategic Plan will accomplish the integration of all the health care providers' network, as an organized health care system, allowing ASES to plan for, provide/purchase, and coordinate all core services along the continuum of health care services for the population served by the *GHP*. The progressive adoption of electronic health records and the necessary secure and effective exchange of the patient health information constitute the backbone of an organized integrated health system.



The proper implementation of the Plan in a structured and progressive way will allow the achievement of the following objectives:

- 
- Focus on meeting the *GHP* population health needs;
 - Efficient information systems that enhance communication and information flow across the continuum of care;
 - Coordinate and integrate health care across the continuum;
 - Able to obtain and manage information on quality outcomes and costs;
 - Patient access to care continuum with multiple points of access; ensuring the patient receives the "right care at the right place at the right time";
 - Population-based needs assessment; focused on defined population as needed;
 - Maximize patient accessibility and minimize duplication of services ;
 - Encourage and facilitate prudent use of resources and eliminate wasteful practices;
 - Align service funding to ensure equitable funding distribution for different services or levels of services;
 - Provider-developed, evidence-based care guidelines and protocols to enforce one standard of care regardless of where patients are treated;
 - Cooperation between health care providers and organizations - medicine management partnerships; and
 - Facilitate prevention and health promotion.




ASES, according to the authority conferred by the law, has required the MCO to promote and request the adoption and implementation of the EHR by their health care provider network and an active participation in the PRHIN (State HIE) to enable the health information exchange between the health care providers.

The adoption of electronic health records and the meaningful use by the GHP health care provider network will allow ASES to establish mechanisms that guarantee, directly and indirectly, the accessibility, quality improvement, and cost and utilization controls of health care services provided and funded by federal and state governments, as well as the protection of patients' rights.

Strategies to Achieve ASES Goals and Objectives

ASES understands that achieving its goals and objectives will require it to work together with the contractors, to ensure that all health care providers move forward in a concerted and consistent manner in support and compliance with this Plan. The following are critical to achieving ASES' goals and objectives.

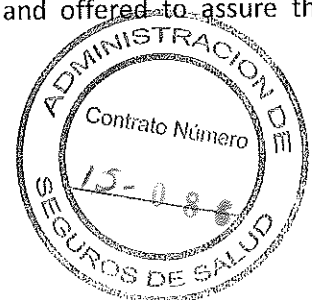
1. **Promote and require the GHP health care provider networks to adopt the meaningful use of a certified health records and an active exchange of patient health information through the State health information organization, Puerto Rico Health Information Network (PRHIN).**

 ASES will request the MCOs to perform a region-specific survey within their GHP health care provider networks to obtain the following information:

- Number of health care service providers/ organizations using a certified electronic health record;
- Number of health care service providers/ organizations that are active participants of a Health Information Exchange;
- Number of health care service providers/ organizations in the process of adopting and implementing a certified electronic health record system;
- Number of health care service providers/ organizations that do not have a certified electronic health record system and the reasons for that (ex. technical issues, financial issues, lack of knowledge, etc.);

Using the results of the survey, ASES and the contractors will develop and present a series of educational initiatives to advance and support, the adoption and implementation of meaningful use of the certified electronic health record by the provider networks.

Other related educational initiatives/programs will be developed and offered to assure the adequate use of the electronic health records to include the following;



- the health information exchange between providers and between providers and the contractors for the benefit of the patient care;

- the privacy and security (Privacy Framework) of the electronic management of patient health information in compliance with the federal and state regulations; and

- the patients insured by *GHP* are informed about the benefits of the electronic health record and the health information exchange between their health care providers.

2. Ensure the Health Care Provider Networks Comply with Meaningful Use Care Goals

-In order to comply with the Federal Government's guidelines of what constitutes a "Meaningful Use" performance, ASES envisions that their provider networks will achieve meaningful use within the CMS program requirements. ASES and the contractors will work together to monitor the provider's engagement in a Health Information Organization and participate in the health information exchange platform.

3. Monitoring EHR Adoption and PRHIN (STATE HIE) Engagement

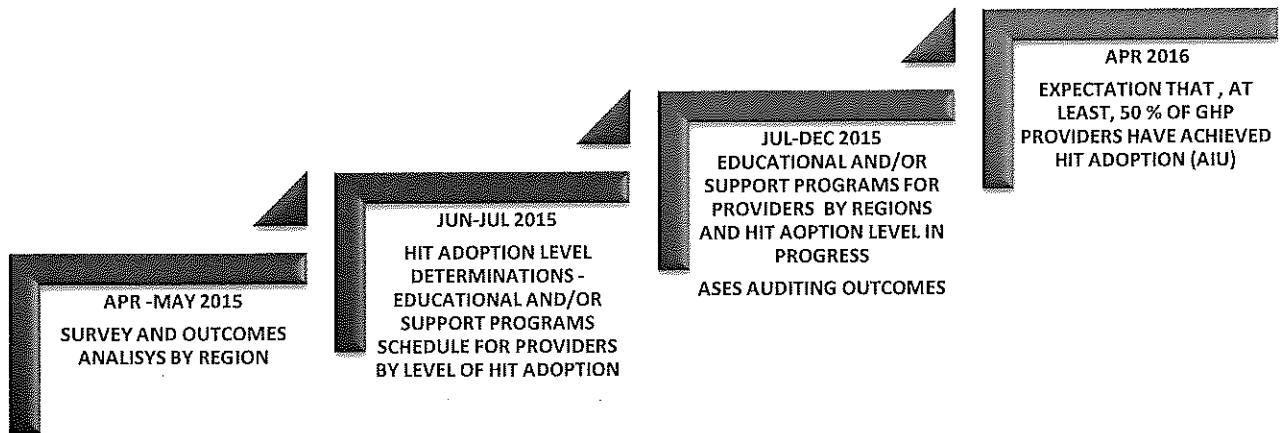
The MCO will develop a milestone and auditing program to be shared with the provider networks to measure EHR adoption and implementation. By measuring the progress, the MCO will be able to identify areas where EHR adoption and/ or PRHIN (STATE HIE) engagement are successful and where more effort is needed to help certain providers so that ongoing progress towards meeting the CMS deadlines is maintained. As a result, the MCO must report ASES the milestones achieved and the findings results from the audits performed.

ASES, as the agency responsible for the implementing the GHP, will start the monitoring program using CMS requirements, as included in the contract ASES will work on a systematic measurement program that will produce reporting to demonstrate and/or validate the GHP provider networks performance. The monitoring program will include:

- Monthly periodic reporting of EHR adoption and PRHIN (STATE HIE) engagement;
- Reporting requirements aligned with CMS EHR Meaningful Use criteria, CMS quality reporting and/ other data fields required by ASES;



HIT ADOPTION AND PRHIN (STATE HIE) ENGAGEMENT EXPECTED TIMELINE



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HIT ADOPTION AND PRHIN (STATE HIE) ENGAGEMENT OPERATIONAL PLAN

GOAL I.

Promote and require the GHP health care provider networks to adopt meaningful use of a certified electronic health record (EHR) and an active exchange of patient health information through a health information exchange PRHIN (STATE HIE)

OBJECTIVES	STRATEGIES	DATE
I.A. To obtain real time data on the GHP health care provider networks and the current status of their adoption and implementation of an EHR, Meaningful Use compliance, and their active participation in the PRHIN (STATE HIE).	I.A.1 Develop and submit to ASES for approval a survey tool related to the adoption and implementation of a certified EHR by the GHP healthcare providers and their participation in the PRHIN (STATE HIE). Preferably, the survey tool should be on-line.	April 6-17, 2015
	I.A.2 Submit the EHR Adoption Survey to the providers. EHR Adoption Survey MUST be completed by <u>May 8, 2015</u> .	April 20-May 8, 2015
	I.A.3 Collection and analysis of the EHR Adoption Survey results the contractors. Determine providers' EHR adoption levels by Region. Preferably, the survey tool should be on-line.	May 11-29, 2015
	I.A.4 Develop the EHR Adoption Communication/Education Plan for GHP health care provider networks in compliance with federal and state requirements. The EHR Adoption Communication/Education Plan will specify those GHP network providers that require additional targeted educational initiatives to be provided in order to accelerate adoption and effective use of EHRs within the GHP provider networks. Submit the EHR Adoption Communication/Education Plan for the GHP Health care provider networks to ASES for approval.	June 1-19, 2015
	I.A.5 The MCO will be responsible to discuss GHP Insured Population/ Patient Education Plan with providers; encourage health care providers for the incorporation of privacy and security policies and procedures; and provide monitoring results to ASES.	June 22-July 10, 2015
I.B Develop and schedule the educational initiatives to be offered to GHP health care providers	I.B.1 Educational initiatives begin targeting providers by EHR Adoption levels. Educational programs must include: <ul style="list-style-type: none"> • EHR adoption policy – federal and state overview • EHR Medicaid Incentive Program • Federal and State legal framework • Level of meaningful use compliance • Privacy and Security Frameworks • Health Information Exchange Platform – Active Participation Requirements 	July 13 – September 4, 2015



- Patients' Rights
- Quality Improvement Programs/Measures Requirements

I.B.2 MCO will schedule the continuing education program for the GHP network providers along with the communication and engagement process for the health care providers.

September 7 -
25, 2015

I.B.3 MCO will conduct follow up surveys to audit the health care provider networks progress in increasing their EHR Adoption level and must provide findings to ASES.

September 28 -
November 27,
2015

GOAL 2.

Ensure that health care provider networks to comply with Meaningful Use Goals

OBJECTIVES	STRATEGIES	DATE
2.A Monitor the Medicaid Meaningful Use certification process and compare with the data obtained under the educational program - follow up surveys	2.A.1 MCO will compare the results obtained from the follow up surveys from health care provider networks related to their progress in EHR Adoption level and the Meaningful Use Incentive Program	November 30 - December 18, 2015

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GOAL 3.**Monitoring EHR Adoption and PRHIN (STATE HIE) Engagement**

OBJECTIVES	STRATEGIES	DATE
3.A Report and analyze progress on EHR educational program	3.A.1 MCO will implement policies that require EHR and engagement with PRHIN (STATE HIE) the standard business practice for GHP Network Providers.	January 11-29, 2016
3.B Integrate a Quality Improvement Culture into GHP Provider Network	3.B.1 MCO will align EHR standards for quality measurements and improvements across GHP/Medicaid and Medicare programs.	January 11-29, 2016
	3.B.2 MCO will accelerate alignment and implementation of electronic clinical quality measures and electronic reporting	February 1- April 1, 2016
	3.B.3 ASES will develop standards and policies to enable electronic management of patient consent forms and PRHIN (STATE HIE) among GHP Network Providers with sensitive health data such as mental and behavioral health conditions.	April 4 –June 3, 2016
	3.B.4 ASES and the contractors will conduct follow up surveys to audit the health care provider networks progress in their HIT adoption, PRHIN (STATE HIE) participation, and quality measurement programs progress	June 6 – September 30, 2016





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PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (18)

BUSINESS ASSOCIATE AGREEMENT



2015-000086

Business Associate Agreement

THIS AGREEMENT is made by and between **Molina Healthcare of PR, Inc.**, having its principal offices located at San Juan, PR (“Business Associate”) and **The Puerto Rico Health Insurance Administration (PRHIA)** (“Covered Entity”) having its principal offices located at San Juan, Puerto Rico. Covered Entity and Business Associate, collectively, may hereinafter be referred to as the “Parties,” as in the parties to this Agreement.

WHEREAS, Covered Entity and Business Associate are parties to one or more agreements and/or may in the future become parties to additional agreements (collectively, the “Underlying Agreements”), pursuant to which Business Associate provides certain services to Covered Entity and, in connection with such services, creates, receives, uses or discloses for or on behalf of Covered Entity certain individually identifiable Protected Health Information relating to patients and/or insured members of Covered Entity (“PHI”) that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 as amended by the Health Information Technology for Economic and Clinical Health Act Title XIII of Division A of the American Recovery and Reinvestment Act, 2009 (HITECH Act) and regulations promulgated there under, as such law and regulations may be amended from time to time (collectively, “HIPAA”); and

WHEREAS, Covered Entity and Business Associate wish to comply in all respects with the requirements of HIPAA, including requirements applicable to the relationship between a Covered Entity and its Business Associates;

Section 1. Definitions.

- a. “Breach” shall have same meaning given to such term as defined in 45 CFR § 164.402.
- b. “Business Associate” shall have the same meaning given to such term as defined in 45 CFR § 160.103.
- c. “Covered Entity” shall have the same meaning given to such term as defined in 45 CFR § 160.103.
- d. “Designated Record Set” shall have the same meaning given to such term as defined in 45 CFR § 164.501.



- e. "Disclosure" shall have the same meaning given to such term as defined in 45 CFR §160.103.
- f. "Electronic Protected Health Information" or "e-PHI" shall have the same meaning given to such term as defined in 45 CFR §160.103 limited to the information transmitted or maintained by the Business Associate in electronic form format or media.
- g. "Individual" shall have the same meaning given to such term as defined in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
- h. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E respectively.
- i. "Protected Health Information" or "PHI" shall have the same meaning given to such term as defined in 45 CFR §160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- j. "Required By Law" shall have the same meaning given to such term as defined in 45 CFR § 164.103 and The Health Information Technology for Economic and Clinical Health Act (HITECH) Division A: Title XIII, Subtitle D.
- k. "Security" or "Security Measures" encompass all of the administrative, physical, and technical safeguards in an information system specified in subpart C of 45, CFR § 164.
- l. "Security Rule" shall mean the Standards for Security of Electronic Protected Health Information as specified in subparts A and C in 45 C.F.R. Parts 160 and 164, respectively.
- m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

Section 2. Obligations and Activities of Business Associate.

2.1 Business Associate may not use or disclose Protected Health Information other than as permitted or required by the Underlying Agreement or as Required by Law.

2.2 Business Associate agrees to use appropriate safeguards, including without limitation, administrative, physical and technical safeguards, to prevent use or Disclosure of the Protected Health Information other than as provided for by this Agreement and to reasonably and appropriately employ the same standards as Required by Law to, protect the confidentiality, integrity and availability of any



Electronic Protected Health Information (e-PHI) that it may receive, maintain or transmit on behalf of the Covered Entity.

2.3 Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or Disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

2.4 Business Associate agrees to report to Covered Entity any use or Disclosure of the Protected Health Information not provided for by this Agreement or any Security incident resulting in an unauthorized access or acquisition of e-PHI, of which it becomes aware, involving Protected Health Information of the Covered Entity.

2.5 Business Associate must in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors, agents or affiliates of the Business Associate, that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information. Business Associate must obtain satisfactory assurances in the form of a written agreement or memorandum of understanding directly from subcontractors stipulating that the subcontractor agrees to comply with the terms and conditions of the Business Associate Agreement. Business Associate must ensure that any agent or subcontractor to whom the Business Associate provides PHI, not export PHI beyond the borders of the Commonwealth of Puerto Rico without express written agreement of the Covered Entity.

2.6 Business Associate agrees to provide access, at the written request of Covered Entity, and in the time and manner designated by Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity in order to meet the requirements under 45 CFR §164.524.

2.7 Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR §164.526 at the written request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.

2.8 Business Associate agrees to make available internal practices, books, and records relating to the use and Disclosure of Protected Health Information



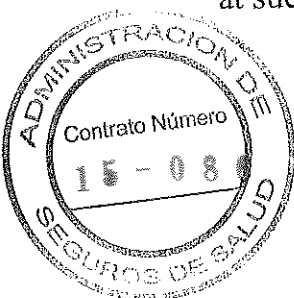
received from, or created or received by Business Associate on behalf of, Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy and Security Rules.

2.9 Business Associate agrees to document such Disclosures of Protected Health Information and information related to such Disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of Disclosures of Protected Health Information in accordance with 45 CFR §164.528.

2.10 Business Associate agrees to provide to Covered Entity or an Individual, in time and manner designated by Covered Entity, information collected in accordance with Section (1)(i) of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of Disclosures of Protected Health Information in accordance with 45 CFR §164.528.

2.11 Business Associate understands and agrees that it will not access or use any Protected Health Information of any Individual except for those Individuals whose PHI has been disclosed to Business Associate and it will further limit access to that Protected Health Information that is necessary to the activities undertaken by Business Associate on behalf of Covered Entity.

2.13 Business Associate will, pursuant to the HITECH Act and its implementing regulations, comply with the requirements of the Privacy Rule, including those contained in 45 CFR §§ 164.502(e) and 164.504(e)(1)(ii), at such time as the requirements are applicable to Business Associate. Business Associate will not directly or indirectly receive remuneration in exchange for any Protected Health Information, subject to the exceptions contained in the HITECH Act, without a valid authorization from the applicable Individual. Business Associate will not engage in any communication which might be deemed to be "Marketing" under the HITECH Act. In addition, Business Associate will, pursuant to the HITECH Act and its implementing regulations, comply with all applicable requirements of the Security Rule, contained in 45 CFR § 164.308, 164.310, 164.312 and 164.316, at such time as the requirements are applicable to Business Associate.



Section 3. Permitted Uses and Disclosures by Business Associate.

3.1 In case Business Associate obtains or creates Protected Health Information, Business Associate may use or disclose Protected Health Information, or any information derived from that Protected Health Information, only as explicitly permitted in the underlying agreement, and only if such use or Disclosure, respectively, is in compliance with each applicable requirement of 45 CFR § 164.504(e). It means that:

3.1.1 Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

3.1.2 Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that Disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person/organization to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person/organization, and the person/organization notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been Breached.

3.1.3 In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.

3.2 Business Associate understands and agrees that its access to Protected Health Information stored in databases and information systems at the Covered Entity is subject to review and audit by the Covered Entity or agents of the HHS and OCR at any time, that remote audits of such access may occur at any time, that on-site



audits of such access will be conducted during regular business hours, and that any review or audit may occur with or without prior notice by the Covered Entity.

Section 4. Application of Security and Privacy Provisions to Business Associate.

4.1 Security Measures: 45 CFR §164.308, 164.310, 164.312 and 164.316, dealing with the administrative, physical and technical safeguards as well as policies, procedures and documentation requirements that apply to Covered Entity shall in the same manner apply to Business Associate as Required By Law. Any additional Security requirements contained in Division A Title XIII Health Information Technology of the American Recovery and Reinvestment Act that apply to Covered Entity shall also apply to Business Associate as of February 17, 2010. Business Associates that require access to Covered Entity electronic patient information systems, electronic health record (EHR) and electronic infrastructure systems (either on site or remote) will supply the necessary information of employees to uniquely identify such employees, as employees with a need to access systems and will supply to Covered Entity Information Security Officer a valid state or federal issued photo ID for such employees to receive a unique user name and password to access the system(s).

4.2 Application of Civil and Criminal Penalties- If Business Associate violates any Security provision as Required By Law specified in Section 4.1 above, sections 1176 and 1177 of the Social Security Act 42 U.S.C. §1320d-5, 1320d-6 shall apply to Business Associate with respect to such violation in the same manner that such sections apply to Covered Entity if it violates such Security provision.

Section 5. Information Breach Notification Requirements.

5.1 Business Associate expressly recognizes that Covered Entity has certain reporting and Disclosure obligations to the Secretary of the Department of Health and Human Services and the Individual in case of a Security Breach of unsecured Protected Health Information (as defined in 45 CFR §164.402).

5.2 Where Business Associate accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured Protected Health Information, Business Associate without unreasonable delay and in no case later than thirty (30) days following the discovery of a Breach of such information, shall notify Covered Entity of such Breach. Such notice shall include the identification of each Individual whose unsecured Protected Health Information



has been, or is reasonably believed by the Business Associate to have been, accessed, acquired or disclosed during the Breach.

5.3 Business Associate shall be liable for the costs associated with such Breach if caused by the Business Associate's negligent or willful acts or omissions, or the negligent or willful acts or omissions of Business Associate's agents, officers, employees or subcontractors.

Section 6. Insurance and Indemnification

6.1 Indemnification. The Business Associate agrees to indemnify, defend and hold harmless Covered Entity and Covered Entity's employees, directors, officers, subcontractors, agents or other members of its workforce from any costs, damages, expenses, judgments, losses, and attorney's fees arising from any breach of this Agreement by Business Associate, or arising from any negligent or wrongful acts or omissions of Business Associate, including failure to perform its obligations under the Privacy Rule. The Business Associate's indemnification obligation shall survive the expiration or termination of this Agreement for any reason.

Section 7. Terms and Termination.

7.1 Term. The Term of this Agreement shall commence as of the Effective Date (as defined below), and shall terminate on the termination date of the underlying agreement or on the date Covered Entity terminates this agreement for cause as authorized on paragraph (7.2) of this section, whichever is sooner.

7.2 Termination for Cause. The parties acknowledge that in the event the Covered Entity learns of a pattern or activity or practice of the Business Associate that constitutes violation of a material term of this Agreement, then the parties promptly shall take reasonable steps to cure the violation. If such steps are, in the judgment of the Covered Entity, unsuccessful, ineffective or not feasible, then the Covered Entity may terminate, in its sole discretion, any or all of the Underlying Agreements upon written notice to the Business Associate, if feasible, and if not feasible, shall report the violation to the Secretary of the Department of Health and Human Services.

7.3 Effect of Termination. Except as provided in paragraph (2) of this section, upon termination of this Agreement or the Underlying Agreement(s) for any reason, Business Associate shall return or destroy all Protected Health Information



pursuant to 45 C.F.R. § 164.504(e)(2)(I) received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification, in writing, of the conditions that make return or destruction infeasible. Said notification shall include: (i) a statement that the Business Associate has determined that it is not feasible to return or destroy the Protected Health Information in its possession, and (ii) the specific reasons for such determination. The Covered Entity may disagree with the Business Associate's determination. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and Disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for as long as Business Associate maintains such Protected Health Information. If it is infeasible for the Business Associates to obtain, from a subcontractor or agent, any Protected Health Information in the possession of the subcontractor or agent, the Business Associate must provide a written explanation to Covered Entity and require the subcontractors and agents to agree to extend any and all protections, limitations, and restrictions contained in this Agreement to the subcontractors; and/or agents' use and/or Disclosure of any Protected Health Information retained after the termination of this Agreement, and to limit any further uses and/or Disclosures to the purposes that make the return or destruction of Protected Health Information infeasible.

7.4 Automatic Termination. This agreement will automatically terminate without any further action of the Parties upon termination or expiration of the Underlying Agreement.

7.5 Effective Date. The effective date of this Agreement (the "Effective Date") shall be the date of the last signature below.

Section 8. Miscellaneous



8.1 Regulatory References. A reference in this Agreement to a section in the Privacy and Security Rules means the section as in effect or as amended, and for which compliance is required.

8.2 Agreement. The Parties agree to take such action as is necessary to amend the Underlying Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the HIPAA; provided.

8.3 Amendments; Waiver. This agreement may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the Parties. A waiver with respect to one event shall not be construed as continuing, or as a bar to a waiver of any right or remedy as to subsequent events. The Parties agree to take such action as is necessary to amend this agreement from time to time as is necessary for compliance with the requirements of the HIPAA rules and any other applicable law.

8.4 Survival. The respective rights and obligations of Business Associate under this Agreement and Covered Entity under this Agreement shall survive the termination of this Agreement and/or the Underlying Agreements, as shall the rights of access and inspection of Covered Entity.

8.5 No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

8.6 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Privacy and Security Rules.



Fred Gordo
President
Molina Health Care of PR, Inc.
SS#: 66-0817946



Ricardo A. Rivera Cardona
Executive Director
PR Health Insurance Administration
SS# 66-0500678





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PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (19)

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QUALITY IMPROVEMENT PROCEDURE MANUAL

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**PUERTO RICO HEALTH INSURANCE ADMINISTRATION
COMMONWEALTH OF PUERTO RICO
PLANNING AND QUALITY AFFAIRS OFFICE**

**QUALITY IMPROVEMENT PROCEDURE MANUAL
Version 2.1**



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I. Table of Contents

II. INTRODUCTION	3
III. RETENTION FUND	3
IV. DEFINITIONS.....	4
V. PREVENTIVE CLINICAL PROGRAMS	6
VI. PERFORMANCE MEASURES	12
VII. ER QUALITY PROGRAM	17
VIII. CONCLUSION.....	18

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Year 2014

II. INTRODUCTION

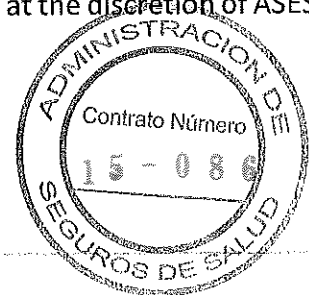
This Quality Improvement Procedure Manual has the sole purpose of providing the necessary guidelines for attaining the required performance indicators for each of the categories measured under the Quality Incentive Program (QIP), as described in Article 12 of the contract executed between the Contractor and the Puerto Rico Health Insurance Administration (ASES, by its acronym in Spanish). ASES shall maintain a Retention Fund of the Per Member Per Month (PMPM) each month as part of the Quality Incentive Program described in Section 12.5.3 A portion of the retained amount shall be associated with each of the Quality Incentive initiatives outlined below:

- Performance measures (Section 12.5.4.1)
- Preventive Clinical Programs (Section 12.5.4.2)
- Emergency Room Use Indicators (Section 12.5.4.3)

ASES will reimburse the Contractor according to compliance with each of the categories of performance indicators in section 12.5. The Planning and Quality Affairs Office will audit the results of the data in the timeframes stated in Section 12.5 of the Contract for the performance indicators in the following categories: Performance measures, Preventive clinical program measures, and ER Utilization measures. This Manual describes in detail the requirements and the specific metrics for each category of the Quality Incentive Program. The Quality Improvement Procedure Manual will enter in effect the Effective Date of the Contract and will be revised every contract year unless required in another timeframe by law or regulation, at the discretion of ASES or by mutual agreement during the term of the contract year.

III. RETENTION FUND

ASES will withhold a portion of annual PMPM otherwise payable to the Contractor in order to incent the Contractor to meet performance targets under the Quality Incentive Program. The



retention fund will be reimbursed to the Contractor when a determination is made by ASES that the Contractor has complied with the quality standards and criteria established by ASES in accordance with 22.3 of the contract. On a quarterly basis the Contractor will submit a quarterly *Retention Fund Report* in accordance to 18.2.9.4 of the contract.

On a monthly basis, ASES will maintain a retention fund according to the following timeframes:

Time Period (Relative Effective Data of Contract Term)	Retention Fund Percentage
4/1/2015 through 12/31/2015	0 % (9 month baseline)
1/1/2016 through 6/30/2016	1% (until end of FY16)
7/1/2016 through 6/30/2017	2% (until end of FY17)

A portion of the retained amount will be associated with each of the Quality Incentive initiatives outlined below for each of the specified timeframes:

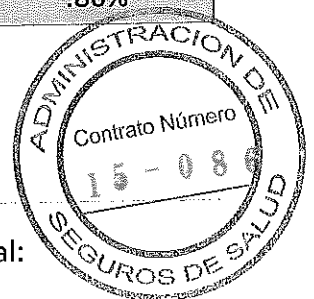
QIP Initiative Year	Retention Fund Breakdown		
	CY 15 (0%) ¹	FY 16 (1%)	FY 17 (2%)
Performance Measures	0%	.40%	.80%
Preventive Clinical Programs	0%	.20%	.40%
Emergency Room Use Indicators	0%	.40%	.80%

IV. DEFINITIONS

The following definitions apply to measures of the Quality Improvement Manual:

1. **Care Management:** An Administrative Function comprised of a set of Enrollee-centered steps to ensure that an Enrollee with intensive needs, including catastrophic or high-risk

¹ The first 9 months from the date of an executed contract ASES will not withhold a retention fund. The first 9 month time period will be used a grace period to determine baseline data for each QIP initiative. The period will end on 12/31/2015. At that time a 1% Retention Fund withholds will be activated.



conditions (described in Attachment 7 of the Contract), receives needed services in a supportive, effective, efficient, timely, and cost-effective manner.

2. **Disease Management:** An Administrative Function comprised of a set of Enrollee-centered steps to provide coordinated care to Enrollees suffering from diseases listed in Section [7.8.3] of this Contract.
3. **Hot Spotting:** The ability to identify in a timely manner heavy users of the systems and their patterns of utilization to provide targeted interventions and care through mapping data.
4. **Incurred date:** Is the date in which the service took place.
5. **Intervention:** activities targeted at the achievement of client stability, wellness, and autonomy through advocacy, assessment, planning, communication, education, resource management, care coordination, collaboration, and service facilitation.
6. **Performance measures:** regular measurement of outcomes and results, which generates reliable data on the effectiveness and efficiency of programs.
7. **Per member per month payment (PMPM):** The fixed monthly amount that the Contractor is paid by ASES for each Enrollee to ensure that Benefits under this Contract are provided. This payment is made regardless of whether the Enrollee receives Benefits during the period covered by the payment.
8. **Preventive Services:** Health care services provided by a physician or other Provider within the scope of his or her practice under Puerto Rico law to detect or prevent disease, disability, Behavioral Health conditions, or other health conditions; and to promote physical and Behavioral Health and efficiency.
9. **Primary Care Physician:** A licensed medical doctor (MD) who is a Provider and who, within the scope of practice and in accordance with Puerto Rico Certification and licensure requirements, is responsible for providing all required Primary Care to Enrollees. The PCP is responsible for determining services required by Enrollees, provides continuity of care, and provides Referrals for Enrollees when Medically Necessary. A PCP may be a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.
10. **Retention Fund:** The amount of Withhold by ASES of the monthly Per Member per Month Payments otherwise payable to the Contractor in order to incentivize the Contractor to meet performance targets under the Quality Incentive Program described in Section [12.5.3]. This amount shall be **equal to** the percent of that portion of the total Per Member per Month Payment that is determined to be attributable to the Contractor's administration of the Quality Incentive Program described in Sections [12.5 and 22.3]. Amounts withheld will be reimbursed to the Contractor in whole or in part (as set forth in Sections [12.5 and 22.3]) in the event of a determination by ASES that the Contractor has complied with the quality standards and criteria established by Section [12.5].
11. **Special Coverage:** A component of Covered Services provided by the Contractor, described in Section [7.7], which are more extensive than the Basic Coverage services,



and for which Enrollees are eligible only by "registering." Registration for Special Coverage is based on intensive medical needs occasioned by serious illness.

12. **Quality Incentive Program:** mechanism to improve the quality of services provided to Enrollees. The program shall consist of three (3) categories of performance indicators: performance measures, preventive clinical program measures and ER Utilization measures.

V. PREVENTIVE CLINICAL PROGRAMS

The Contractor shall comply with the objectives of each of the following Preventive Clinical Programs as stated in the GHP Contract in section 12.5.4.2. The Preventive Clinical Programs are:

1. Pre-Natal and Maternal Program as described in 7.5.8.3 of the Contract.
2. Wellness Plan as described in section 12.5.8 of the Contract.
3. Care Management as described in section 7.8.2 of the Contract.
4. Disease Management as described in 7.8.3 of the Contract.
5. Provider Education as described in section 10.2.2 of the Contract.
6. Physician Incentive Programs as described in section 10.7 of the Contract.

ASES shall release to the Contractor, in accordance with Section 22.3, the applicable percent (see table below) of the Retention fund for compliance with the objectives for each of the Preventive Clinical Programs.

QIP Initiative	Retention Fund Breakdown		
	CY 15 (0%) ²	FY 16 (1%)	FY 17 (2%)
Preventive Clinical Programs	0%	.20%	.40%



² The first 9 months from the date of an executed contract ASES will not withhold a retention fund. The first 9 month time period will be used a grace period to determine baseline data for each QIP initiative. The period will end on 12/31/2015. At that time a 1% Retention Fund withholds will be activated.

1. Prenatal and Maternal Plan

Goal Statement: Increase the number of pregnant women who receive early prenatal care.

REPORTING: For each region, report the following metrics for enrollees receiving prenatal and maternal services:

- Number of pregnant women enrolled in GHP by trimester and age;
- Number of pregnant women enrolled in GHP by trimester and age who received HIV tests;
- Number of pregnant women screened for substance abuse with the 4P Plus screening tool;
- Number of pregnant women in postpartum care screened for depression with the Edinburgh screening tool;
- Number of pregnant women who received educational interventions.

OUTCOME(S): Increase annually by 3% the number of pregnant women with HIV tests in the First and Third Trimester as established by public policy of the Department of Health.

- In quarters 1-3 the Contractor will report the number of Providers (OB-GYN) and pregnant enrollees with educational interventions.
- In the 4th quarter the Contractor will report the 3% increase in HIV tests among pregnant enrollees using as comparison the trend of HIV testing in births from August 1, 2013 through April 30, 2014.
- Screen 50% of pregnant women registered by quarter for alcohol and tobacco use with 4P Plus screening tool.
 - Report the number of cases referred to the behavioral health provider for smoking cessation counseling and treatment.
- Screen 50% of women in postpartum period during the measurement quarter for Depression using Edinburgh screening tool.
 - Report the number of cases referred to the behavioral health provider with an Edinburgh score of 10 or above.
- Reach 70% of pregnant women in registry with educational interventions regarding Prenatal care in the following topics :
 1. Importance of Prenatal and Postpartum visits.
 2. Breastfeeding
 3. Stages of birth
 4. Oral Health
 5. Family Planning
 6. Behavioral Health topics in the areas of Domestic Violence, Post partum Depression, Tobacco Cessation, Alcohol Use/Abstinence and Substance Abuse,



Parenting, HIV Screening and prevention and socio emotional screening in children.

7. Newborn Care



2. Wellness Program:

Goal Statement: Increase the number of members who receive preventive health information and services.

OUTCOME(S):

- Develop 5 educational campaigns on the following topics to be applied during the measurement year:
 - a. Nutrition and Exercise; Knowing your BMI
 - b. Importance of preventive dental exam
 - c. Awareness of HPV vaccination
 - d. Preventive Cancer Screening (PAPS, Mammography, Oral cancer examination).
 - e. Stress Management
- *Minimum 1 educational campaign by quarter.*

The Contractor shall submit a detailed description of the Educational Campaign and copies of all materials (written and oral) that it or its Subcontractors plan to distribute to ASES for review and approval. This requirement includes, but is not limited to posters, brochures, Web sites, and any other related materials. Neither the Contractor nor its Subcontractors shall distribute any materials without prior written approval from ASES.

EPSDT:

- Quarterly educational outreach for PCPs providing a list of EPSDT eligible children who are not in compliance with periodicity schedule.
- The Contractor shall provide to each PCP, at least four times per year (April, July, November and January), a list of the PCP's EPSDT Eligible Children who are not in compliance with the EPSDT periodicity Schedule.

3. Care Management Program

Goal Statement: Achievement of optimal health, integration of Physical Health and Behavioral Health services, access to care and appropriate utilization of resources, balanced with the patient's right to self-determination.

OUTCOME(s):

- New cases
 - Report on the number of new enrollees in Care Management in the following categories:
 - Enrollees with special health care needs who qualify for Special Coverage
 - Enrollees diagnosed with a Serious Mental Illness or a Serious Emotional Disability ("SMI/SED")
 - Enrollees participating in the Buprenorphine program
 - Enrollees who have accessed the emergency room seven (7) or more times within twelve (12) months
 - Enrollees who are pregnant and have a behavioral health diagnosis.
 - Report on Prior Authorizations (PA) and Prior Authorization denials on each condition on special coverage registry and SMI/SED including Buprenorphine program)
- Screen at least 50% of adult members registered in Special Coverage for depression using PHQ-9³ screening tool.
 - Report the number of cases referred to the behavioral health provider with a PHQ-9 score of 10 or above.

4. Disease Management Program

Goal Statement: Enhance the treatment and prevention of diseases that contribute most heavily to the causes of death.

OUTCOME(s):

- Submit a hot spotting report by Region, PMG and municipality of residence of enrollees stratified by the following conditions:
 - Asthma
 - Diabetes (Type 1 or 2)
 - Congestive Heart Failure
 - Hypertension
 - Chronic renal disease (Stages 1 and 2)
 - Obesity
 - Mental health disorders
 - Alcohol abuse or dependence
 - Substance use disorders



³ PHQ-9: Patient Health Questionnaire – 9 (Screening for depression)

The report must include: number of severe cases identified, percent of severe cases among PMG population, number of active cases, number of health cases referred to mental health treatment, and the number of interventions (educational and care coordination) performed for the population identified.

Minimum per quarter: one intervention by member.

5. Provider Education

Goal Statement: The Provider Education Program is aimed to promote compliance with clinical quality guidelines and standards among all primary care physicians, and to keep them up to date regarding the best practices in the managed care model.

OUTCOME(s):

Provide educational activities to PCP and BHPCPs in coordination with the PBM providers for the following topics:

- Primary Care Integration Model
- Poly-pharmacy
- EHR Poly-pharmacy
- Electronic Health Records/e-prescribing
- Diabetes Care Management
- Renal Clinical Guidelines
- Quality Incentive Program Guidelines
- Mental health conditions
- Working with patients with conditions of special concern, including autism, ADHD, depression, diabetes, alcohol and substance abuse, tobacco cessation, among others.



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The Contractor must provide a minimum of 5 hours per quarter for a total of 20 hours per year. A report on topics, contact hours, PBM and providers attending the activities will be provided each quarter.

- Reach 70% of PCPs (with 25 or more pediatric assigned lives) with technical assistance⁴ in the administration of MCHAT and Ages and Stages Questionnaire (ASQ) in their practices, with a minimum per quarter of 17.5%.

⁴ **Technical Assistance:** to assist providers to attain and maintain regulatory standards.

6. Physician Incentive Plan

Goal Statement: Ensure the participation and commitment of the PCPs to Preventive Services and improve the quality of the services to all members.

OUTCOME(s):

- Evaluate 100% of the PCPs through Medical Record Review:
 - The Contractor will submit in the first three quarters reports on the number of PCP evaluated and the score obtained by region and Integrated PMG.
 - By April 2014 the Contractor will provide a list by Integrated PMG and region of the certified PCP and BHP eligible for the financial incentive.



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VI. PERFORMANCE MEASURES

The reporting templates for each of the performance measures mentioned below will be provided to the Contractor through the ASES FTP site. Each reporting template will be in Excel format. ASES shall reimburse the Contractor the percent applicable of the Retention fund as shown in the following table in accordance with Section 22.3 of the contract for successful compliance with the performance measures below based upon annual evaluation of this criterion. The Contractor shall demonstrate a three percent (3%) increase in the measurement year **.75 quarterly**, for the following performance measures:

QIP Initiative	Retention Fund Breakdown		
	CY 15 (0%) ⁵	FY 16 (1%)	FY 17 (2%)
Performance Measures	0%	.40%	.80%

- Breast Cancer Screening
- Cervical Cancer Screening
- Cholesterol Management
- Diabetes Care Management
- Access to Preventive Care Visits
- Access to Dental Preventive Care Visits
- Timeliness in Prenatal Care
- Asthma Management
- Follow-up care for children prescribed ADHD medication
- Antidepressant medication management
- Initiation of drug or alcohol abuse treatment
- Follow up after hospitalization for mental health



The Performance Measures reports are based on claims incurred in the measurement period for each region. The Contractor shall provide data for each region in a separate tab and a summary tab that combines data for all regions.

For each report submission, the Contractor shall use the same template that was submitted in previous quarter(s). The Contractor may not update data submitted for previous reporting periods when new claims data is available. Then, with the 4th quarter submission, the Contractor may update data submitted for previous reporting periods ("year to date") as applicable.

⁵ The first 9 months from the date of an executed contract ASES will not withhold a retention fund. The first 9 month time period will be used a grace period to determine baseline data for each QIP initiative. The period will end on 12/31/2015. At that time a 1% Retention Fund withholds will be activated.

The Contractor shall submit the report with the following file name structure: Contractor Name_PM##_ Date Report Due (e.g. Contractor A_ PM01_ 20140150). The Contractor shall ensure that all data is captured in the workbook prior to submitting the report.

The 1st submission of the reports, excluding the Timeliness in Prenatal Care, will establish the baseline for each measure. Regarding the Timeliness in Prenatal Care, the Contractor will report the trend of the year prior the measurement year. The submissions dates for this reports will be provided by ASES through a normative letter with the established due dates.

SPECIAL AGREEMENTS

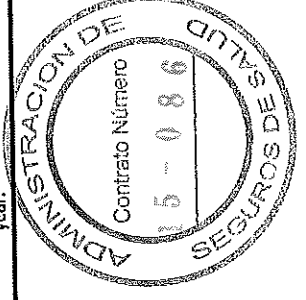
1. The Contractor shall demonstrate a sustained improvement by performance measure on a quarterly basis.
2. The number of members with a LDL-C screening during the measurement year will be evaluated in the Cholesterol Management for High Risk Population Performance Measure. The Contractor will include the results under the Diabetes Care Management for information purposes only.
3. Asthma Management for Contract Year 2015-2016
 - i. For this measure, PRHIA will evaluate, as the results of the Contractor interventions the population outreached for this purposes during the first to second quarter. At the end of the 3rd quarter onwards the Contractor will report the 3% increase of unique members identified as having persistent Asthma under control during the measurement year (Steps 2-5).
 - ii. Definitions of Treatment Steps are based on The Global Strategy for Asthma Management and Prevention (www.ginasthma.org).
4. Timeliness in Prenatal Care
 - i. PRHIA will evaluate the trend in the Contract Year 2015-16 of the pregnant members that initiate their prenatal care services during the Third Trimester. And for the next contract year will establish the numerator.



REQUIREMENTS BY PERFORMANCE MEASURE

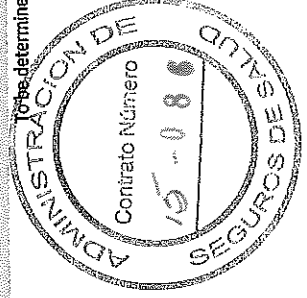
Physical Health

Measure	Measure Description	Denominator	Numerator
1 Breast Cancer Screening	The number of women 42-69 years of age who had a mammogram to screen breast cancer.	Indicate the number of women without a Breast cancer screening the year prior to the measurement year.	The number of women with a Breast Cancer Screening during the measurement year.
2 Cervical Cancer Screening	The number of women 24-64 years of age who receive one or more Pap Test to screen for cervical cancer.	Indicate the number of women without a Cervical cancer screening the year prior to the measurement year.	The number of women with a cervical cancer screening during the measurement year.
3 Cholesterol Management for High Risk Population	Members 18-75 years with a high risk diagnosis who have had a LDL-C screening.	Indicate the number of members without a LDL-C screening the year prior to the measurement year.	The number of members with a LDL-C screening during the measurement year.
4 Diabetes Care Management	Members 18-75 years of age with Diabetes (Type 1 or 2) who had each of the following screening tests: A1c, eye exam, LDL-C, nephropathy screening.	Indicate the number of members without a Microalbumin Test the year prior to the measurement year.	The number of Members in the denominator who have had a HgA1c Test, LDL-C Test, Eye Exam and Microalbumin Test respectively, during the measurement year.
5 Access to Preventive Visits	Members who had at least one preventive care visit with a PCP	Indicate the number of members without a preventive care visit with a PCP the year prior to the measurement year.	The number of members with a preventive care visits with a PCP during the measurement year.
6 Annual Dentist Visit	Members 2- 65 who had at least one preventive care visit with a dental provider	Indicate the number of unique members without a preventive care visit with a dental provider the year prior to the measurement year.	The number of members with a preventive care visits with a dental provider during the measurement year.
7 Timeliness in Prenatal Care	Period when pregnant members initiate prenatal care services	Indicate the number of pregnant members that initiate prenatal care services by gestational trimester during the measurement period.	N/A. PRHIA will evaluate the trend in the Fiscal Year 2013-14 of the pregnant members that initiate their prenatal care services during the Third Trimester. And for the next fiscal year will establish the numerator.
8 Asthma Management	Members who are identified as having persistent Asthma within the current year. Identify the persistent Asthma members by step therapy.	Indicate the number of unique members identified as having persistent Asthma with a lack of control the year prior to the measurement year.	The number of unique members identified as having persistent Asthma under control during the measurement year.

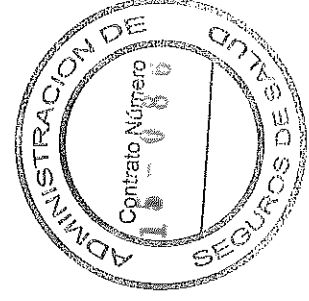


Behavioral Health

Measure	Measure Description	Denominator	Numerator
1 Follow-up care for children prescribed ADHD medication			
1-A Initiation Phase	Children ages 6-12 who were prescribed an ADHD medication and had a follow-up visit with a practitioner during the 30-day.	To be determined by ASES and MCO.	To be determined by ASES and MCO.
1-B Continuation/Maintenance Phase	Children ages 6-12 who were prescribed an ADHD medication, remained on the medication for at least 210 days and had two follow-up visits within the 9 month.	To be determined by ASES and MCO.	To be determined by ASES and MCO.
2 Antidepressant medication management	The percentage of Medicaid enrollees age 18 and older with a diagnosis of major depression that were newly treated with antidepressant medication, and remained on an antidepressant medication treatment. Two rates are reported:		
2A Effective Acute Phase Treatment	The percentage of newly diagnosed and treated Medicaid enrollees who remained on an antidepressant medication for at least 84 days (12 weeks).	To be determined by ASES and MCO.	To be determined by ASES and MCO.
2B Effective Continuation Phase Treatment	The percentage of newly diagnosed and treated Medicaid enrollees who remained on an antidepressant medication for at least 180 days (6 months).	To be determined by ASES and MCO.	To be determined by ASES and MCO.
3 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment			
3A Initiation of AOD Treatment	Adolescents and adults with a new episode of alcohol or other drug dependence (AOD) should have treatment initiated through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.	To be determined by ASES and MCO.	To be determined by ASES and MCO.



Measure	Measure Description	Denominator	Numerator
3B Engagement of AOD Treatment	Adolescents and adults who initiated treatment should have two or more additional services with a diagnosis of AOD within 30 days on the initiation visit.	To be determined by ASES and MCO.	To be determined by ASES and MCO.
4 1. Follow up after hospitalization for mental health	The percent of acute care facility discharges for enrollees who were hospitalized for a mental health diagnosis and were discharged to the community and were seen on an outpatient basis by a mental health practitioner within seven days and within 30 days.		
4A 7 days	The percent of acute care facility discharges for enrollees who were hospitalized for a mental health diagnosis and were discharged to the community and were seen on an outpatient basis by a mental health practitioner within seven days.	Discharges to the community from an acute care facility (inpatient or crisis stabilization unit) with a discharge diagnosis of ICD-9-CM codes 290.0 through 290.43, 293.0 through 298.9, 300.00 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9.	Discharges followed by an outpatient encounter with a mental health practitioner (see definition below) up to seven days after discharge.
4B 30 days	The percent of acute care facility discharges for enrollees who were hospitalized for a mental health diagnosis and were discharged to the community and were seen on an outpatient basis by a mental health practitioner within 30 days.	Discharges to the community from an acute care facility (inpatient or crisis stabilization unit) with a discharge diagnosis of ICD-9-CM codes 290.0 through 290.43, 293.0 through 298.9, 300.00 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9.	Discharges followed by an outpatient follow-up encounter with a mental health practitioner (see definition below) up to 30 days after discharge.




VII. ER QUALITY PROGRAM

Goal Statement: Develop an ER Quality Initiative Program focusing on reducing the inappropriate use of ER services.

The ER Quality Initiative Program shall be designed to identify high users of Emergency Services (including behavioral health) for non-emergency situations and to allow for early interventions in order to ensure appropriate utilization of services and resources. The program design required by ASES for the ER Quality Initiative will be based on the "Hot Spotting Model of the Camden Coalition of Health Providers". The activities for the work plan shall include, but not limited to, the following:

- Hot spotting report by Region, PMG and municipality of residence of enrollees by severity level.
- Establish outreach activities and care coordination for High ER utilizers.

Member identification will be as follows:



Severity Criteria	
Level 1: Mild	3-6 visits a year
Level 2: Moderate	7-11 visits a year
Level 3: Severe	12 or more visits a year

ASES will reimburse to the Contractor, in accordance with Section 22.3 the percent applicable of the Retention fund as shown in the table below for compliance with the above program based upon a quarterly review of the approved work plan.

QIP Initiative	Retention Fund Breakdown		
	CY 15 (0%) ⁶	FY 16 (1%)	FY 17 (2%)
Emergency Room Use Indicators	0%	.40%	.80%

⁶ The first 9 months from the date of an executed contract ASES will not withhold a retention fund. The first 9 month time period will be used a grace period to determine baseline data for each QIP initiative. The period will end on 12/31/2015. At that time a 1% Retention Fund withholds will be activated.

VIII. CONCLUSION

The compliance with the quality categories established in this Manual will be measured and shall be accomplished with by the Contractor on a quarterly basis. Contractor shall comply with the required quarterly metrics in order to receive the reimbursement of the amount retained by ASES for each quarter as defined in Section 22.3 of the Contract.



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PUERTO RICO

Administración de Seguros
de Salud de Puerto Rico (ASES)

PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

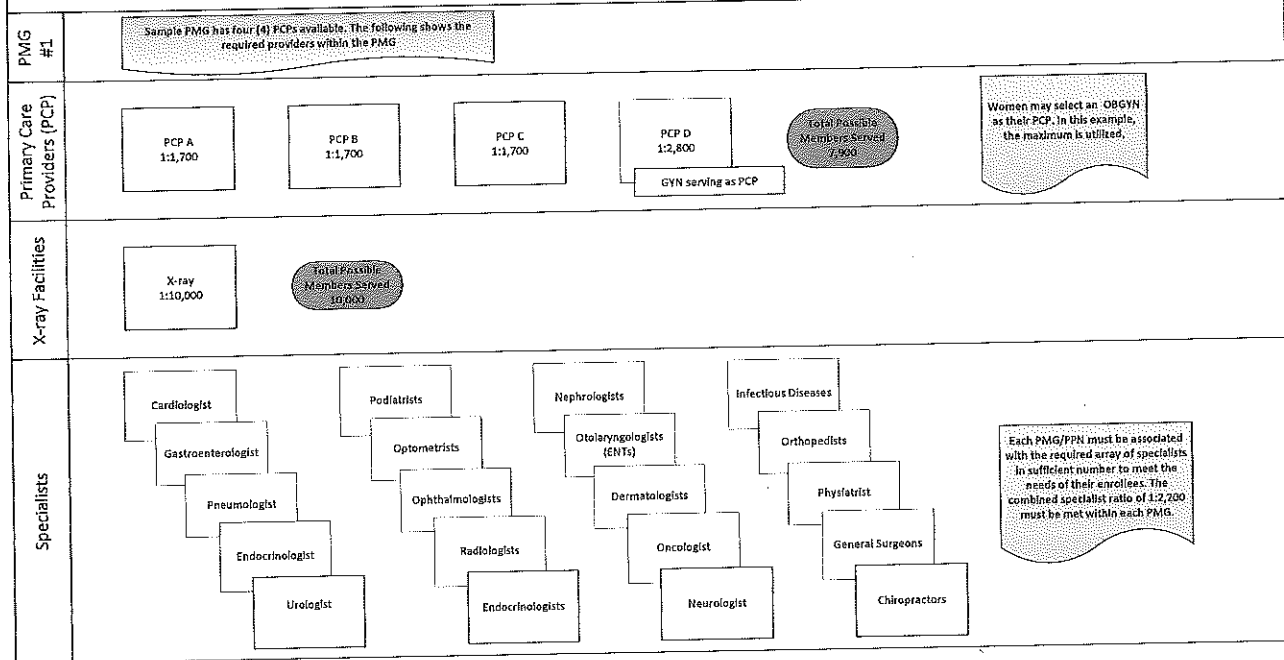
APPENDIX (20)

PREFERRED PROVIDER NETWORK DIAGRAM

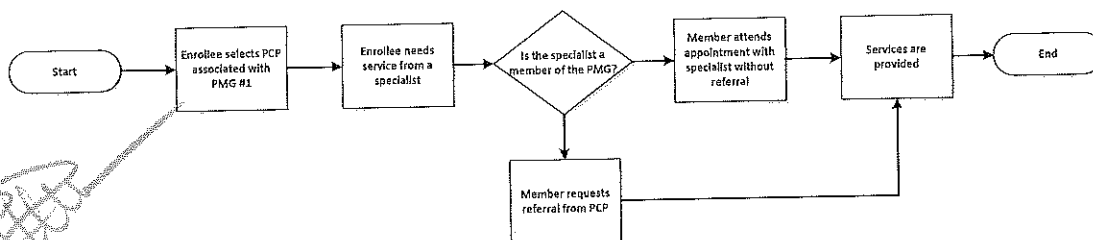


GHP Preferred Provider Network (PPN)

- Upon enrollment in GHP each enrollee is permitted to select a PCP.
- Each PCP is a member of a PMG – the providers associated with the PMG become the enrollees PPN.
- Each PMG must meet the ratio requirements described in Section 9.4 of the GHP contract
- Each PMG is designated as an individual PPN. Within a selected PMG as depicted below, the enrollee may access any provider within the selected PMG without a referral or co-pays.
- When an enrollee receives a prescription from any provider within the PMG, they may fill the prescription without the requirement of obtaining a counter-signature from the assigned Primary Care Provider (PCP)



Enrollee Movement within an individual PPN/PMG





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Administración de Seguros
de Salud de Puerto Rico (ASES)

PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (21)

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ASES GUIDELINES FOR REVERSE COLLOCATION

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ATTACHMENT 21

GUIDELINES FOR REVERSE COLLOCATION OF THE PRIMARY CARE PHYSICIANS IN MENTAL HEALTH FACILITIES

In accordance with the provisions of the Puerto Rico Mental Health Code, Law No. 408 of October 2, 2000, as amended, and the Puerto Rico Patient's Bill of Rights and Responsibilities, the Government Health Plan (GHP) is committed to promoting mental and physical health integration, in order to improve program effectiveness and quality of life for enrollees.

Reverse collocation is an integrated care model in which medical services are available to members being treated in behavioral health facilities. It has been known that patients with co-morbid conditions that include chronic or acute medical conditions and behavioral health diagnoses are at higher risk for increased utilization and costs in health care. Persons with serious mental illness have high levels of medical co-morbidity compared to the general population, as well as increased risk for diabetes, obesity, and high cholesterol due to the use of some second-generation antipsychotic medications (Milbank Memorial Fund, 2010)

In the reverse collocation model, a primary care physician is located part or full time in a behavioral health facility to monitor the physical health of patients.

Collocated Primary Care Physicians (PCPs) are independently sub-contracted and supervised by the contractor. They use the Behavioral Health Facility (BHF) records, and coordinate follow up with the member's PMG as necessary. The Collocated PCP can make the same primary interventions and referrals as any PCP in the PMG.

Behavioral Health Facilities (BHF)

The following BHF will be considered for purposes of the Reverse Collocation requirements.

1. Psychiatric Hospitals (or a unit within a general hospital)
2. Emergency or Stabilization Units
3. Partial Hospitalization Units
4. Intensive Ambulatory Services Units
5. Ambulatory Services Units
6. Addiction Services Unit (detoxification, ambulatory, inpatient)

Required Reverse Collocation Staff per BHF.

1. Ambulatory Services Units must have at least one collocated PCP 4 days per week for 4 hours.
2. Addiction Services Units must have at least one collocated PCP 3 days per week for 4 hours.
3. Psychiatric Hospitals are required to have at least a PCP on call on a daily basis.



4. Partial Hospitalization Units must have at least one collocated PCP 2 days per week for 4 hours.
5. Stabilization units must have one PCP for consultation (on call) on a daily basis.

In the event that a BHF does not comply with the required collocation level, may be subjected to penalties according to the following matrix:

Sanction Level	Sanction Type	Timeframe to cure	Comments
0	Notice of Non Compliance with Reverse Collocation Level and CAP	60 days (Day 1-60)	A corrective action plan ("CAP") will be required of every BHF that does not comply with the required Reverse Collocation level. All BHF with an approved CAP must comply with the terms of the CAP and achieve the required collocation within the timeframes established in the CAP.
1	Fine	30 days (Day 61-90)	Fines to be defined in accordance to contract.
2	Contract Cancelation	(Day 91)	



CONSENTIMIENTO PARA LA ESTERILIZACIÓN

NOTA: LA DECISIÓN DE NO ESTERILIZARSE QUE USTED PUEDE TOMAR EN CUALQUIER MOMENTO, NO CAUSARÁ EL RETIRO O LA RETENCIÓN DE NINGÚN BENEFICIO QUE LE SEA PROPORCIONADO POR PROGRAMAS O PROYECTOS QUE RECIBEN FONDOS FEDERALES.

■ CONSENTIMIENTO PARA ESTERILIZACIÓN ■

Yo he solicitado y he recibido información de

(médico o clínica)

sobre la esterilización. Cuando inicialmente solicité esta información, me dijeron que la decisión de ser esterilizada/o es completamente mía. Me dijeron que yo podía decidir no ser esterilizada/o. Si decido no esterilizarme, mi decisión no afectará mi derecho a recibir tratamiento o cuidados médicos en el futuro. No perderé ninguna asistencia o beneficios de programas patrocinados con fondos federales, tales como A.F. D. C. o Medicaid, que recibo actualmente o para los cuales seré elegible.

ENTIENDO QUE LA ESTERILIZACIÓN SE CONSIDERA UNA OPERACIÓN PERMANENTE E IRREVERSIBLE. YO HE DECIDIDO QUE NO QUIERO QUEDAR EMBARAZADA, NO QUIERO TENER HIJOS O NO QUIERO PROCREAR HIJOS.

Me informaron que me pueden proporcionar otros métodos de anticoncepción disponibles que son temporales y que permitirán que pueda tener o procrear hijos en el futuro. He rechazado estas opciones y he decidido ser esterilizada/o.

Entiendo que será esterilizada/o por medio de una operación conocida como _____.

Me han explicado las molestias, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la operación no se realizará hasta que hayan pasado 30 días, como mínimo, a partir de la fecha en la que firme esta Forma. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no ser esterilizada/o no resultará en la retención de beneficios o servicios médicos proporcionados a través de programas que reciben fondos federales.

Tengo por lo menos 21 años y nací el: _____ (día, mes, año)

Yo, _____, por medio de la presente doy mi consentimiento de mi libre voluntad para ser esterilizada/o por _____ (médico)

por el método llamado _____. Mi consentimiento vence 180 días a partir de la fecha en la que firme este documento.

También doy mi consentimiento para que se presente esta Forma y otros expediente médicos sobre la operación a:

Representantes del Departamento de Salud y Servicios Sociales, o Empleados de programas o proyectos financiados por ese Departamento, pero sólo para que puedan determinar si se han cumplido las leyes federales.

He recibido una copia de esta Forma.

(firma) fecha: _____ (día, mes, año)

Se ruega proporcione la siguiente información, aunque no es obligatorio hacerlo: (Definición de raza y origen étnico)

Origen étnico: ☐ Hispano o latino ☐ No hispano o latino
Raza (marque según aplique): ☐ Indígena americano o indígena de Alaska ☐ Asiático ☐ Negro o afroamericano ☐ Natural de Hawái u otras islas del Pacífico ☐ Blanco

■ DECLARACIÓN DEL INTÉRPRETE ■

Si se han proporcionado los servicios de un intérprete para asistir a la persona que será esterilizada:

He traducido la información y los consejos que verbalmente se le han presentado a la persona que será esterilizada/o por el individuo que ha obtenido este consentimiento. También le he leído a él/ella la Forma de consentimiento en idioma _____ he explicado el contenido de esta forma. A mi mejor saber y entender ella/él ha entendido esta explicación.

(firma del intérprete)

(fecha)

■ DECLARACIÓN DE LA PERSONA QUE OBTIENE CONSENTIMIENTO ■

Antes de que _____

(nombre de persona)

firmara la Forma de Consentimiento para la Esterilización, le he explicado a ella/él los detalles de la operación _____, para la

esterilización, el hecho de que el resultado de este procedimiento es final e irreversible, y las molestias, los riesgos y los beneficios asociados con este procedimiento.

He aconsejado a la persona que será esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le he explicado que la esterilización es diferente porque es permanente.

Le he explicado a la persona que será esterilizada que puede retirar su consentimiento en cualquier momento y que ella/él no perderá ningún servicio de salud o beneficio proporcionado con el patrocinio de fondos federales.

A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender la naturaleza del procedimiento y sus consecuencias.

(firma de la persona que obtiene el consentimiento) (fecha)

(lugar)

(dirección)

■ DECLARACIÓN DEL MÉDICO ■

Previamente a realizar la operación para la esterilización a

(nombre de persona esterilizada/o)

en _____ Le expliqué a él/ella los detalles de esta operación para la esterilización _____

(especifique tipo de operación)

del hecho de que es un procedimiento con un resultado final e irreversible, y las molestias, los riesgos y los beneficios asociados con esta operación.

Le aconsejé a la persona que sería esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le expliqué que la esterilización es diferente porque es permanente.

Le informé a la persona que sería esterilizada que podía retirar su consentimiento en cualquier momento y que ella/él no perdería ningún servicio de salud o ningún beneficio proporcionado con el patrocinio de fondos federales.

A mi mejor saber y entender, la persona que será esterilizada tiene a lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y libre voluntad ser esterilizada/o y parece entender el procedimiento y las consecuencias de este procedimiento.

(Instrucciones para uso alternativo de párrafos finales: Utilice el párrafo 1 que se presenta a continuación, excepto para casos de parto prematuro y cirugía abdominal de emergencia cuando se ha realizado la esterilización a menos de 30 días después de la fecha en la que la persona firmó la Forma de Consentimiento para la Esterilización. Para esos casos, utilice el párrafo 2 que se presenta más adelante. Tache con una X el párrafo que no se aplique.)

(1) Han transcurrido por lo menos 30 días entre la fecha en la que la persona firmó esta Forma de Consentimiento y la fecha en la que se realizó la esterilización.

(2) La operación para la esterilización se realizó a menos de 30 días, pero a más de 72 horas, después de la fecha en la que la persona firmó la Forma de Consentimiento debido a las siguientes circunstancias (marque la casilla apropiada y escriba la información requerida):

☐ Parto prematuro

Fecha prevista de parto: _____

☐ Cirugía abdominal de urgencia (Describa las circunstancias): _____

(firma del médico)

(fecha)

DECLARACIÓN SOBRE LEY DE REDUCCIÓN DE TRÁMITES

Una agencia federal no debe llevar a cabo o patrocinar la recolección de información, y el público no está obligado a responder a la misma o a facilitar la información, a no ser que dicha solicitud de información presente un número de control válido de la OMB. La carga horaria para el público que completa esta forma variará; sin embargo, se ha estimado un promedio de una hora por cada respuesta, cálculo que incluye el tiempo para revisar las instrucciones, buscar y presentar los datos exigidos y completar la forma. Para enviar sus comentarios sobre la carga horaria estimada o cualquier otro aspecto de la información requerida, escriba a OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Se debe informar al público que responde a esta forma que la recolección de información solicitada en la misma se autoriza en virtud de 42 CAR parte 50, subparte B, que tiene que ver con la esterilización de personas en programas de salud pública que son financiados por el gobierno federal. El propósito de la recolección de esta información es asegurar que las personas que solicitan la esterilización sean informadas sobre los riesgos, los beneficios y las consecuencias de esta operación, y para asegurar el consentimiento voluntario e informado de todas las personas que se someten al procedimiento de esterilización en programas de salud pública que reciben asistencia federal. Se pide a las personas que llenan la forma que incluyan datos sobre su raza y grupo étnico, aunque esta información no es requerida. Toda la demás información solicitada en esta forma de consentimiento es requerida. Si la persona que llena la forma no proporciona la información requerida o si no firma esta forma de consentimiento, podría resultar en que no recibiera el procedimiento de esterilización financiado por un programa de salud pública patrocinado con fondos federales.

Toda la información de datos y circunstancias personales obtenidas por medio de esta Forma son confidenciales y no se divulgarán sin el consentimiento de la persona, en conformidad con todos los reglamentos aplicables de confidencialidad.



CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ . When I first asked _____
Doctor or Clinic
for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.
I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____ . The discomforts, risks

Specify Type of Operation
and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____
Date

I, _____, hereby consent of my own
free will to be sterilized by _____

Doctor or Clinic
by a method called _____ . My

Specify Type of Operation
consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature *Date*

You are requested to supply the following information, but it is not required: (Ethnicity and Race Designation) (please check)
Ethnicity: *Race (mark one or more):*

- | | |
|---|--|
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> American Indian or Alaska Native |
| <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Asian |
| | <input type="checkbox"/> Black or African American |
| | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| | <input type="checkbox"/> White |

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____

language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter's Signature

Date

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
Name of Individual

consent form, I explained to him/her the nature of sterilization operation _____, the fact that it is

Specify Type of Operation
intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Signature of Person Obtaining Consent *Date*

Facility

Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

_____ on _____
Name of Individual *Date of Sterilization*

I explained to him/her the nature of the sterilization operation _____, the fact that it is

Specify Type of Operation
intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
Individual's expected date of delivery: _____
☐ Emergency abdominal surgery (describe circumstances): _____

Physician's Signature

Date



PAPERWORK REDUCTION ACT STATEMENT

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, SW., Washington, DC 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations. [43 FR 52165, Nov. 8, 1978, as amended at 58 FR 33343, June 17, 1993; 68 FR 12308, Mar. 14, 2003]





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PUERTO RICO

Administración de Seguros
de Salud de Puerto Rico (ASES)

PUERTO RICO GOVERNMENT HEALTH PLAN MCO CONTRACT

APPENDIX (23)

POLICIES AND PROCEDURES FOR REFUNDING OF FEDERAL SHARE OF MEDICAID OVERPAYMENTS TO PROVIDERS

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION
POLICIES AND PROCEDURES FOR REFUNDING OF FEDERAL SHARE OF
MEDICAID OVERPAYMENTS TO PROVIDERS

A. OBJECTIVES (42 CFR 433.300)

To establish the policies and procedures of the Puerto Rico Health Insurance Administration (ASES for its anachronism in Spanish) to recoup overpayments made to its providers in accordance with 42 CFR 433, Subpart F—*Refunding of Federal Share of Medicaid Overpayments to Providers* and to implement:

- 1) Section 1903(d)(2)(A) of the Social Security Act (the "Act"), which directs that quarterly Federal payments to the States under title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.
- 2) Section 1903(d)(2) (C) and (D) of the Act, which provides that a State has 1-year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.
- 3) Section 1903(d)(3) of the Act, which provides that the Secretary will consider the pro rata Federal share of the net amount recovered by a State during any quarter to be an overpayment.

B. DEFINITIONS (42 CFR 433.304)

- 1) **Abuse** (in accordance with 42 CFR 455.2) - provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.
- 2) **Discovery** (or discovered) - identification by any ASES, the Federal Government, or the provider of an overpayment, and the communication of that overpayment finding or the initiation of a formal recoupment action without notice as described in 42 CFR 433.316.
- 3) **Fraud** (in accordance with 42 CFR 455.2) - an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
- 4) **Overpayment** - the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act.



PUERTO RICO HEALTH INSURANCE ADMINISTRATION

POLICIES AND PROCEDURES FOR REFUNDING OF FEDERAL SHARE OF MEDICAID OVERPAYMENTS TO PROVIDERS

- 5) **Provider** (in accordance with 42 CFR 400.203) - any individual or entity furnishing Medicaid services under a provider agreement with the Medicaid agency.
- 6) **Recoupment** - any formal action by ASES to initiate recovery of an overpayment without advance official notice by reducing future payments to a provider.
- 7) **Third party** (in accordance with 42 CFR 433.136) - an individual, entity, or program that is or may be liable to pay for all or part of the expenditures for medical assistance furnished under a State plan.

C. APPLICABILITY (42 CFR 433.310)

The provisions of these policies and procedures apply to:

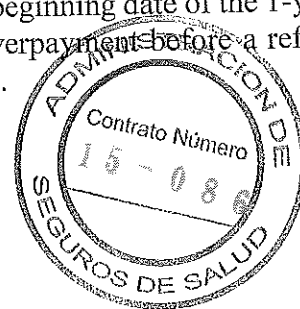
- 1) Overpayments made to providers that are discovered by ASES;
- 2) Overpayments made to providers that are initially discovered by the provider and made known to ASES; and
- 3) Overpayments that are discovered through Federal reviews.

D. BASIC REQUIREMENTS FOR REFUNDS (42 CFR 433.312)

- 1) ASES has 1-year from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS.
- 2) ASES must refund the Federal share of overpayments at the end of 1-year period following discovery, whether or not ASES has recovered the overpayment from the provider. Notwithstanding, ASES is not required to refund the Federal share of an overpayment made to a provider when ASES is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business in accordance with 42 CFR 433.318.
- 3) The date upon which an overpayment occurs is the date upon which ASES, using its normal method of reimbursement for a particular class of provider (e.g., check, interfund transfer), makes the payment involving unallowable costs to a provider.

E. WHEN DISCOVERY OF OVERPAYMENT OCCURS AND ITS SIGNIFICANCE. (42 CFR 433.316)

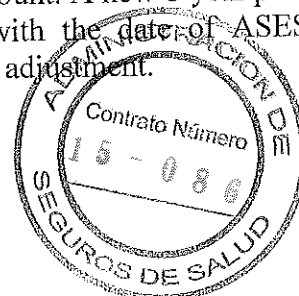
- 1) The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.



PUERTO RICO HEALTH INSURANCE ADMINISTRATION

**POLICIES AND PROCEDURES FOR REFUNDING OF FEDERAL SHARE OF
MEDICAID OVERPAYMENTS TO PROVIDERS**

- 2) Unless ASES chooses to initiate a formal recoupment action against a provider without first giving written notification of its intent, ASES must notify the provider in writing of any overpayment it discovers in accordance with ASES' policies and procedures and must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures.
- 3) An overpayment resulting from a situation other than fraud is discovered on the earliest of:
- a) The date on which ASES first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;
 - b) The date on which a provider initially acknowledges a specific overpaid amount in writing to ASES; or
 - c) The date on which ASES initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.
- 4) Overpayments resulting from fraud. An overpayment resulting from fraud is discovered on the date of the final written notice (as defined in 42 CFR 433.304) of the overpayment determination that ASES sends to the provider.
- 5) If a Federal review at any time indicates that ASES has failed to identify an overpayment or that ASES has identified an overpayment but has failed to either send written notice of the overpayment to the provider that specified a dollar amount subject to recovery or initiate a formal recoupment from the provider without having first notified the provider in writing, CMS will consider the overpayment as discovered on the date that the Federal official first notifies ASES in writing of the overpayment and specifies a dollar amount subject to recovery.
- 6) Any adjustment in the amount of an overpayment during the 1-year period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in ASES' administrative policies and procedures) has the following effect on the 1-year recovery period:
- a) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 1-year recovery period for the outstanding balance.
 - b) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount. A new 1-year period begins for the incremental amount only, beginning with the date of ASES' written notification to the provider regarding the upward adjustment.



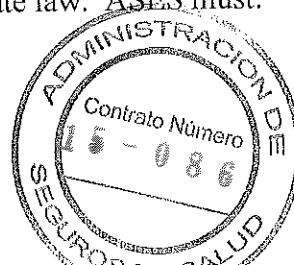
PUERTO RICO HEALTH INSURANCE ADMINISTRATION

POLICIES AND PROCEDURES FOR REFUNDING OF FEDERAL SHARE OF MEDICAID OVERPAYMENTS TO PROVIDERS

- 7) A partial collection of an overpayment amount by ASES from a provider during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount due to CMS.
- 8) Any appeal rights extended to a provider do not extend the date of discovery.

F. OVERPAYMENTS INVOLVING PROVIDERS WHO ARE BANKRUPT OR OUT OF BUSINESS (42 CFR 433.318)

- 1) ASES is not required to refund the Federal share of an overpayment made to a provider as required by 42 CFR 433.312(a) to the extent that ASES is unable to recover the overpayment because the provider has been determined bankrupt or out of business in accordance with the provisions of this section. ASES must notify the provider that an overpayment exists in any case involving a bankrupt or out-of-business provider and, if the debt has not been determined uncollectable, take reasonable actions to recover the overpayment during the 1-year recovery period in accordance with policies prescribed by applicable State law and administrative procedures.
- 2) Overpayments are considered debts that ASES is unable to recover within the 1-year period following discovery if the following criteria are met:
 - a) The provider has filed for bankruptcy, as specified in paragraph (c) of this section; or
 - b) The provider has gone out of business and the State is unable to locate the provider and its assets, as specified in paragraph (4) of this section.
- 3) ASES is not required to refund to CMS the Federal share of an overpayment at the end of the 1-year period following discovery, if:
 - a) The provider has filed for bankruptcy in Federal court at the time of discovery of the overpayment or the provider files a bankruptcy petition in Federal court before the end of the 1-year period following discovery; and
 - b) ASES is on record with the court as a creditor of the petitioner in the amount of the Medicaid overpayment.
- 4) ASES is not required to refund to CMS the Federal share of an overpayment at the end of the 1-year period following discovery if the provider is out of business on the date of discovery of the overpayment or if the provider goes out of business before the end of the 1-year period following discovery. A provider is considered to be out of business on the effective date of a determination to that effect under State law. ASES must:



PUERTO RICO HEALTH INSURANCE ADMINISTRATION
POLICIES AND PROCEDURES FOR REFUNDING OF FEDERAL SHARE OF
MEDICAID OVERPAYMENTS TO PROVIDERS

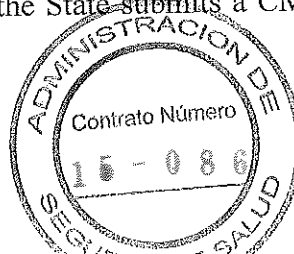
- a) Document its efforts to locate the party and its assets. These efforts must be consistent with applicable State policies and procedures; and
- b) Make available an affidavit or certification from the appropriate State legal authority establishing that the provider is out of business and that the overpayment cannot be collected under State law and procedures and citing the effective date of that determination under State law.

A provider is not out of business when ownership is transferred within the State unless State law and procedures deem a provider that has transferred ownership to be out of business and preclude collection of the overpayment from the provider.

- 5) If the 1-year recovery period has expired before an overpayment is found to be uncollectable under the provisions of this section, if ASES recovers an overpayment amount under a court-approved discharge of bankruptcy, or if a bankruptcy petition is denied, ASES must refund the Federal share of the overpayment in accordance with the procedures specified in 42 CFR 433.320.

G. PROCEDURES FOR REFUNDS TO CMS (42 CFR 433.320)

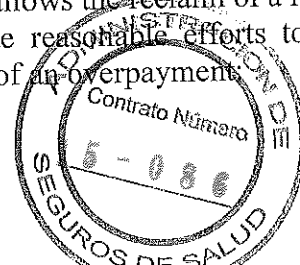
- 1) In accordance with section 1903(d) of the Social Security Act, ASES shall reduce its claims of reimbursement to the extent of any overpayment in the expense reports submitted to CMS, and on the corresponding quarter with respect to the adjustment.
- 2) ASES must refund the Federal share of overpayments that are subject to recovery to CMS through credit on the Quarterly Statement of Expenditures (Form CMS-64). Accordingly, the Federal share of overpayments subject to recovery must be credited on the Form CMS-64 report submitted for the quarter in which the 1-year period following discovery, established in accordance with 42 CFR 433.316, ends.
- 3) A credit on the Form CMS-64 must be made whether or not the overpayment has been recovered by ASES from the provider.
- 4) *Effect of reporting collections and submitting reduced expenditure claims.* (1) The State is not required to refund the Federal share of an overpayment at the end of the 1-year period if the State has already reported a collection or submitted an expenditure claim reduced by a discrete amount to recover the overpayment prior to the end of the 1-year period following discovery.
- 5) If ASES does not refund the Federal share of such overpayment, the State will be liable for interest on the amount equal to the Federal share of the non-recovered, non-refunded overpayment amount. Interest during this period will be at the current Value of Funds Rate (CVFR), and will accrue beginning on the day after the end of the 1-year period following discovery until the last day of the quarter for which the State submits a CMS-64 report refunding the Federal share of overpayment.



PUERTO RICO HEALTH INSURANCE ADMINISTRATION

POLICIES AND PROCEDURES FOR REFUNDING OF FEDERAL SHARE OF MEDICAID OVERPAYMENTS TO PROVIDERS

- 6) ASES is not required to report on the Form CMS-64 any collections made on overpayment amounts for which the Federal share has been refunded previously. Furthermore, if ASES has refunded the Federal share of an overpayment and subsequently makes recovery by reducing future provider payments by a discrete amount, ASES need not reflect that reduction in its claim for Federal financial participation.
- 7) If the amount of an overpayment is adjusted downward after the agency has credited CMS with the Federal share, ASES may reclaim the amount of the downward adjustment on the Form CMS-64. Under this provision:
- a) Downward adjustment to an overpayment amount previously credited to CMS is allowed only if it is properly based on the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution processes specified in ASES' administrative policies and procedures.
 - b) The 2-year filing limit for retroactive claims for Medicaid expenditures does not apply. A downward adjustment is not considered a retroactive claim but rather a reclaiming of costs previously claimed.
- 8) If an overpayment has not been determined uncollectable in accordance with the requirements of 42 CFR 433.318 at the end of the 1-year period following discovery of the overpayment, ASES must refund the Federal share of the overpayment to CMS in accordance with the procedures specified above.
- 9) If ASES recovers any portion of an overpayment under a court-approved discharge of bankruptcy, ASES must refund to CMS the Federal share of the overpayment amount collected on the next quarterly expenditure report that is due to CMS for the period that includes the date on which the collection occurs.
- 10) If a provider's petition for bankruptcy is denied in Federal court, ASES must credit CMS with the Federal share of the overpayment on the later of:
- a) The Form CMS-64 submission due to CMS immediately following the date of the decision of the court; or
 - b) The Form CMS-64 submission for the quarter in which the 1-year period following discovery of the overpayment ends.
- 11) If a provider is determined bankrupt or out of business under this section after the 1-year period following discovery of the overpayment ends and ASES has not been able to make complete recovery, ASES may reclaim the amount of the Federal share of any unrecovered overpayment amount previously refunded to CMS. CMS allows the reclaim of a refund if ASES submits to CMS documentation that it has made reasonable efforts to obtain recovery. If ASES reclaims a refund of the Federal share of an overpayment,



PUERTO RICO HEALTH INSURANCE ADMINISTRATION

POLICIES AND PROCEDURES FOR REFUNDING OF FEDERAL SHARE OF MEDICAID OVERPAYMENTS TO PROVIDERS

- b) In bankruptcy cases, ASES must submit to CMS a statement of its efforts to recover the overpayment during the period before the petition for bankruptcy was filed; and
 - c) In out-of-business cases, ASES must submit to CMS a statement of its efforts to locate the provider and its assets and to recover the overpayment during any period before the provider is found to be out of business in accordance with 42 CFR 433.318.
- 12) ASES must report the following information to support each Quarterly Statement of Expenditures Form CMS-64:
- a) Amounts of overpayments not collected during the quarter but refunded because of the expiration of the 1-year period following discovery;
 - b) Upward and downward adjustments to amounts credited in previous quarters;
 - c) Amounts of overpayments collected under court-approved discharges of bankruptcy;
 - d) Amounts of previously reported overpayments to providers certified as bankrupt or out of business during the quarter; and
 - e) Amounts of overpayments previously credited and reclaimed by ASES.

H. MAINTENANCE OF RECORDS (42 CFR 433.322)

ASES must maintain a separate record of all overpayment activities for each provider in a manner that satisfies the retention and access requirements of 45 CFR 92.42.

