Governor of Puerto Rico
WANDA VÁZQUEZ GARCED

October 30, 2020

The Honorable Charles E. Grassley
Chairman
Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Frank Pallone
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Ron Wyden
Ranking Member
Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
2322 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Grassley, Chairman Pallone, Ranking Member Wyden, and Ranking Member Walden,

I thank you for your continued support of Puerto Rico's Medicaid program. In coordination with the Puerto Rico Department of Health Secretary, Lorenzo González Feliciano, MD, I write to provide you with the *Puerto Rico Medicaid: Annual Report to Congress* (Annual Report) as required by the *Further Consolidated Appropriations Act 2020*, P.L. 116-94. Please find the attached Annual Report submitted to you in accordance with Division N, Title I, Subtitle B, Section 202, Subsection (d) of P.L. 116-94 (42 U.S.C. § 1308(g)(9)(A)).

The Annual Report entails a comprehensive description of the current state of Puerto Rico's Medicaid delivery system. The Annual Report also describes the challenges, opportunities, and efforts of the Government of Puerto Rico since the enactment of P.L. 116-94 to comply with the law and further strengthen the island's Medicaid program. Furthermore, the Annual Report also details the need for additional federal funding to avert a fiscal cliff once the additional Medicaid funding and increased Federal Medical Assistance Percentage (FMAP) expires at the end of fiscal year 2021 on September 30, 2021.

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Medicaid is designed to treat our nation's most vulnerable populations, including low-income families, the elderly, children, and individuals with disabilities. Even prior to the Coronavirus (COVID-19) pandemic, the U.S. citizens of Puerto Rico suffered from serious health conditions that require urgent care, including mental health issues and chronic diseases such as cancer, diabetes, Hepatitis C, and HIV. The increased federal Medicaid funding enacted by P.L. 116-94 secured life-saving services to the approximately 1.2 million beneficiaries that depend on Medicaid to meet their most basic physical and behavioral health needs. Therefore, the Annual Report urges the need for Congress to act by enacting a permanent solution to ensure Puerto Rico's Medicaid Program and Medicaid beneficiaries on the island do not face cuts in essential medical services.

If you require additional information or have any questions, please contact Jennifer M. Storipan, Esq., Executive Director of the Puerto Rico Federal Affairs Administration at (202) 778-0710 or via email at jstoripan@prfaa.pr.gov.

Sincerely,

Wanda Vázquez Garced
Governor of Puerto Rico

cc: Congresswoman Jenniffer Gonzalez-Colon (PR-At-Large)
The Honorable Lorenzo González Feliciano, Secretary, Puerto Rico Department of Health
Jorge E. Galva, Executive Director, Health Insurance Administration of Puerto Rico
Jennifer M. Storipan, Esq., Executive Director, Puerto Rico Federal Affairs Administration

Puerto Rico Medicaid

Annual Report to Congress

Government of Puerto Rico
October 30, 2020

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Introduction

On behalf of the Puerto Rico Government and the agencies that oversee the delivery of Medicaid and Children's Health Insurance Program (CHIP) services, including the Puerto Rico Department of Health (PRDOH), Medicaid and the Puerto Rico Health Insurance Administration (PRHIA), thank you for this opportunity to report on Puerto Rico's expenditure of the current funding and progress towards compliance with the conditions and requirements set forth in Section 1108(g)(6)-(8) of the Social Security Act (Act), which was added by Section 202 of the "Further Consolidated Appropriations Act 2020", (P.L. 116-94).

This report addresses a comprehensive description of the current state of the Medicaid delivery system, the challenges and opportunities and the efforts made over the past 11 months to comply with the law and further strengthen the program. The relief provided through the increased funding to our Medicaid program has provided added security for our citizens that this critical program can continue without immediate cuts to benefits and services.

During the period between November 2018 and May 2019, the sitting Governor of Puerto Rico, the sitting Medicaid Director, the Executive Director of the PRHIA and the Executive Director of the Fiscal Oversight and Management Board (FOMB) approached Members of Congress through letters and direct testimony imploring Members of Congress to recognize the critical needs of the 3.2 million American citizens living in Puerto Rico.

With the passing of P.L. 116-94, Congress answered that call and provided funding necessary to continue providing life-saving services to the approximately 1,276,017 individuals and families that depend on Medicaid to meet their most basic physical and behavioral health needs. This funding, dependent on completion of certain tasks detailed later in this report, helped temporarily avert a looming October 1, 2019 "fiscal cliff" when the additional funding and increased matching rate from the Bipartisan Budget Act and Affordable Care Act would expire and Puerto Rico would revert back to the capped allotment of funds and current law matching rate.

Each dollar the federal government does not provide for Medicaid, the Government of Puerto Rico must find. Like many states, Puerto Rico's spending on Medicaid will account for an unprecedented portion of its annual budget. This is not a temporary or short-term challenge, with the negative effects of the Coronavirus 2019 (COVID-19) pandemic on employment and the economy. We are also faced with the unknown threats of natural disasters like hurricanes and earthquakes, which will further exacerbate these issues. We expect that, unemployment and poverty will continue to rise and make the Medicaid safety net even more vital to our well-being.

The Government and people of Puerto Rico are grateful for the temporary relief and have worked diligently to meet the expectations of the United States Government with regard to responsible expenditure of the funds, ongoing improved accountability and thorough documentation of the continuing need for federal support in Puerto Rico.

Unfortunately, we are facing another looming “fiscal cliff” beginning in Federal Fiscal Year (FFY) 2022 when Puerto Rico’s funding and matching rate reverts back to current law, despite the ongoing efforts to provide the most efficient and cost-effective high quality care. The current supplemental Medicaid funding will expire on September 30, 2021 and, if no additional federal funds are appropriated, Section 1108 Act funds will only cover approximately 24% of the total federal program cost at current benefit and population levels. The federal share of Plan Vital (Vital) costs are projected to reach $2.3 billion annually by FFY 2024 while the federal Medicaid cap under current law would only be approximately $546 million creating a “fiscal cliff” of approximately $1.7 billion.

Additional federal funding must be approved for FFY 2022 and beyond in order to adequately plan and implement strategies to provide care for the current population and potentially new members that have found themselves recently unemployed. Furthermore, sufficient time is needed to plan and implement further improvement to the program and addition of mandatory benefits that the Vital currently does not cover such as long term care and non-emergency transportation. Without the additional federal funding, the Medicaid program in Puerto Rico would be devastated and unsustainable as we do not have the local funding necessary to make up this deficit in federal funds.

The Government of Puerto Rico continues to encourage Congress to act now to create a permanent solution that provides for state-like treatment for Puerto Rico’s Medicaid Program to include, at a minimum, the elimination of the annual Medicaid cap and the calculation of the Federal Medical Assistance Percentage (FMAP) according to the formula used for the states. This will provide for reliable and sustainable funding for our health delivery system. Going forward the federal financing of the Medicaid program in Puerto Rico should be more closely tied to that of the states and the size and needs of its low income population. Puerto Rico’s continued progress in current initiatives and flexibility to meet the needs of the members and the provider community that serves them, is dependent on enacting a permanent solution, including eliminating the capped allotment and right-sizing the federal matching rate permanently. The Government of Puerto Rico has a fiduciary obligation to maintain a balanced budget and without a permanent federal funding solution it makes it very difficult for Puerto Rico to make decisions to increase provider rates and expand eligibility coverage.

Creating system-wide changes requires time and planning. Within the healthcare system, each change involves research and forecasting, working with regulators like the Centers for Medicaid and Medicare Services (CMS), working with Puerto Rico regulators, including the Department of Insurance, the Office of Budget and Management, the Board of Directors (BOD) of PRHIA and the Fiscal Oversight and Management Board. We must develop new expectations, develop tools for oversight and management, train staff and create meaningful cultural change within our agencies. We are working every day, to adopt a new way of thinking and move away from daily emergency

management that has become our reality through hurricanes, earthquakes and now the COVID-19 pandemic. Due to the lack of extended time free of emergency that directly affects the health and well-being of our citizens, it has been challenging to baseline and identify a “new normal”. Puerto Rico has learned during the COVID-19 pandemic about the financial fragility of the provider community, particularly hospitals, most of which were already in financial trouble. We must stabilize the system overall so that it can withstand future emergencies, which are inevitable. This can only be accomplished if Puerto Rico is provided state-like treatment in its Medicaid Program.

We are hopeful that the evidence of progress so far and the clear documentation of the needs of American citizens living in Puerto Rico will compel Congress to continue to partner with us in investing in a permanent solution for the future.

2

Medicaid Environment

Agency Organization

PRDOH is the Single State Agency for administering the State Medicaid Program. For purposes of the Medicaid program administration, PRDOH is the State Medicaid Agency. Puerto Rico Medicaid is administered by PRDOH and PRHIA. This is a long-standing sister agency relationship, defined by an interagency memorandum of understanding. The PRHIA (commonly referred to as Administración de Seguros de Salud [ASES]) was created in 1993 to oversee, monitor and evaluate services offered by the insurance companies under contract with PRHIA. PRHIA is overseen and monitored by BOD.

The Medicaid Program, a government program under the PRDOH, oversees the Medicaid State Plan, manages eligibility, beneficiary enrollment and is responsible for the operation of the Medicaid Management information System (MMIS) for the program. In addition, PRHIA, Medicaid and the Government of Puerto Rico follow guidance issued each year by congressionally mandated FOMB.

In addition to meeting federal requirements, PRHIA and Medicaid must also abide by regulations established by the Government of Puerto Rico. Appendix A provides a sample of these regulations that pertain to contracting and are considered as part of PRHIA's and Medicaid's contracting reform plans that are addresses later in this report.

Puerto Rico Department of Health

The PRDOH's administration of its Medicaid program under Title XIX of the Act is structured as a "categorical program" denominated the "Medicaid program." The PRDOH Medicaid program's charter is to ensure appropriate delivery of health care services under Medicaid, CHIP and the Medicaid Preferred Drug Program; the latter two are structured as extended Medicaid programs.

Since the inception of the Medicaid program in Puerto Rico, and up until the early 1990's, the Puerto Rico Medicaid program's role was mostly limited to providing the categorically needy easy access to the Medicaid program by operating "local offices" located throughout all the municipalities on the Island. In these offices, citizens could apply for Medicaid coverage by providing demographic and socio-economic information for their family unit. Based upon federal Medicaid program eligibility rules, the family's eligibility for Medicaid would be determined. If eligible, the individual and family were certified and enrolled in the Medicaid program. Health care services to Medicaid-eligible individuals and families were delivered through the Puerto Rico Government's public health service facilities. The aforementioned block grant covered a portion of these services, with the balance covered by local funds.

Puerto Rico Health Insurance Administration

In 1993, the Government of Puerto Rico enacted a far-reaching transformation of the entire public health system. The Puerto Rico Health Reform Program, referred initially as “Reforma,” and now known as “Vital” marked the creation of a state-run health insurance program under a managed care model. These reforms expanded Medicaid coverage for individuals and families with incomes between 50%–100% of the federal poverty guideline—significantly increasing the number of citizens with government-subsidized health coverage.

In 1993, an interagency memorandum of understanding (since then updated multiple times), was established to delegate the implementation of the Medicaid State Plan’s service delivery model to PRHIA, a public corporation established by Law Number 72 of September 7, 1993, as amended. Under this agreement, the PRDOH retained responsibility for eligibility determination, policy, Medicaid State Plan maintenance and financial administration. This agreement requires PRHIA to implement and deliver services through a managed care model. The process of selecting the insurance carriers, negotiating and managing the contracts with insurers was assigned to PRHIA pursuant to Law Number 72. The Medicaid program retained the role of eligibility determination for Medicaid and Reforma.

In 2006, PRHIA implemented the Medicare “Platino” program to provide additional coverage benefits to beneficiaries of Medicaid and Reforma who are also eligible for Medicare (i.e., “dually eligible”) and are enrolled in a Medicare Advantage Organization. Medicare Platino program wraps around Medicare Advantage (MA), giving the dually eligible any additional benefits coverage provided by Reforma.

The Puerto Rico Health Insurance Administration Board of Directors

The BOD is a public corporation that governs PRHIA. The BOD is made up of 11 members, where six are Ex-Officio Members and five members are appointed by the Governor of Puerto Rico with the advice and consent of the Government of Puerto Rico Senate. The Ex-Officio Members include the Secretaries of Health, the Treasury Department Secretary, the Administrator of the Administration of Mental Health and Addiction Services, the Director of the Office of Management and Budget, the Executive Director of The Puerto Rico Fiscal Agency and Financial Advisory Authority and the Insurance Commissioner, or their delegates. The Governor of Puerto Rico appoints the President of the BOD from among its members.

The primary purpose and functions of the BOD includes:

- Implementation of medical-hospital services based on health insurance
- Negotiation and contracting for medical-hospital insurance coverage
- Negotiation and contracting with health service plans for health services

- Organization of alliances and conglomerates of beneficiaries with the purpose of representing them in the negotiation and contracting of their health plans
- Maintenance of an administrative and financial structure to manage funds and revenues, administer cash and make disbursements
- Establishment of guidelines for the appointment, contracting and remuneration of its personnel
- Negotiation and award of contracts, documents and other public instruments with juridical persons and entities
- Direction to insurers to keep a record of services rendered in categorical programs subsidized by the federal government, and document the relationship of their beneficiaries, payment claims and the pertinent financial and statistical reports
- Approval, amendment and repeal regulations that govern the business and activities of PRHIA
- Appointment of an Executive Director for PRHIA
- Facilitation of Contracting Committee to evaluate each contracting proposal and the recommendations (The Contracting Committee evaluates each proposal, the necessity of it, the amount for each service and the maximum amount for the contract year)
- Facilitation of an Internal Audit Committee to monitor PRHIA's audit work, corrective action plans, and executions of internal and external processes

Financial Oversight and Management Board for Puerto Rico

FOMB was created under the Puerto Rico Oversight, Management and Economic Stability Act of 2016. FOMB consists of seven members appointed by the President of the United States and one Ex-Officio Member designated by the Governor of Puerto Rico. FOMB is tasked with working with the people and Government of Puerto Rico to create the necessary foundation for economic growth and to restore opportunity to the people of Puerto Rico.

FOMB work fulfills the mandate of PROMESA—ensure fiscal sustainability and restore access to capital markets. Due to the unending series of unpredictable disasters, the effort has focused on utilizing certified fiscal plans and budgets to ensure Puerto Rico is able to respond to these crises while also moving toward medium and long-term fiscal and economic sustainability. FOMB established a contract review policy pursuant to Section 204(b)(2) of PROMESA to require the FOMB’s approval of certain contracts to assure that they “promote market competition” and “are consistent with the approved fiscal plan” (the “Policy”).

In its oversight of the Medicaid delivery system, all government contracts and amendments with an aggregate value of $10 million or more are subject to the FOMB’s approval. FOMB may review any contract below such threshold at its sole discretion. All proposed contracts or amendments stemming from the rate negotiations between PRHIA and the Vital managed care organizations (MCOs) must be

submitted to the FOMB for review and approval prior to execution. Additionally, pursuant to Section 204(b)(4) of PROMESA, certain proposed rules, regulations, administrative orders and executive orders must be submitted for FOMB's review prior to enactment.

Agency Consolidation

Currently, a partnership between the two health administration agencies, PRHIA and Medicaid, manages federal Medicaid and CHIP (MAC) funds and the oversight and administration of the Vital and Medicare Platino programs. The consolidation of the health administration agencies is part of the FOMB's five year fiscal plan to continue to create efficiencies and resulting cost savings.

An independent assessment has been completed and work has begun on identifying any administrative duplication of efforts, identifying any gaps or needed functions within the administration and planning for the complex issues that will arise as the agencies prepare to merge. Challenges to completing the merge of the two agencies are related to the preservation of the integrity of the PRHIA's operation, its core staff expertise, seniority and salary scale, and the fiscal flexibility essential to maintain the flow of premium payments to the MCOs.

The Government of Puerto Rico is considering a proposal that, if accepted, will result in Medicaid merging with PRHIA and becoming a new entity called the Department of Medicaid. The new Department of Medicaid will have a more state-like structure similar to model states like Tennessee and would be a directorate under the Secretary of Health at the PRDOH. PRHIA and Medicaid presented a bill that was shared with the Health Commission of the House of Representatives in June 2020.

Healthcare Needs

At the end of calendar year 2019, roughly 43.5% of Puerto Ricans received their health coverage through the Government of Puerto Rico's Medicaid program, which is the highest share of Medicaid/CHIP-funded health insurance coverage of any U.S. state.

Puerto Ricans experience higher rates of chronic conditions when compared to national averages including, but not limited to, hypertension (18% of Medicaid population), asthma (14.1% of Medicaid population) and diabetes (12.4% of Medicaid population). In total, 16% of the Puerto Rico Medicaid population have at least one chronic condition.

Table 2-1 Top 10 Chronic Conditions 2019

Top 10 Chronic Conditions in Calendar Year 2019 [1,2]	Percentage
Hypertension (Includes stroke & peripheral vascular disease)	18.0%
Asthma	14.1%
Diabetes without CAD	12.4%
Depression, substance abuse and other mental health disorder	7.6%
Thyroid disorders	4.7%
Intellectual disability	4.4%
Cancer	4.1%
Neurologic disorders	3.7%
Renal failure and/or post kidney transplant	3.5%
Severe heart failure/transplant/rheumatic heart disease/non-rheumatic valvular heart disease	3.0%
Total	**75.4%**

[1] Chronic condition data does not include Platino members.
[2] Uncategorized chronic conditions make up approximately 10% of the Medicaid Population.

Seventy-two of Puerto Rico's 78 municipalities are deemed "medically underserved areas," with 500 doctors leaving per year (pre-Hurricane Irma and Maria in 2017). Puerto Rico has half the rate of specialists (e.g., emergency physicians, neurosurgeons) as compared to the mainland in critical fields. This is especially notable for specialist providers who serve enrollees with chronic conditions, where needed specialists are scarce leading to severely underserved Puerto Ricans in certain areas of the Island.

Funding

Puerto Rico's Government-funded managed care program Vital, currently covers individuals through three primary funding sources: federally-matched Medicaid funds, CHIP and the Commonwealth's self-funded insurance program for low-income adults who do not qualify for Medicaid.

As noted in the introduction, approximately 50% of the total population covered under the federally matched Medicaid and 23.3% of the Puerto Rican Medicaid population receive some benefits from the Government as part of the Platino program, which supports MA program recipients who also qualify for Medicaid (also known as "dual-eligible"). The stability of the Government funded healthcare program is vital to the future of Puerto Rico.

Since federal Medicaid funding for U.S. territories is subject to an annual cap, Medicaid expenditures eligible for federal matching would typically exceed the annual Medicaid cap unless that cap is

supplemented by additional federal funding enacted by law. Since 2011, Puerto Rico has received temporary relief from rising healthcare costs through increased levels of federal reimbursement made available through the passage of the Affordable Care Act and the Bipartisan Budget Act of 2018. The temporary funding relief under both of these laws has now expired.

Further Consolidated Appropriations Act

On December 20, 2019, P.L. 116-94 was enacted, which provided supplemental federal funding (up to $5.7 billion total) to Puerto Rico's Medicaid program through September 30, 2021. In addition, P.L. 116-94 raised the FMAP from the standard level of 55% to 76% for most populations. P.L. 116-94 requires seven key additional requirements be met in order for Puerto Rico to avoid a penalty reduction in this increased FMAP and the progress in meeting those requirements is the subject of this report.

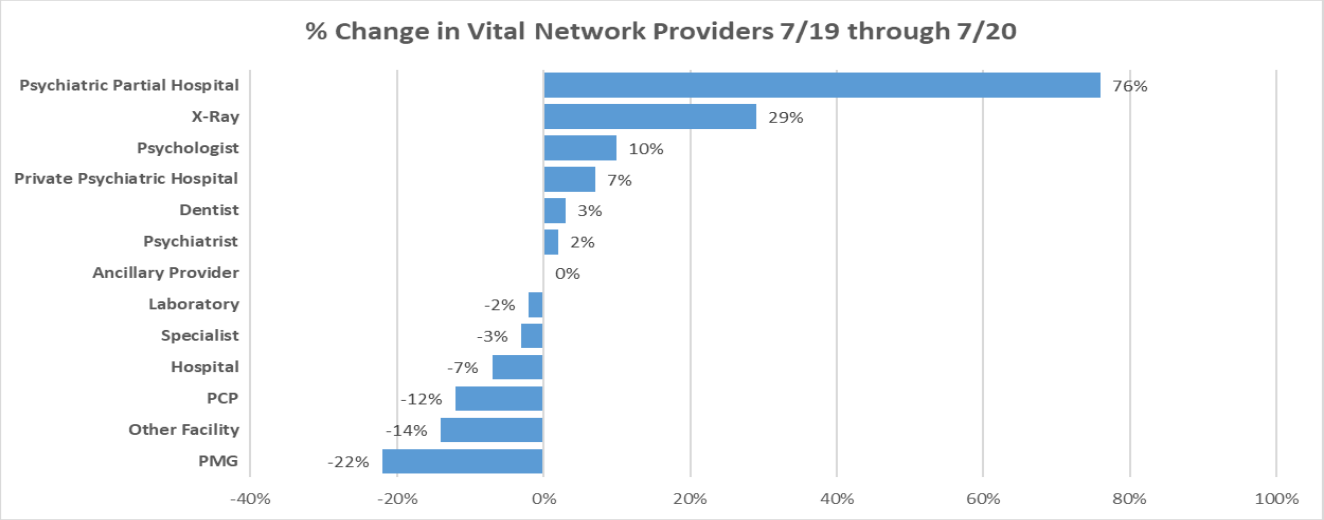
In response to the COVID-19 pandemic, the Families First Coronavirus Response Act was enacted on March 18, 2020. This legislation added an additional $183 million in Medicaid cap funding for Puerto Rico through FFY 2021. Additionally, this legislation added an additional 6.2% to our FMAP. This 6.2% remains available through March 31, 2021 unless the COVID-19 Public Health Emergency (PHE) is further extended and the FMAP will be 82.2% during this period.

Provider Experience

For a sustained period of time and in particular since Hurricane Maria and Irma in 2017, the Medicaid program has experienced a significant attrition of available providers for Medicaid beneficiaries. When Vital went live in 2018, the program model shifted from a regional system (MCOs managed one or more regions) to an island-wide model. The Vital model requires MCOs to contract with providers in all municipalities to increase beneficiary access to providers and provide better opportunity for continuity of care. While providers on the Island may have benefited from more opportunity to contract with MCOs and serve beneficiaries, they continue to leave Puerto Rico. Providers noted the primary reasons for migration to the U.S. mainland is pursuit of better working conditions and higher reimbursement rates. Over time, the attrition of providers has exacerbated access limitation to beneficiaries across the Island; in particular, for beneficiaries with chronic health care needs such as diabetes or asthma whom require specialist care to treat their conditions.

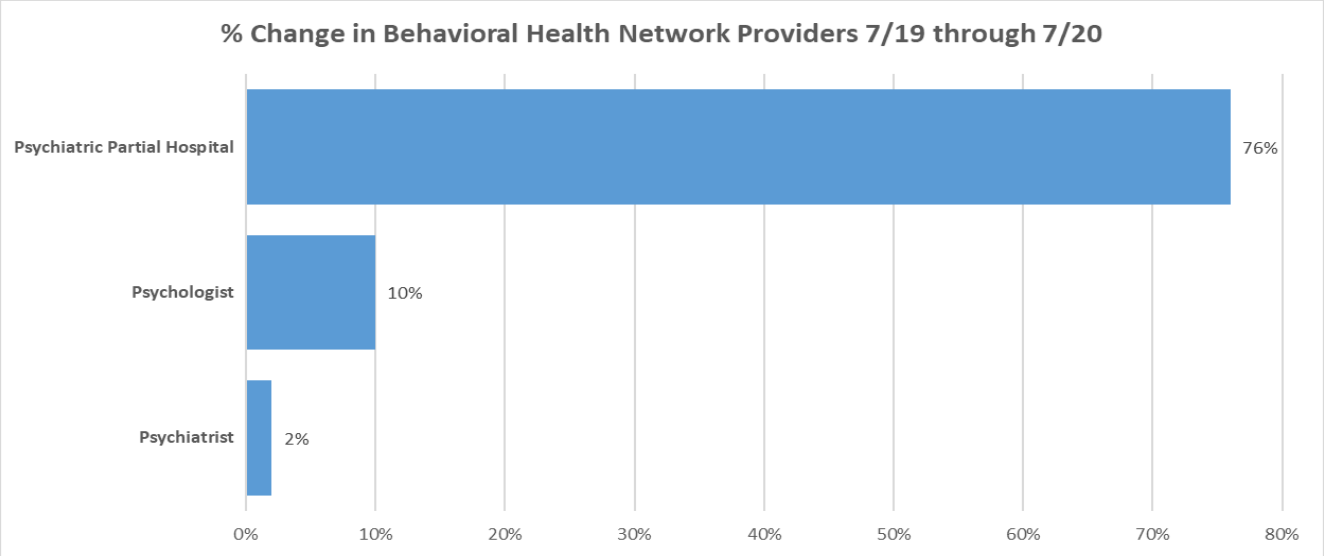
In aggregate, available network providers for beneficiaries has decreased by 4% year over year (FFY 2019 through FFY 2020). The sharpest provider attrition has been the reduction in availability of primary medical groups (PMGs), primary care providers and hospitals during that period.

Figure 2-1 Percent Change Vital Network Providers 7/2019 through 7/20



Despite the decrease in aggregate, available behavioral health providers have increased by 10% over the same period (FFY 2019 through FFY 2020) with the increase in psychologists and psychiatric partial hospitals.

Figure 2-2 Percent Change Vital Behavioral Health Network Providers 7/19 through 7/20



As required by P.L. 116-94 and as documented in this report, PRHIA and Medicaid have taken a number of notable actions to help turn the tide of attrition through improved reimbursement to providers and investments in the stability of critical providers such as hospitals.

Efforts have been made to improve working conditions through better oversight in monitoring program access. In addition to increasing reimbursement rates, there has been an investment in data analytics software (including Geo Access software) and improving data exchanges and information sharing. PRHIA and Medicaid continue to improve oversight and increase provider rates, but without permanent and reliable federal Medicaid financial support from the federal government to allow sustained reimbursement rates comparable to the U.S. mainland, Puerto Rico may not be able to incentivize providers to stay on the Island leading to even more profound network shortages and poorer health outcomes.

Member Experience

The Medicaid beneficiary experience in Puerto Rico is unique to the Island and comes with its own challenges and limitations. This includes catastrophic weather events, deterioration of island-wide infrastructure, poor health outcomes and access to care and limited employment opportunities. Despite the resiliency of the population, Puerto Rico has been particularly at risk during the COVID-19 pandemic due to a more senior population with chronic and or co-morbid health conditions. The necessary restrictions to prevent the spread of COVID-19 has created a delay in preventative care that is so critical to improving health outcomes overall. In addition to the current challenges facing the population, the population is expecting a continued rise in unemployment or underemployment and an increase in need for federal assistance. As discussed previously, the current opportunity to be determined eligible for Medicaid in Puerto Rico is well below that of a similar state on the U.S. mainland.

Table 2-2 Current Medicaid Income Eligibility 2019

Current Medicaid Income Eligibility 2019

Household Members	100% of PRPL	133% +5% of PRPL PR Medicaid Eligibility	100% of FPL	133% +5% of FPL U.S. Medicaid Eligibility	PRPL/FPL
1	$459	$633	$1,041	$1,436	44.1%
2	$542	$748	$1,409	$1,945	38.5%
3	$626	$864	$1,778	$2,453	35.2%
4	$709	$978	$2,146	$2,961	33.0%
5	$792	$1,093	$2,514	$3,470	31.5%
6	$876	$1,209	$2,883	$3,978	30.4%
7	$959	$1,323	$3,251	$4,486	29.5%
8	$1,043	$1,439	$3,619	$4,994	28.8%
9	$1,126	$1,554	$3,988	$5,503	28.2%
10	$1,210	$1,670	$4,356	$6,011	27.8%

A proposal to increase the Medicaid income standard to 85% of the federal poverty level (FPL) and potentially increase Medicaid eligibility by 240,000 was presented to the FOMB this year and was rejected by them. The reason cited by the FOMB in rejecting this proposal is that there was no certainty that the increased federal funding to sustain eligibility at the increased level would be available after FFY 2021. It is situations like this which call for there to be a permanent solution to Medicaid funding issues for Puerto Rico and the other U.S. territories. Without such a solution we cannot plan for or actually implement changes in our program with any degree of certainty that they can be sustained.

Table 2-3 85% Federal Poverty Proposal

New Beneficiaries—Scenario Analysis

85% of Federal Poverty Level 2020

Monthly Income	Current	Proposed 2020
PRPL/FPL	28%–44%	85%
Medicaid	1,162,000	1,509,124
CHIP	85,000	87,833
Commonwealth	138,000	28,800
Total	**1,385,000**	**1,625,756**
New Participants		**240,756**

Access to care for all Puerto Ricans (not just Medicaid/CHIP beneficiaries) is a significant challenge, especially in more rural areas of the Island outside of the San Juan metro area due to a shortage of clinics and trauma centers. In the FOMB 2020 fiscal plan, it was reported that under the DOH, there are 107 Health Professional Shortage Areas (HPSA) and 72 Medically Underserved Areas in Puerto Rico.[1] Based on the number of additional physicians required to remove HPSA status, Puerto Rico meets 1.92% of demand for primary care (versus the 45.11% national average), 16.56% of demand for dental care (versus the 29.79% national average), and 14.57% of demand for mental health services (versus the 27.24% national average).[2]

One way member experience is gauged is through annual MCO member satisfaction survey analysis. Per Vital contract requirements, MCOs are responsible for administering Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey annually in adherence to National Committee for

[1] Health Resources & Services Administration, May 2020

[2] KFF data as of September 30, 2019

Quality Assurance protocols.[3] The purpose of the CAHPS® member survey is to evaluate consumer satisfaction with health care, health plan, providers (primary care provider and specialty), access to care and effectiveness of care.

CAHPS® survey results for each MCO are reviewed by PRHIA as an additional layer of oversight to determine if member experience is aligned with other quality and oversight monitoring or red flags that need to be investigated further through other quality and oversight mechanisms. For example, if results for the composite measures "Getting Needed Care" and "Getting Care Quickly" indicated that members may be lacking or encountering barriers to access to care, PRHIA would in turn review network time and distance analysis for the plan to further drill down into the potential causes for these member experience results.

In the recent 2020 adult CAHPS® surveys completed by the MCOs, the summary rate results by MCO for the "Rating of Health Care," "Getting Care Quickly" and "Flu Vaccinations" measures indicated the need for further investigation.

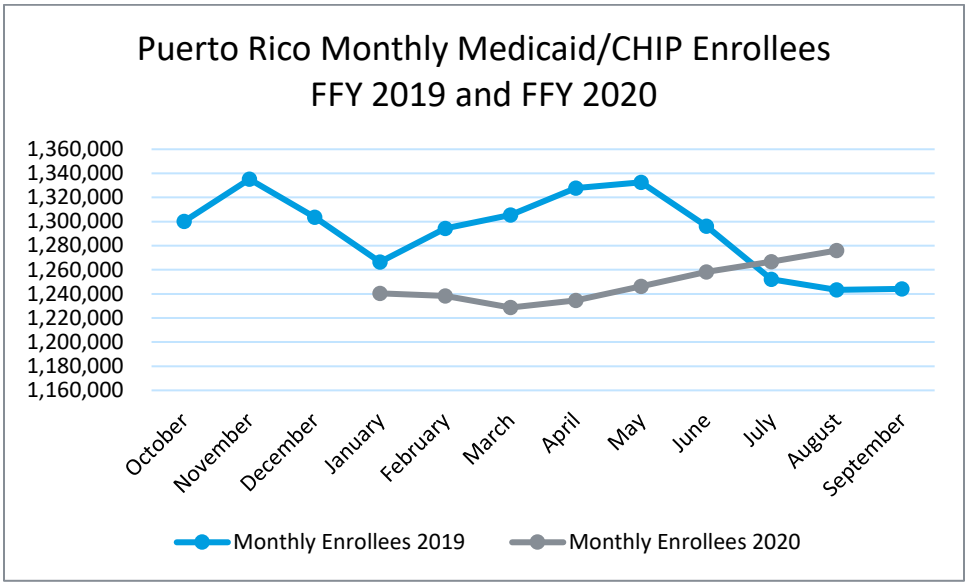
Population/Change in Numbers and Demographics Program Enrollment

In 2019, the Medicaid program experienced a reduction in enrollment as more Puerto Ricans migrated to the U.S. mainland. That trend has changed in 2020 and Puerto Rico expects an upward trend in Medicaid enrollment to continue due to COVID-19, and the return of many citizens who fled to mainland states post hurricane Maria.

On March 15, 2020, all Medicaid eligibility offices were closed until September 14, 2020. While certain eligibility functions were completed remotely, a large proportion of residents do not have access to remote technology and were unable to visit eligibility offices person due the pandemic. As of August 2020, Medicaid enrollment has increased 1.2% since August 2019, and this trend is expected to increase sharply over the last calendar quarter of 2020.

[3] 18.6.2.3 The Contractor shall submit an annual Enrollee Satisfaction Survey Report that includes, but is not limited to, a summary of the Enrollee survey methods, findings, analysis and evaluation. The report shall present information separately for CAHPS and ECHO. The survey and findings shall be presented by populations as determined by ASES (e.g., Adults, children, Behavioral Health and Chronic Conditions). The report must provide an action plan addressing areas for improvement of the Contractor as identified in the survey results. Refer to Section 12.6 of this Contract for additional information regarding the survey.

Figure 2-3 Monthly Medicaid/CHIP Enrollees FFY 2019 and FFY 2020



Program Expenditures

Total Puerto Rico MAC expenditures have remained relatively stable with a modest 7% growth rate between FFY 2019 and FFY 2020 in spite of the ongoing recovery from the various storms, earthquakes and the ongoing COVID-19 pandemic. While there has been a small reduction in enrollment numbers previously, there has been a recent increase in enrollment as COVID-19 restrictions are easing and more people seek health care coverage.

Puerto Rico MAC administrative expenditures declined in FFY 2020 by nearly $83.9 million. The significant decreases are the result of the following:

- Puerto Rico's general administrative expenses in FFY 2020 decreased by approximately $14.3 million as compared to FFY 2019 because in 2019 Puerto Rico used the vast majority of the funds provided by the Bipartisan Budget Act for the disaster relief and recovery emergency spending related to Hurricane Maria.
- There was a decrease of approximately $26 million in Eligibility and Enrollment System because the main investment in the development and implementation of the eligibility and enrollment program was made during FFY 2019 and the system in moving to operational status in FY 2020.
- There was a decrease of approximately $12.8 million due to stabilization of enrollment broker activities after the implementation of Vital in the fall of 2018.
- The Health Information Technology program was transferred from PRHIA to the DOH during FFY 2020, resulting in a decrease of approximately $10.8 million.

- The main expenditures for operation of the MMIS program was made during FFY 2019 due to the data entry efforts after implementation of the MMIS. Accordingly, for FFY 2020 there was a decrease of approximately $20 million as the MMIS moved to normal ongoing operations.

Table 2-4 Medicaid Program Expenditure Summary FFY 2019 & FFY 2020

PR Medicaid Program Expenditure Summary FFY 2019 & FFY 2020

FFY 2019 Medical Assistance Expenditures			
Program	**Total**	**Federal**	**Local**
Medicaid	2,417,551,130	2,469,804,738	(52,253,608)
CHIP	101,735,028	94,287,869	7,447,159
EAP	35,411,184	19,476,151	15,935,033
Total 2019	2,554,697,342	2,583,568,758[5]	(28,871,417)

FFY 2020 Medical Assistance Expenditures[4]			
Program	**Total**	**Federal**	**Local**
Medicaid	2,683,822,392	2,388,535,611	295,286,782
CHIP	108,818,148	108,047,447	770,701
EAP	36,110,302	31,454,421	4,655,881
Total 2020	2,828,750,843	2,528,037,480	300,713,363

FFY 2019 Administrative Expenditures			
Program	**Total**	**Federal**	**Local**
Total 2019	156,284,436	156,284,436	0

FFY 2020 Administrative Expenditures			
Program	**Total**	**Federal**	**Local**
Total 2020	72,381,417	49,586,418	22,794,999

FFY 2019 Total All Expenditures			
Program	**Total**	**Federal**	**Local**
Total 2019	2,710,981,778	2,739,853,194	(28,871,417)

FFY 2020 Total All Expenditures			
Program	**Total**	**Federal**	**Local**
Total 2020	2,900,882,333	2,577,436,453	323,445,880

Pharmacy Experience

The Puerto Rico pharmacy program has experienced increases in drug expenditures although there have been decreases in member enrollment in FFY 2019 and FFY 2020. Not unlike other Medicaid programs, high cost specialty drug products have become a greater portion of the drug spend and utilization, increasing to over 50% of total per member per month (PMPM) gross cost by first quarter of Calendar Year (CY) 2020. Specialty therapeutic classes with the largest drug cost increases include rheumatoid arthritis, growth hormone and hemophilia treatments, similar to other state Medicaid programs.

[4] Reflects actual expenditures as of 10/15/2020

[5] In FFY 2019, federal expenditures exceeded total expenditures due to reclassification of FFY 2015 expenditures related to the Group VIII population that was recorded in FFY 2019 (Q2).

To help mitigate pharmacy cost trends, Puerto Rico has implemented a number of strategies, including, but not limited to:

- The government is enforcing a mandatory generic policy that requires providers to dispense lower cost generic alternatives whenever possible. The mandatory generic policy results in average generic dispensing rates greater than 90%, which is significantly higher than most other state Medicaid programs.

- The government is reviewing robust monthly, quarterly and annual trend reporting provided by the clinical and financial staff of Puerto Rico's pharmacy benefit manager (PBM) and rebate vendor. Puerto Rico uses the reports to identify and monitor trends to help inform policy and economic decisions.

- The government is negotiating directly with drug manufacturer, AbbVie, for lower unit pricing for Hepatitis C treatment, MAVYRET, and developing a wholesaler and pharmacy network for distribution to treat more Medicaid enrollees diagnosed with Hepatitis C.

- The government is implementing a drug-specific Specialty Drug Reimbursement list for pharmacies to better align drug ingredient cost reimbursement with pharmacy acquisition costs for these high cost drugs.

- The government is coordinating MCO, PBM and pharmacy provider participation in the High Cost High Needs program to help better manage enrollees' specific, chronic health care conditions with the goal to improve care and lower overall health care costs.

Puerto Rico is experiencing higher drug cost trends compared to other state Medicaid programs throughout the country. With the specialty drug pipeline expanding and several potential blockbuster therapies anticipated to launch for previously untreated conditions, actively managing the pharmacy benefit will continue to be a priority for Puerto Rico.

Expenditure Projections

Total Vital costs are projected to reach $3.9 billion annually by FFY 2024. The cost increase is primarily driven by provider reimbursement increases implemented in FFY 2019 and FFY 2020 in response to provider exodus from the Island and healthcare infrastructure spending. Costs are projected to grow at 5.1% annually based primarily on historical program trends and continued provider reimbursement increases. However, during FFY 2021 and FFY 2022 higher growth rates can be expected due to delayed care and long term effects of the COVID-19 epidemic.

As noted above and displayed in Table 2-5 below, additional federal funding totaling at least $1.7 billion is needed to avoid the "fiscal cliff" in FFY 2022 and beyond or our program is unsustainable. Federal funding above the base Section 1008 cap must be approved for FFY 2022 and beyond in order to adequately plan and implement strategies to provide care for the current population and potentially new members that have found themselves recently unemployed. In addition sufficient time is needed to plan and implement further improvement to the program and addition of mandatory

benefits that the Vital program currently does not cover such as long term care and non-emergency transportation. Without the additional federal funding Puerto Rico will be unable to sustain its current Medicaid program and that will have devastating impact on the health care for our most vulnerable population and would have a disastrous impact on the PR budget and the Island's overall economic condition.

Table 2-5 Projected Vital Expenditures by Funding Source (Millions)

Federal Matching Eligible Premium Expenditures	FFY2021	FFY2022	FFY2023	FFY2024
Federal Medicaid	$2,395.8	$2,517.4	$2,645.8	$2,780.8
CHIP	$128.5	$135.1	$141.9	$149.2
Dual Eligibles	$297.2	$310.8	$325.1	$340.1
Federal Health Insurance Provider Fee	$0.0	$0.0	$0.0	$0.0
Total	$2,821.6	$2,963.3	$3,112.9	$3,270.1

Federal Matching Eligible Non-Premium Expenditures	FFY2021	FFY2022	FFY2023	FFY2024
Healthcare Related Programs	$272.4	$254.9	$241.0	$225.2
Administrative and Operating Costs	$130.1	$130.1	$130.1	$130.1
Total	$402.4	$385.0	$371.1	$355.2

State Population - Commonwealth Expenditures	FFY2021	FFY2022	FFY2023	FFY2024
Premium	$221.2	$232.5	$244.3	$256.8
Non-Premium Expenditures	$25.1	$25.1	$25.1	$25.1
Total	$246.4	$257.6	$269.4	$281.9

Total Program Expenditures	**$3,470.3**	**$3,605.9**	**$3,753.4**	**$3,907.2**
Required Federal Funds	**$2,713.3**	**$2,285.2**	**$2,379.9**	**$2,478.6**
Puerto Rico Funds	**$757.0**	**$1,320.7**	**$1,373.5**	**$1,428.6**
Appropriated Federal Funds	**$3,121.6**	**$546.3**	**$561.1**	**$576.4**
Federal Funds Shortfall (Fiscal Cliff)	**$408.2**	**-$1,738.9**	**-$1,818.7**	**-$1,902.2**

1. Projection includes all program medical and administrative costs.

2. FFY 2022-2024 federal funds decrease is due to return to 55% FMAP.

3. Required federal funds are calculated as the amount of funds needed at the appropriate FMAP.

3

Activities in Support of the Law

PRHIA and Medicaid are actively building and improving program oversight to meet the requirements in Section 1108(g)(6)-(8) of the Act. We are happy to report full compliance with the Act and significant progress on future tasks. This section of the annual report provides quarterly summary and a detailed account of completed and ongoing activities as they pertain to each required provision of Section 1108(g) of the Act.

In the past 11 months, PRHIA and Medicaid have maintained an open and clear channel of communication with the CMS to provide quarterly updates on all activities underway to support the law. To date, two updates have been shared with CMS are attached to this report: Appendix E—CMS Quarterly Update #1 and Appendix F—CMS Quarterly Update #2.

Summary of Completed Activities: January 2020–March 2020

PRHIA and Medicaid have:

- Completed a cost analysis and documentation necessary to seek CMS approval to implement a minimum fee schedule at 70% of the Medicare fee schedule for licensed professionals eligible to receive payment for professional services under Puerto Rico's Medicaid program
- Signed a comprehensive memorandum of understanding (MOU) between Medicaid and PRHIA to collaborate and combat fraud, waste and abuse
- Hired the temporary position for Program Integrity Lead and in process of hiring additional staff and working with Puerto Rico's government to establish position/roles
- Designed and began implementing a Comprehensive Oversight and Monitoring Plan (COMP), which addresses the requirements of both Section 1108(g)(7) of the Act and 42 CFR 438.66
- Began analysis of contracting reform requirements and local requirements
- Began planning and procuring support to meet Payment Error Rate Measurement (PERM) and Medicaid eligibility quality control (MEQC) requirements

Summary of Completed Activities: April 2020–July 2020

PRHIA and/or Medicaid have:

- Completed and submitted analysis and documentation necessary to seek CMS approval to implement a minimum fee schedule at 70% of the Medicare fee schedule for licensed professionals eligible to receive payment for professional services under Puerto Rico's Medicaid program. In doing so, Puerto Rico has completed the requirement in law and secured the additional 200 million per year for FFY 2020 and FFY 2021.
- Medicaid took all necessary steps to create an official position within the Puerto Rico Government for the Program Integrity Lead.
- Medicaid procured a vendor, which is in the final stages of FOMB approval, to address PERM and MEQC requirements.
- PRHIA updated the COMP, which addresses the requirements of Section 1108(g)(7) of the Act, 42 CFR 438.66, and CMS MAC Scorecard measures. (Appendix B)

Directed Payment Arrangement for Physician Services

Requirement	Status
For fiscal years 2020-2021, additional funding in the amount of $200,000,000 per fiscal year is available when Puerto Rico's State Plan establishes a reimbursement floor, implemented through a directed payment arrangement plan, for physician services that are covered under the Medicare Part B schedule in the Puerto Rico locality established under section 1848(b) that is not less than 70 percent of the payment that would apply to such services if they were furnished under part B of title XVII during such fiscal year	No further action is required to meet this requirement.

In the spring of 2020, PRHIA completed a cost analysis and documentation necessary to seek CMS approval to implement a minimum fee schedule of 70% of the Medicare Part B fee schedule for licensed professionals under Puerto Rico's Medicaid program. PRHIA submitted the directed payment preprint to CMS on March 31, 2020 with an effective date of April 1, 2020 through September 30, 2021. PRHIA also revised the Vital contract and drafted a memo for all MCOs to communicate the rate and contract changes.

In June 2020, PRHIA received CMS approval for the period of April 2020 through September 2021. In August 2020, PRHIA also received FOMB approval for the Vital contract and capitation rate amendments to effectuate this provider reimbursement increase.

This arrangement will increase the average payment for professional services from 64.7% to 89.4% of what Medicare Part B would pay for the same services. The average payment for professional services under this directed payment is projected to be higher than the minimum of 70% of the Medicare Part B fee schedule because there is significant variation in managed care reimbursement for professional services. The minimum fee schedule will result in an increase in reimbursement of approximately $223.5 million for the period of April 1, 2020 through September 30, 2021.

Program Integrity Lead

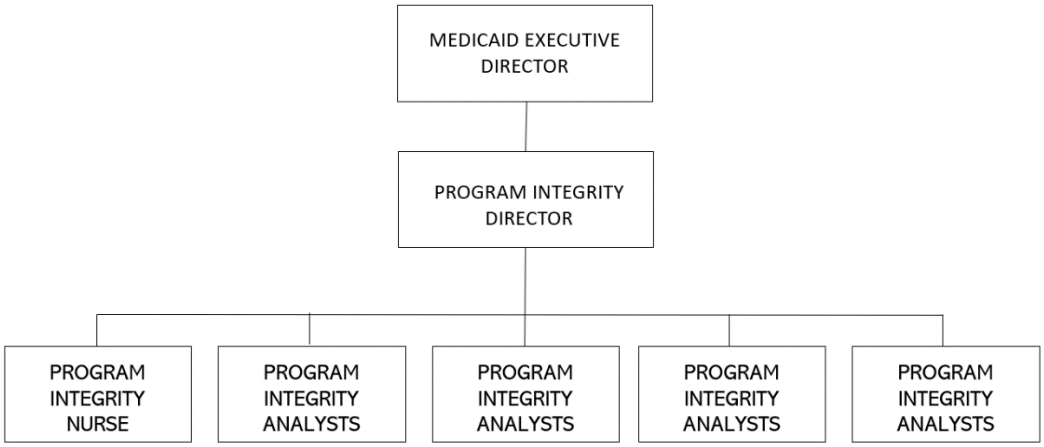
Requirement	Status
Not later than six months after the date of enactment of this paragraph, the agency responsible for the administration of Puerto Rico's Medicaid program under title XIX shall designate an officer (other than the director of such agency) to serve as the Program Integrity Lead for such a program. (Due 6/20/2020)	No further action is required to meet this requirement.

Puerto Rico has made significant strides with improving and implementing program integrity oversight over the past two years. In January 2019, Puerto Rico established the Puerto Rico Medicaid Fraud Control Unit (MFCU). This unit serves as the main liaison with the Department of Justice and as a key tenant in program integrity oversight across the Island. In December 2019, Medicaid established a Puerto Rico Program Integrity Unit (PIU) that was approved and recognized as an official government position as of July 2020. In June 2020, PRHIA hired a Compliance Director who is the main liaison for PRHIA to support program integrity oversight across the Island. In July 2020, PRHIA and Medicaid signed an MOU across the two agencies to ensure clearly defined processes, roles and responsibilities. The MOU gave PRHIA the responsibility for managing the MCO's contract while specific program integrity related investigations are conducted by the PIU in conjunction with the MCOs' program integrity units.

Medicaid Program Integrity Unit

The Puerto Rico Medicaid Program began to develop the Puerto Rico PIU in October 2019. This leadership position reports directly to the Medicaid Program Executive Director and the Puerto Rico Secretary of Health. Initially, Medicaid filled the role with a contractor but since August 2020 an official position has been in place and PIU is fully operational. To date six positions have been filled to support the unit including: one Program Integrity Director, one registered nurse and four program integrity analysts.

Figure 3-1 Program Integrity Unit Organizational Chart



Since its formation, the PIU has developed internal policies and procedures based on 42 CFR Part 455 and implemented an MOU across agencies (Medicaid, MFCU and PRHIA).

The Mission of Program Integrity Unit

The PIU's mission is to protect the Medicaid funds against losses from fraud and abuse and other improper payments, and to improve the integrity of the health care system. The mission is achieved through the activities of prevention, detection, investigation, referrals and prosecution of fraud, waste and abuse.

PIU Activities include:

- Monitoring of claims patterns, desk audits and reviews
- Data mining activities to identify outlier and high-risk payment providers
- Preliminary and complete investigations of alleged or potential fraud, waste or abuse
- Auditing to ensure compliance with the MCOs contracts and agreements
- Pursuing civil and criminal prosecution where evidence indicates fraudulent activity has occurred
- Money restitution where warranted
- MMIS monitoring and case tracking
- Interagency information exchange with the MFCU at the Puerto Rico Department of Justice and PRHIA Compliance and Legal departments

The PIU is actively looking to increase staff positions to strengthen PRMMIS operations and various program integrity functions. The PIU is currently working to collaborate with other states to identify other methods to enhance the PRMMIS and Medicaid Enterprise to support the PIU with results that can lead to recommendations for policy changes and potentially amendments to the Puerto Rico State plan or Vital contract. For example:

- PIU is in the process of setting policies and procedures for the MCOs that will allow for controlling duplicate billing, appropriate use of billing codes, recommend new rules or policies as Prior authorization for optional services.
- PIU is implementing provider enrollment functions at Medicaid to support provider profiling and will allow PIU to identify providers that should not be enroll based on history or allow enrollment with restrictions.
- PIU is establishing enhanced recoupment policies and procedures.
- PUI is strengthening audit and oversight functions to improve member eligibility oversight and the enhancement of Puerto Rico compliance with federal rules.

Puerto Rico Health Insurance Administration Compliance Officer

PRHIA's Chief Compliance Officer is in charge of the Compliance Department. This person serves as a counterpart to the Program Integrity Lead at Medicaid and will work closely with PIU with a focus on contract compliance. PRHIA will provide administrative back up on cases reviewed by PIU.

PRHIA is currently developing a risk assessment with Medicaid and Department of Justice (DOJ) to identify fraud, waste and abuse concerns and associated risk factors including, but not limited to:

- Vendor and contractor contracts
- Credentialing requirements and provider contracts
- Development of monthly provider payment reviews
- MCO transition
- Guarantee that the key program integrity metrics were part of the COMP to track various program integrity related measures including, but not limited to, federal statutes, MCO contract requirements, fraud, waste and abuse cases, investigations, provider terminations/exclusions, grievances/appeals and PERM (The updated COMP is Appendix B to this report.)
- Finance schedules to its reporting requirements to gather claims audits for PERM
- Internal compliance staff training

PRHIA will leverage the information from the completed risk assessment with Medicaid and MFCU to track and monitor program integrity activities in a cohesive manner. PRHIA also developed an internal work plan to improve internal program integrity oversight and included an evolving work plan as Appendix C.

Payment Error Rate Measurement Requirement

Requirement	Status
Not later than 18 months after the date of enactment of this paragraph, Puerto Rico shall publish a plan, developed by Puerto Rico in coordination with the Administrator of CMS and approved by the Administrator, for how Puerto Rico will develop measures to satisfy the PERM requirements under subpart Q of part 431 of title 42, Code of Federal Regulations (or any successor regulation). (Due 6/20/2021)	In process

In September 2020, Medicaid procured a vendor to support this initiative. The vendor is tasked with developing measures to satisfy the PERM requirements under subpart Q of part 431 of title 42, Code of Federal Regulations. The preliminary steps to meet this requirement are outlined in Appendix G. Medicaid will continue to provide updates to CMS on the status with meeting this requirement.

Contracting Reform

Requirement	Status
Not later than 12 months after the date of enactment of this paragraph, Puerto Rico shall publish a contracting reform plan to combat fraudulent, wasteful, or abusive contracts under Puerto Rico's Medicaid program under title XIX that includes — "(I) metrics for evaluating the success of the plan;" and "(II) a schedule for publicly releasing status reports on the plan." (Due 12/20/2020)	In process

PRHIA and Medicaid are actively working to strengthen contracting practices and to implement the required contracting reform plan. The development of the contracting reform plan cover multiple areas of contracting including, but not limited to, operational services, professional services and nonprofessional services. The goal of contracting reform is to ensure that the Government of Puerto Rico has protocols in place that maximize competition, lower costs (where possible), avoid duplication and increase coordination and accountability of all contractors and vendors.

Since December 2019, PRHIA and Medicaid have been in the process of procuring an independent auditing firm to audit MCO contractual compliance, recoupments and other issues currently under review at the FOMB. In addition, PRHIA and Medicaid meet regularly with the Government Accountability Office to review, discuss and determine new and revised contracting processes. PRHIA developed an internal process and flow chart that includes periodic reviews of all current consultant/trade/business associate contracts and compliance activities.

In September 2020, Medicaid procured a vendor to develop a comprehensive approach to advance the contracting operations and will engage in two workshops that will help develop the plan to reform contracting. The planned workshops and activities (Appendix G) are subject to change but will first be focused on developing a vision, guiding principles and improvement objectives for contracting reform. The second part of the project will be designed to develop a governance structure and metrics for evaluating the success of contracting reform including, but not limited to, new business processes for combating fraud, waste and abuse and building accountability and the implementation of key performance measures to monitor the success of the reform practices.

PRHIA developed a comprehensive contracting reform plan with a focus on PRHIA-specific contractors and vendors (Appendix D). The comprehensive contracting reform plan is a systematic process that aims to review current vendors and oversee professional service proposal evaluations in a structured and consistent manner. The plan sets out required steps towards proposal evaluations in a step-by-step manner, clearly delineates departmental responsibilities and establishes a required checklist that the current vendors and future proposals must meet to be considered for contracting.

At PRHIA, each department directly contract with vendors to support and/or supplement expertise needed for the department. Each department director presents the case to the PRHIA Executive Director for review and approval. It is the discretion of the PRHIA Executive Director to approve contracting requests for each department and is subject to BOD approval.

The process also requires a formal presentation by the PRHIA Executive Director to the BOD Contracting Committee to evaluate proposals and offer recommendations. The BOD’s Contracting Committee evaluates each proposal, determines the necessity of the proposed services, associated costs and the duration of the proposed contract. In the event the BOD reaches consensus to accept a proposal, the PRHIA legal and finance departments prepare and submit the required documentation to the Government Budget Management Office and Governor Secretary Office, according to the Memorandum OSG-2019-001 & Circular Letter 168-19 of FOMB.

FOMB has developed a specific platform for approved service proposals to ensure consistency across departments and agencies. All BOD approved proposals are submitted using the Government’s Contracting Processing Platform that sends proposals directly to the Office of Budget Management for a budget review and to the Governor’s Secretary Office for contract approval. PRHIA has included a draft of contracting reform process as Appendix D, which details the required steps to contracting within PRHIA departments, the BOD and FOMB and the Governor’s Secretary Office, including local regulations as listed in Appendix A.

In a recent procurement, PRHIA was able to realize immediate cost savings opportunities and strengthened oversight and management functions following this process with the procurement of enrollment counselor services. PRHIA has also reviewed its contracts with the Pharmacy Benefits Manager and Pharmacy Program Administrator to ensure maximum contractual savings and efficiency in the conversion to participation in the Medicaid Drug Rebate Program.

Medicaid Eligibility Quality Control Unit

Requirement	Status
Not later than 18 months after the date of enactment of this paragraph, Puerto Rico shall publish a plan, developed by Puerto Rico in coordination with the Administrator of CMS and approved by the Administrator, for how Puerto Rico will comply with the Medicaid eligibility quality control (MEQC) requirements of subpart P of part 431 of title 42, Code of Federal Regulations (or any successor regulation). (Due 6/20/2021)	In process

The Puerto Rico Quality Control Unit (QCU) evaluates Medicaid eligibility determinations to ensure the proper use of rules, regulations and procedures are applied during initial and subsequent eligibility determinations. The QCU was first established in 1980 and was updated in 2011 to improve and automate operations. The main development at that time was the development and implementation of an in-house management information tool “Medicaid Quality Management System” (MQMS) that was again updated in October 2019. In November 2019, Medicaid received confirmation from CMS that no compliance issues were noted for QCU or the MQMS.

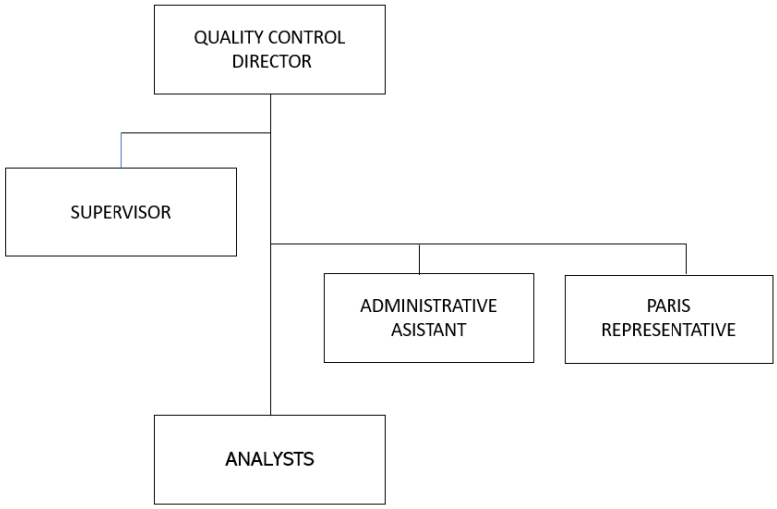
QCU hosts eligibility offices in strategic parts of the Island to improve member access for enrollment. The strategic locations of eligibility offices have changed over time and been reduced slightly since PRHIA contracted with an Enrollment Counselor to support Medicaid eligibility operations. QCU maintain all eligibility determination functions.

Eligibility rules and procedures are based on Puerto Rico’s state plan and the QCU procedures manual. On a quarterly basis, QCU conduct random samples of eligibility determinations to evaluate whether eligibility rules and regulations are applied correctly. These reports are reviewed by the Medicaid director and other senior staff to analyze findings and development recommendations for improvement.

Medicaid is in the process of evaluating regulatory guidance by CMS regarding MEQC to determine any additional gaps that will be detailed in the vendor’s scope of work for the MEQC plan due in 2021. Medicaid submitted the contract approval request currently sitting with FOMB. PRHIA are also in the process of adding claims and encounter schedules to its reporting requirements to gather MCO claims audit information for PERM reporting to support the plan roll out beginning in 2021.

Figure 3-2 Quality Control Unit Organizational Chart

To date QCU consists of nine positions including: one Quality Control Director, one Public Assistance Reporting Information System (PARIS) representative, one Administrative Assistant and six eligibility determination reviewers.



In September 2020, Medicaid procured a vendor to support this initiative. The vendor is tasked with developing a plan to continue Puerto Rico's compliance with the MEQC requirements of 42 CFR part 431, subpart P. The preliminary steps to meet this requirement are outlined in Appendix G. Medicaid will continue to provide updates to CMS on the status with meeting this requirement.

Federal Medicaid Budget (CMS-37)

Requirement	Status
Beginning with the first quarter beginning on or after the date that is one year after the date of the enactment of this subsection) For each quarter with respect to which Puerto Rico is required under subparagraph (A) to ensure that information described in such subparagraph is available, Puerto Rico shall submit to the Administrator of the CMS a report on such information for such quarter, which may include the submission of a quarterly Form CMS-37. (Due 3/31/21)	No further action is required to meet this requirement

The Puerto Rico Medicaid Program is in compliance with 42 U.S.C. 1396a(rr)(1)(A) and (B). Specifically with regard to 42 U.S.C. 1396a(rr)(1)(A)(i), Puerto Rico established and maintains a

system for tracking any amounts paid by the federal government to Puerto Rico with respect to the State Plan of Puerto Rico. The system includes the use of the quarterly Form CMS-64 (Quarterly Medicaid Assistance Expenditures for the Medical Assistance Program), which is submitted to CMS through the online Medicaid Budget and Expenditure System (MBES) on a quarterly basis. Specifically with regard to 42 U.S.C. 1396a(rr)(1)(A)(ii), the total amount Puerto Rico expects to spend for each quarter during the current FFY and for the next FFY under the State Plan of Puerto Rico, is reported on the Form CMS-37 (Medicaid Program Budget Report) to CMS online through the MBES.

For several years, Puerto Rico has established and maintained a system for tracking any amounts paid by the federal government to Puerto Rico with respect to the State Plan of Puerto Rico. Such system includes the use of the quarterly CMS-64 and the CMS-37 reporting forms. During the summer of 2020, Medicaid finalized procedures to reflect the changes required by the P.L. 116-94 enacted by Congress, including a narrative report that will be submitted with the CMS-37 and CMS-64. Puerto Rico is currently in compliance with CMS-64 and CMS-37 requirements.

CMS-64

Per 42 U.S.C. 1396a(rr)(1)(A)(i), the Medicaid Office submits quarterly the CMS-64 report through the MBES. The expenses reported on Form CMS-64 are determined using the cash basis and are based on the tabulation of actual Medicaid expenditures supported by source documents such as invoices, cost reports, copies of checks or wire transfers' authorizations and/or eligibility records. Such supporting documents are compiled in a readily reviewable format and sent to CMS for acknowledgment before any drawdown of federal funds is performed. Upon acknowledgement of receipt by CMS, the drawdown of federal funds is performed. The tabulation of actual Medicaid expenditures is made using a Request of Funds Control tool that is reconciled periodically with the U. S. Department of Health and Human Services Payment Management System.

Upon submission of the CMS-64, the Request of Funds Control tool is sent to CMS as supporting evidence of the expenditures reported in therein. Additionally, since the second quarter of FFY 2014 Puerto Rico prepares and submits quarterly to CMS a Variance Report based on the same data used for the CMS-64. That report compares the total amount expended (federal share) for the current quarter and, as required now by subsection 1396a(rr)(1)(A)(i)(I), the total amount expended by Puerto Rico during any previous quarter of such fiscal year. To describe how such amounts are so expended the quarterly Variance Report is classified by program (e.g., Medicaid, Medicaid Administration, CHIP, MMIS), as required now by 42 U.S.C 1396a(rr)(1)(A)(i)(II).

CMS-37

Per 42 U.S.C. 1396a(rr)(1)(B), the Medicaid office identifies the total amount that Puerto Rico expects to spend during the quarter under the State Plan of Puerto Rico, and a description of how Puerto Rico expects to spend such amount is reported on Form CMS-37 through MBES. The projected expenses reported on Form CMS-37 are prepared and supported by a CMS-37 worksheet. The preparation of the CMS-37 is done by obtaining the most current and reliable data, developing and applying updated

assumptions for projecting Medicaid expenditures, and reviewing and submitting the report. Upon submission of the CMS-37, the CMS-37 worksheet tool is sent to CMS as supporting evidence of the projected expenditures reported therein. Under the actual system described above, Puerto Rico ensures that the information is available with respect to each quarter in a fiscal year.

All policies and procedures established for the preparation of the CMS-64 and CMS-37 reports are duly documented in its relative sections of the Finance Division Manual under the custody of the Finance Director of the Puerto Rico Medicaid Program. Procedures were updated to reflect the changes required by P.L. 116-94 enacted by Congress including a narrative report that is currently submitted with the CMS-37 and CMS-64.

Reporting on Medicaid and CHIP Scorecard Measures

Requirement	Status
Beginning 12 months after the date of enactment of this subsection, Puerto Rico shall begin to report to the Administrator of CMS on selected measures included in the Medicaid and CHIP Scorecard developed by CMS. (Due 12/20/2020)	In process

The overarching expectation of the MCOs is to increase the quality of patient care while controlling costs. To monitor MCO performance, PRHIA and Medicaid utilizes several reporting sources. Annual Healthcare Effectiveness Data and Information Set measures are used to measure improvement using nationally recognized performance improvement measures. The Health Care Improvement Program (HCIP) has been implemented, and utilizes a retention fund to reward positive health outcomes based on four categories of performance indicators: Chronic Care Initiative, High Cost Conditions Initiative, Healthy People Initiative and Emergency Room High Utilizers Initiative. Lastly, PRHIA and Medicaid have developed a COMP that prioritizes key performance indicators (KPIs) based on Vital specific needs. The COMP is a tiered oversight metrics approach to monitor KPIs related to six main areas: finance, quality, network, program integrity, pharmacy and program administrative information. The operational and financial performance metrics provide insight into the efficiency and type and volume of care given to Medicaid beneficiaries in managed care. Detailed metrics show how the MCO operates, measures compliance with regulatory and contractual obligations, and illustrates the MCO’s financial health; therefore, key metrics serve as an indicator of potential issues, inefficiencies, or instability that could lead to contractual violations. These reporting avenues align with 42 CFR 438.66 and the MAC Scorecard. Both Medicaid and PRHIA are leveraging vendors to help evaluate data, develop benchmarks and to align MCO and MMIS information with the CMS MAC Scorecard.

PRHIA completed a crosswalk of the State Health System Performance (SHSP) measures, a component of the CMS MAC Scorecard, which validated that the majority of measures are currently captured and reviewed. In the coming months, PRHIA and Medicaid are revising certain metrics to

address any SHSP metrics not currently captured today. In addition, PRHIA and Medicaid are coordinating efforts to establish reporting for the program integrity metrics for State Administrative Accountability. PRHIA and Medicaid will continue to coordinate program integrity information to ensure scorecard metric improvement targets are reasonable and achievable. PRHIA and Medicaid will collaboratively address metrics that fail to meet benchmarks or improvement targets to determine appropriate corrective actions.

Expenditure Activities under the Law

During 2019, the Governor of Puerto Rico, PRHIA and Medicaid lobbied congress for funds necessary to maintain the operations of Vital, the Government Health Program. The basis for the increase, were sustainability initiatives representative of planning and objectives of the Government of Puerto Rico. The Government's efforts were directed to achieve two main objectives: preserve the baseline funding for the existing Vital operations (approximately 2.8 billion dollars of federal and state matching funds) and provide Puerto Rico with approximately $700 million incremental dollars in order to fund the sustainability initiatives described below.

Planned initiative #1 was established to increase the artificially low and static PRPL to 85% of the FPL, which would enable the inclusion of a large number of ineligible individuals to Vital. Increasing the PRPL would have increased enrollment leading to approximately additional $350 million in expenditures out of the $700 million incremental funds appropriated by congress. Ultimately, FOMB denied the request due to the pending "fiscal cliff" and lack of local funds to sustain the initiative without federal support. Without this initiative moving forward, the Government of Puerto Rico was left to come up with a back-up plan to use approximately half of the funds provided for FFY 2020.

Initiative #2 was established to create a buy-in program to purchase Medicare Part B coverage for the Platino (Medicare-Medicaid dual eligible) beneficiaries of Vital. PRHIA and Medicaid engaged CMS early in February 2020 to receive guidance for the implementation of this initiative. CMS engaged PRHIA to develop an estimation of the potential impact of the buy-in program and contrasted the incremental funds with the cost of the buy-in program. After the analysis, CMS reached the conclusion that the incremental funds authorized in PL 116-94 were insufficient to fully fund the buy-in initiative.

Initiative #3 sets the provision of a minimum floor of 70% of the current Medicare Fee Schedule to Medicare Part B providers participating in Vital. As noted above, PRHIA completed and issued a Vital contract amendment and received FOMB approval on July 27, 2020. CMS approved the directed payment for period April 1, 2020 through September 30, 2021. The increase of payment to Part B providers represents a minimum floor for payments. Any provider with an arrangement paying a higher percentage was allowed to keep the percentage already negotiated until the next round of contracting with the MCOs. The initiative projected to spend approximately $140 million a year. It is estimated through this initiative up to $22 million was paid during May and June 2020 alone. This is the highest expenditure initiative approved by CMS.

Initiative #4 was designed to increase hospital reimbursement to compensate for the operational losses arising from the provision of care for Medicaid beneficiaries. Hospitals in Puerto Rico have endured extremely low reimbursement for services provided to Medicaid beneficiaries that subsequently creates operational losses for hospitals. In concert with the Puerto Rico Hospital Association, PRHIA determined operational losses estimate approximately $106 million every year. CMS approved this initiative on July 16, 2020 for the period of January 1, 2020 through September 30, 2020. Payments from this additional reimbursement pool will be made on a quarterly basis and will be separate from PMPM, and will be reimbursed as non-premium payments. The payments were also estimated using a Diagnosis Related Group (DRG) methodology, ensuring payments will be compatible with PRHIA's transition to DRG based hospital payment methodologies.

Initiative #5 was designed to increase reimbursement to physicians with a sub-capitated arrangement in order to gradually take them to a PMPM equivalent 70% Medicare reimbursement. The sub-capitated arrangement includes two portions:

1. A 10% flat increase for retroactive reimbursement for January 2020–June 2020 worth approximately $12 million

2. An increase of reimbursement to 70% Medicare PMPM equivalent, which will lead to approximately $50 million each year

Initiative #6 is focused on eliminating Hepatitis C in Puerto Rico by 2030. This initiative was approved by CMS on June 9, 2020 and to date approximately $2 million has been spent on the initiative with an annual expense expected to be $36 million each year.

During the last 11 months, these initiatives were planned and implemented with various levels of success. It has taken the Government of Puerto Rico time to prioritize and operationalize each initiative, many of which have required either making state plan amendments or directed payment authorizations, and all of the initiatives required approval by the FOMB. Due to the timing of efforts and of the review and approval process by CMS and FOMB, and noting that most of the necessary CMS approvals occurred primarily between February and June of 2020, PRHIA has made the most use of the appropriated funding possible.

In order to mitigate the delays associated with CMS and FOMB approvals, PRHIA secured guidance from CMS to ensure that retroactive payments tied to increased provider reimbursement would be considered "prior payment adjustments", therefore allowing PRHIA to draw dawn on FFY 2020 funds for the payment of said adjustments. Recently, PRHIA issued payment in the amount of $40 million in order to cover the new 2020–2021 contract rates, which include increases payable for the last quarter of FFY 2020. The total amount of FFY 2020 that PRHIA will be able to draw down is in the environs of $191 million.

4

Other Improvements

In addition to the requirements outlined in the law, Puerto Rico has made additional efforts to further stabilize and enhance the healthcare delivery system in Puerto Rico. These efforts as described below are all part of the long-term plan to address identified needs. Efforts are focused on further improving conditions for providers working towards an appropriately resourced network of professionals and facilities, providing additional necessary services to members and creating a comprehensive oversight and monitoring plan.

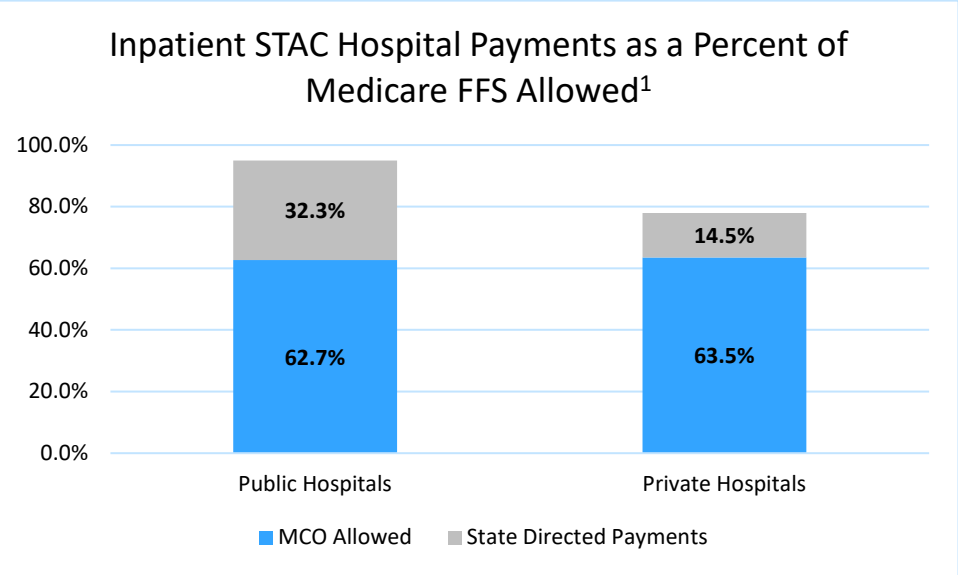
Increases to Provider Reimbursement

In addition to the federally mandated increase to reimbursement for professional services, PRHIA has implemented or submitted three directed payments under the Vital program to address reimbursement for inpatient and hospital services, sub-capitated providers (primary care and behavioral health services) and dental services.

Inpatient Hospital Payments

On May 20, 2020, PRHIA submitted a directed payment preprint for a uniform increase to managed care payments for inpatient services provided by public and private short-term acute care (STAC) hospitals. CMS approved the directed payment on July 14, 2020 for the period of January 1, 2020–September 30, 2021. The estimated value of the increase over the approval period for public STAC hospitals is $48.4 million and will increase inpatient reimbursement from approximately 62.7% of Medicare to 95% of Medicare. The estimated value of the increase over the approval period for private STAC hospitals is $131.8 million and will increase inpatient reimbursement from approximately 63.5% of Medicare to 78% of Medicare.

Figure 4-1 Summary of Payments Relative to Medicare Fee-For-Service (FFS) Allowed for Public and Private STAC Hospital



[1]The total inpatient STAC hospital directed payments for the period of January 1, 2020 through September 30, 2021 is $48.40 for public hospitals and $131.8 for private hospitals.

Sub-Capitated Providers

On June 9, 2020, PRHIA submitted a directed payment preprint for a uniform 10% increase to PMGs and behavioral health providers that are reimbursed by the MCOs on a sub-capitated basis for the period of January 1, 2020 through June 30, 2020. Section 1108(g)(6)(B)(ii) of the Act excluded sub-capitated providers from the 70% of Medicare Part B minimum fee schedule for professional services; therefore, this directed payment for sub-capitated providers would increase reimbursement for a significant portion of Medicaid providers. Under this reimbursement model, the provider receives a PMPM amount for enrollees attributed to the provider as payment in full for services rendered during the month. PMGs are a grouping of associated primary care physicians and other providers that have contractually agreed to offer a coordinated model of care that integrates physical and behavioral health services to enrollees. All Vital enrollees are affiliated with a PMG and all PMGs are reimbursed on a sub-capitated basis. Some behavioral providers are under similar reimbursement arrangements. The total computable investment for this directed payment for the six-month period is estimated to be $13 million.

This is pending CMS approval and is an excellent step in stabilizing the provider community for the benefit of the beneficiaries and providers alike. Further improvements will be needed to incentivize the growth of the network and ensure the resources are available when they are needed. At this stage, ASES has already negotiated the inclusion of the $50 million capitation payment increase into the new rates with the MCOs, also providing strong contractual language to insure that these payment flow to

the physicians under capitated arrangements. ASES will diligently follow up on this matter in order to determine if further regulatory action is needed to insure that the increase effectively reaches and benefits this physician group.

Dental Fee Schedule Increase

For the period of July 1, 2019 through June 30, 2020, PRHIA established a minimum fee schedule for dental services under the Vital program through the directed payment mechanism. A renewal directed payment preprint for July 1, 2020 through September 2021 to revise the minimum fee schedule to account for cost inflation on dental procedures was submitted to CMS on May 21, 2020 and is pending federal review and approval.

Expansion of Medicaid Benefits

Hepatitis C Antiviral Medication Coverage

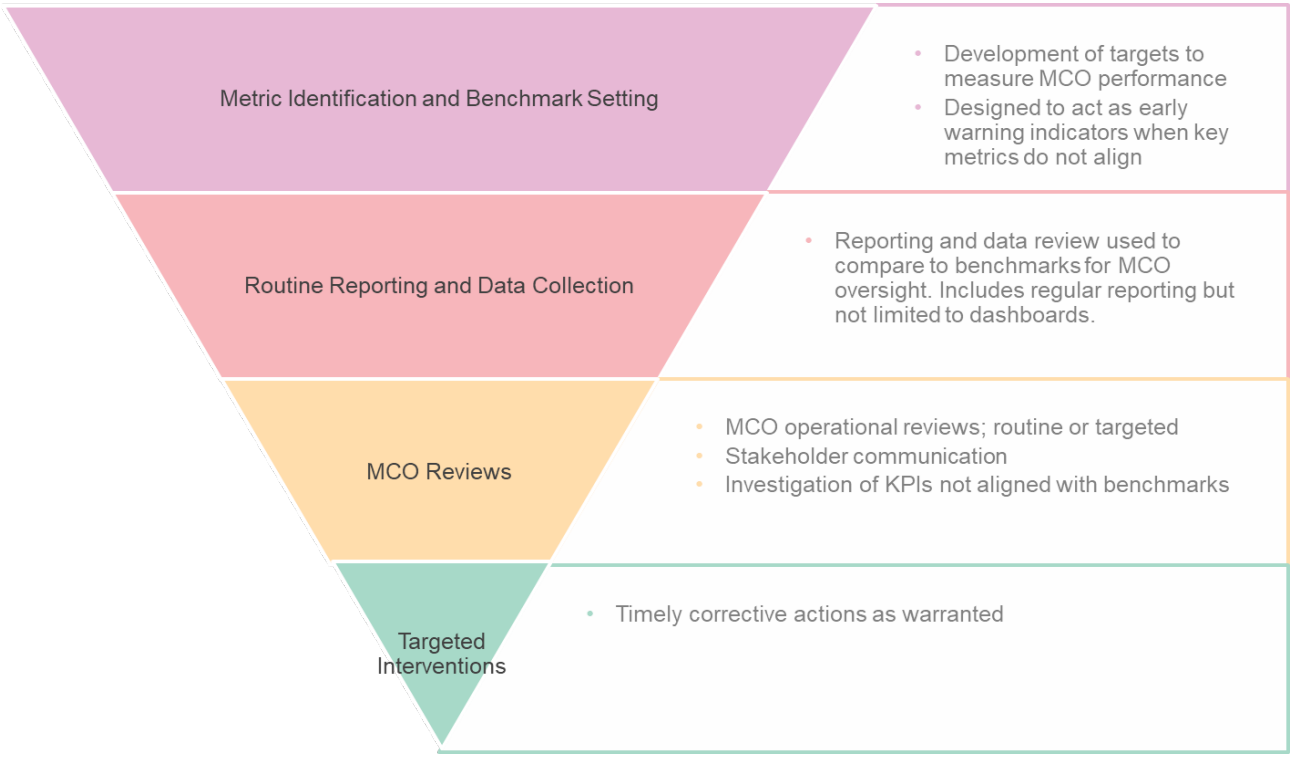
On March 17, 2020, Puerto Rico Medicaid Program filed a state plan amendment (SPA PR-2-0008) for FFS Medicaid coverage of MAVYRET (Glecaprevir/Pibrentasvir), a Hepatitis C antiviral medication. CMS approved the SPA on July 21, 2020 with an effective date of March 17, 2020. Due to the significant cost of this medication, PRHIA will reimburse providers directly for the course of treatment rather than building the costs in the Vital PMPM payments. The estimated federal share for three quarters of FFY 2020 is $12,540,945 and $25,721,979 for FFY 2021.

Infrastructure

Comprehensive Oversight Monitoring Plan

PRHIA is in the process of implementing the COMP to monitor MCO activities, including contractual obligations, federal requirements and overall financial health. The COMP identifies KPIs and related comparison benchmarks to monitor MCO performance in several areas: clinical quality, finance, program integrity, network adequacy, claims and encounter operations, and pharmacy operations.

Figure 4-2 Comprehensive Oversight Monitoring Plan



The current version of the COMP includes 178 KPIs categorized and tiered into the six key operating areas representing 40 distinct contract standards. Each KPI is assigned a tier, a comparison benchmark with an acceptable range for the metric, common causes for that KPI to fall out of the acceptable range, a “drill” path to investigate out-of-range metrics and a list of stakeholders that should be notified.

Each KPI is assigned a tier level using a top-down approach. Tier 1 KPIs are designed for executive leadership. They include high level reporting standards that allow executive leadership to monitor MCO performance and overall financial health. Tier 2 KPIs are designed for department heads of the key operating areas that allow directors to quickly ascertain potential problems. Tier 3 KPIs are detailed on a granular level and are often assigned to analyst or operating area subject matter experts to intervene as issues are identified.

KPIs are mapped to several data sources of data to monitor MCOs including, but not limited to:

- Enrollment and disenrollment reports for each MCO
- Member and provider grievance and appeal logs
- Findings from the State's External Quality Review process

- Self-reported MCO data on required quality and operational measures, such as clinical quality measures, financial health measures, network adequacy measures and compliance measures
- Audited and unaudited financial and encounter data submitted by each MCO
- Customer service performance data and beneficiary support data

The COMP integrates these data sources into a dashboard software that allows the user drill into the detail used to calculate the KPI. Currently, 30–40 KPIs are in production, including all tier 1 KPIs. Staff training and development of reporting for the remaining KPIs is underway.

The approach to MCO monitoring using KPIs and comparison benchmarks allows PRHIA to efficiently review MCO performance and compliance with contractual standards. The example shows the comparison of total cost of medical care to the expected medical expense used in Vital capitation rate books. This type of comparison serves as an early warning system to fraud, waste or abuse, mismanagement of care or opportunities for better care management.

Staff training includes review of the KPIs, benchmarks, drill paths and communication plans. PRHIA expects the results to ultimately support the reporting requirements to CMS under 42 CFR 438.66(b). While the COMP itself is expected to be a living document with regular review and updates, PRHIA anticipates full implementation over the next fiscal year.

Checklist/Toolkit

To further expand on efforts outlined in the COMP, PRHIA has analyzed existing internal compliance procedures to evaluate MCO performance across the operational domains defined in the Vital Model contract. At a high level, these efforts include developing a plan to define the evaluation, review, monitoring and audit activities needed to support a comprehensive compliance program. In addition, a Compliance Toolkit was developed that dissects each of the Vital Contractual provisions and identifies the following:

1. Lead department responsible for the oversight of each contractual requirement
2. Source of information that informs compliance against requirement
3. Monitoring activity needed to support oversight of these requirements

This toolkit is intended to streamline oversight processes and to leverage findings from ongoing MCO reporting, complaints received from providers and members, and documents reviewed to allow for a holistic approach to MCO performance and potentially to assist in identifying systemic issues.

The PRHIA Compliance Department has examined key risk areas that will require operational audits of each MCO. Examples of key risk areas include Fraud Waste and Abuse compliance, Medical Loss Ratio, effectiveness of HCIP, and management of High Cost High Need enrollees. Survey procedures

for these audits are currently under development and will include a review of each MCO's most recent KPIs, documents and MCO interviews.

System Improvements

PRHIA and Medicaid have been making improvements to the MMIS systems across programs (PRMMIS). The project started in 2018 and was focused on ensuring Puerto Rico adopted MMIS technology and management to support the improvement of Medicaid services and policies.

PRMMIS is an integrated group of computer system functions and operations procedures developed according to CMS requirements and guidelines to provide operational and reporting excellence for the Medicaid Program. The goals with implementing PRMMIS are to transform the Medicaid enterprise to an information driven agency, which leverages modern technology to improve healthcare outcomes, improves Medicaid program oversight and provides user access to data and meaningful information. The project continues to evolve and involves a consortium of key stakeholders (PRHIA, Medicaid, MCOs, the PBM and key vendors/staff).

PRHIA and ASES have also been actively working to advance Medicaid Information Technology Architecture (MITA) maturity levels through process and technology improvements. Since the initial MITA State Self-Assessment that was completed in 2015, PRHIA and Medicaid have been working to improve data quality and data integration across the Medicaid Enterprise. Since the 2015 assessment, Medicaid through PRMMIS automated data transfer and validation processes resulting in increased data quality and reliability. Each year Medicaid conducts an annual assessment identifying improvements year over year and recommends future improvements that may be achieved with technology investments. PRHIA and Medicaid are also implementing a Health Information Exchange platform, which should support future connectivity and interoperability between Medicaid and stakeholders.

FOMB 2020 Fiscal Plan

Each year the FOMB delivers a notice to the Governor providing a schedule for the process of development, submission, approval and certification of fiscal plans, the status of implementation activities for the 2020 fiscal plan is provided below. While the FOMB consults with the Governor in establishing a schedule, the FOMB retains sole discretion to set or, by delivery of a subsequent notice to the Governor, change the dates of such schedule as it deems appropriate and reasonably feasible.

For nearly four years, fiscal plans have pressed for major structural reforms to restore competitiveness, enable growth, and spur a return to prosperity. The fiscal plans have accompanied these reforms with targeted investments and support for those on the front lines of service delivery and cover a period of five fiscal years from the fiscal year in which it is certified by the FOMB.

2020 Fiscal Plan

The 2020 fiscal plan financial forecasts note Puerto Rico's current financial trajectory is not sustainable in the long-term and will not raise Puerto Rico and its residents to a level of prosperity comparable to even the poorest states on the U.S. mainland.[6]

PRHIA and Medicaid, under the guidance of the FOMB and the Government of Puerto Rico, are aggressively leveraging all opportunities to implement and build program integrity practices at all levels to demonstrate their adherence to the law and generate real program savings and accountability reforms that reduce the long-term growth rate of healthcare expenditures. Given the uncertainty as to future federal reimbursement levels, the 2020 fiscal plan assumed that no further supplemental funding will be provided beyond current programs, and thus, the Commonwealth must be prepared to cover.

Medicaid Reform Measures

To meet the requirements set forth in Section 1108(g) of the Act and in the FOMB's 2020 fiscal plan and reduce health care delivery costs on the Island, PRDOH, PRHIA and Medicaid have taken tremendous steps over the past 11 months to improve the efficiency and effectiveness of oversight and available tools.

Program Integrity

The 2020 fiscal plan requires PRHIA and Medicaid to achieve savings between FFY 2022 and FFY 2025 by improving enrollment verification and the reduction of other forms of fraud, waste and abuse. As discussed later in this report, both PRHIA and Medicaid have taken an aggressive approach with the development and implementation of concrete oversight and monitoring practices to achieve these savings. Such as implementing a comprehensive oversight and monitoring program, enhanced data analytics, focused analyses on encounter data submissions, enhanced internal review procedures and improved inter-agency coordination across stakeholders (Office of Inspector General, DOJ, PRHIA and Medicaid).

To ensure coverage is offered only to eligible individuals through robust enrollment verification, PRHIA and Medicaid have contracted and developed plans to achieve full compliance with PERM and MEQC requirements.

In addition, PRHIA and Medicaid integrated PRHIA data with the MMIS, established Medicaid PIU and improved coordination with MFCU and the PRHIA Compliance Department. PRHIA and Medicaid have established procedures and rules for procuring Medicaid contracts, and are in the process of improving enrollment verifications through employer certification and PARIS checks.

[6] Fiscal Plan for Commonwealth of Puerto Rico—Certified as of May 27, 2020, Pg. 10

Value-Based Payment Initiatives

The 2020 fiscal plan requires PRHIA and Medicaid to pursue value-based improvement initiatives to curtail inflation while improving health outcomes across the system. PRHIA and Medicaid have begun the design of certain value-based reforms with a focus on reducing emergency room visits and the average length of stay in hospitals by members. This started with the improvement of data analytics and data validation in 2020 with a focus on these two measures. PRHIA and Medicaid will leverage this information in their development of provider incentive plans informed by data.

PRHIA has begun development of a DRG methodology to reimburse hospitals the fixed amounts based on certain medical diagnoses. Currently, PRHIA is testing the initial stages of this model, and it is due to be launched in 2021.

5

Next Steps/Closing

The people of the Puerto Rico are grateful for everything that the federal government is doing to support our recovery from the recent disasters and for providing assistance in addressing the impacts of the COVID-19 pandemic. However, a critical and necessary component of our ongoing ability to address these issues is the continued viability of our Medicaid program. We believe this viability is dependent on a comprehensive and permanent solution for our Medicaid and CHIP programs. We want to work with the Congress and Administration on a permanent solution to the Medicaid funding issues in order to ensure that Puerto Rico can have a reliable and sustainable Medicaid program based upon the actual needs of its citizens.

Puerto Rico has responded to the provisions required by congress quickly, making progress on all requirements, reporting proactively to our regulators and acting with good faith and flexibility through all of the approvals and barriers in our path. Through the cooperation and efforts made by Medicaid and PRHIA, the Government of Puerto Rico has strengthened and begun to stabilize the provider community and begun enhancing the infrastructure of operations allowing for increased management and oversight, accountability and reporting. Changes of this magnitude require both the financial investment of federal dollars and investment of leadership to ensure the implementation of planned initiatives is completed.

In November 2020, the gubernatorial elections may result in a transfer of leadership of Medicaid and PRHIA. It is this administration's hope, that any new leadership will embrace the work completed thus far and maintain the trajectory of the work completed. Please afford Puerto Rico the opportunity to continue these efforts. The combination of insufficient federal allotment at a low matching rate means that Puerto Rico will have an uncharacteristically high burn rate for state generated funding. The sustainability measures described in this report are not enough to make up for the shortfalls in the budget. It is crucial that Puerto Rico secures permanent additional funding in addition to a higher matching rate. Without this relief:

- Continued work on sustainability efforts may need to be abandoned to allow funds maximization to provide care for people.
- No additional benefits that would help stabilize the population's health needs can be covered (e.g., Non-Emergency Medical Transportation).
- No coverage for additional populations through an update to the PRPL can be included in Medicaid.

- Reevaluation or elimination of planned increases to provider rates will be necessary and subject to uncertainty.

Thank you for this opportunity to report to Congress on the needs of the people of Puerto Rico and the efforts made to meet those needs through the provision of Medicaid services.

Appendix A

Compendium of Relevant Contracting Reform Puerto Rico Regulations

Compendium of Relevant Contracting Reform Puerto Rico Regulations

The Puerto Rico Medicaid Program is part of the Puerto Rico Department of Health (DOH). The DOH as a public Agency has to follow all the contracts rules and regulations that are established by the Central Government.

As part of the DOH, the Puerto Rico Medicaid Program complies with all the Puerto Rico rules and regulations established by the local Government among these regulations are the following:

1. Law to Establish Uniform Parameters in the Procurement Processes of Professional and Consultative Services for the ELA Government Agencies and Entities Law No. 237 of August 31, 2004.
2. The real state contracts to lease office space for all government Agencies is regulated by Puerto Rico Law 235 enacted on December 19, 2014.
3. All contracts have to be publicly registered on the Puerto Rico Comptroller's Office according to Puerto Rico Law 18 of October 30, 1975 and amended by Law 17 of November 29, 1990 and Law 127 of May 31, 2004.
4. Regulation No. 33 of September 15, 2009, as amended, known as "Registry of Contracts, Deeds and Related Documents, and Sending Copies to the Office of the Controller of the Commonwealth of Puerto Rico".
5. The Circular Letter 141-17 of the Office of the Governor requires previous authorization before approving and signing all government contracts that exceed $10,000 a year.
6. The Puerto Rico Department of the Treasury (Hacienda) established circular letter CC1300-16-16 to regulate the required documentation before signing any government contract.
7. On February 19, 2019 the DOH Secretary created a circular letter to establish the procedure to seek approval of the contracts in the Department of Health.
8. Anti-Corruption Code for the New Puerto Rico, Law No. 2 of January 4, 2018.
9. On July 2006 the Comptroller's Office of Puerto Rico created the following booklet called: "Principios Legales y de Sana Administración que regulan la contratación de Servicios Profesionales y Consultivos en el Sector Publico".
10. Article 4.3 of the Organic Law of the Government Ethics Office of Puerto Rico, Law No. 1 of January 3, 2012.
11. Article 8 of Law No. 147 of June 18, 1980, as amended, Organic Law of the Office of Management and Budget - on prohibition of spending more than 50% of budget in election year.
12. Law to Address the Economic, Fiscal, and Budgetary Crisis to Guarantee the Functioning of the Government of Puerto Rico, Law No. 3 of January 23, 201.
13. Article 35 of the 2019 General Services Administration Centralization of Government Purchases Act, Act No. 73 of July 19, 2019, as amended, on the Single Registry of Supplier.
14. Law No. 66 of June 17, 2014, as amended, Special Fiscal and Operational Sustainability Law of the Government of the Commonwealth of Puerto Rico.
15. Law No. 14 of 2004, as amended, Law for Investment in the Puerto Rican Industry.
16. Article 1 of Act No. 48 of 2013, as amended, to establish the Special Contribution of 1.5% in professional services contracts.

Appendix B

Comprehensive Oversight and Monitoring Plan

MERCER

Draft Managed Care Organization

Comprehensive Oversight Plan

Administración de Seguros Salud de Puerto Rico
June 17, 2020

welcome to brighter

Contents

1

Introduction

The Puerto Rico Department of Health and Human Services (ASES) contracted with Mercer Government Human Services Consulting (Mercer), a division of Mercer Health & Benefits LLC, to create a comprehensive Medicaid managed care organization (MCO) oversight and monitoring plan. ASES and the Puerto Rico Department of Medicaid are working together to administer and manage Medicaid and are jointly responsible for oversight of Medicaid funds. Each organization has specific responsibilities to administer Medicaid but must work together to combat fraud, waste and abuse (FWA) and to ensure program oversight. Medicaid is primarily responsible for program eligibility and Medicaid Management Information Systems (MMIS) operations. ASES is responsible for contracting and overseeing MCOs and provider networks. In tandem, ASES and the Department of Medicaid are putting in place key oversight metrics and benchmarks.

Managed care is expected to increase the quality of patient care while controlling costs. Operational and financial performance metrics provide insight into the efficiency, type and volume of care given to Medicaid beneficiaries in managed care. Detailed metrics show how the MCO operates, measures compliance with regulatory and contractual obligations, and illustrates the MCO's financial health; therefore, key metrics serve as an indicator of potential issues, inefficiencies, or instability that could lead to contractual violations.

ASES and the Department of Medicaid are in the process of developing comprehensive oversight at various levels of the program, including high-level program statistics and demographics to very specific key performance indicators (KPIs) for certain conditions and cohorts. This document describes how ASES can measure and manage Medicaid MCO performance through the use of key performance metrics. These metrics will be compared to benchmarks or expected outcomes, over time, and against peers in order to communicate MCO performance to key stakeholders.

Approach

Successful MCO oversight and monitoring requires a thoughtful blueprint of specific and targeted metrics to ensure compliance with Federal and Puerto Rico regulatory requirements as well as MCO contractual requirements. In addition, consistent and proactive oversight provides the ability to efficiently respond to executive and legislative inquires as well as to understand MCO-specific trends and outcomes. Population based metrics allows ASES to measure member impact and cost drivers.

The majority of the data collected is self-reported by the MCOs, meaning the MCOs are responsible for reporting results truthfully, accurately and completely by submitting a signed attestation of such with

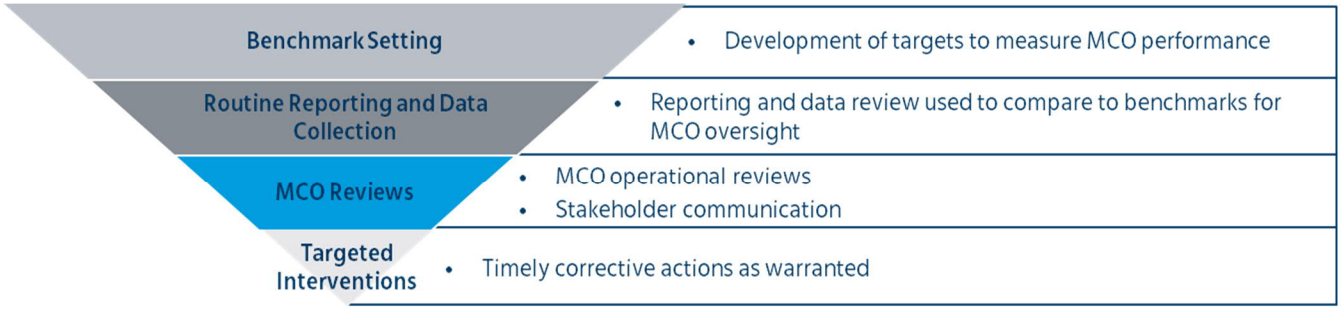
each report submission. ASES may rely on other sources such as External Quality Reviews (EQRs), MCO operational reviews and annual financial audits to provide additional level of assurance that the self-reported information is reliable and accurate.

Consistent monitoring will allow ASES to consider relevant communication with the MCOs regarding MCO-specific as well as overall system trends. As well as timely Corrective Action Plans (CAPs) and targeted intervention where appropriate. In conjunction with the Department of Medicaid, ASES will also implement processes to reconcile self-reported MCO data with MMIS encounters at a later stage of this implementation.

Structure

A top-down concept may be used to streamline the ASES oversight program and tailor it to various audiences and/or the level of review needed based on results. The top-down approach to oversight is structured by identifying high-level metrics to measure MCO performance and comparing those metrics to benchmarks, either over time, against peer submissions, or to expectations. This comparison is done by consistent review of routine reporting and validated by MCO operational reviews (audits) subsequently enabling ASES to identify key targeted interventions as needed to maintain operational efficiency and contractual compliance.

The table below represents key components of a successful oversight program:



Key Components

This oversight plan includes the following key components:

- An oversight and monitoring program including a description of the metrics, acceptable ranges for results and common causes for movement outside of acceptable ranges.
- A series of reporting templates to capture MCO data.

- The Plan Vital Reporting Guide to explain how to complete the reporting templates.
- A series of sample dashboard metrics that will summarize, at varying levels, the results of MCO reported information versus regulatory and contractual requirements and/or industry standard performance metrics.
- Operational review opportunities to compliment the MCO-reported information and address areas where MCOs may be incurring challenges.
- Options for CAPs or targeted interventions as deemed necessary.
- A Communication Plan to notify key stakeholders when a measure appears to be outside the expected range.

These components work in conjunction with required MCO-reported information to monitor the operational and financial performance and efficiency of the MCOs, as well as to evaluate compliance with contractual, Federal, and Puerto Rico requirements. They are designed to provide insight into MCO operations and serve as a management tool for evaluating if MCOs are performing as expected.

The oversight and monitoring tools provide a focused, comprehensive look at self-reported data from the MCOs and enhance the ability to oversee the program by qualified, experienced staff. In conjunction with the Department of Medicaid, this information will be leveraged to develop benchmarks and KPIs to inform prospective oversight and data benchmarks.

Oversight Areas

This plan focuses on six key areas for oversight of the MCOs. While certain areas are not mutually exclusive, each oversight area includes key components that include specific reporting requirements.

Oversight Area 1 — Network Access and Availability: This area focuses on provider and network access and availability requirements as required by the Plan Vital contract.

Oversight Area 2 — Program Integrity (PI): This area focuses primarily on FWA activities and coordination requirements and is designed to support ASES and the Department of Medicaid with outward reporting requirement to maintain PI and Federal Medicaid funding.

Oversight Area 3 — Quality and Clinical Management: This area focuses on key quality and clinical elements, and includes the identification of key trends and the comparison thereof to national and Puerto Rico specific benchmarks.

Oversight Area 4 — Financial: This area focuses on key financial elements for analysis of the profitability, solvency, efficiency, accuracy and compliance of each MCO and their corresponding reports. Metrics are compared against expectation, against peers and over time — looking at trends. Financial results are directly correlated with all other areas.

Oversight Area 5 — Claim and Encounter: This area focuses on the timeliness, completeness and accuracy of claims processing and payment and submission of encounter data.

Oversight Area 6 — Pharmacy Benefits: This area focuses on pharmacy operations, including oversight of Pharmacy Benefit Manager (PBM) operations, prescription costs and utilization trends. This area also focuses on brand or generic usage and the impact of specialty prescription drugs.

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Identifying and Managing Benchmarks

As mentioned in Section 1, a top-down approach to oversight starts by identifying high-level metrics to measure MCO performance and comparing those metrics over time, against peer submissions, and to expectations. Multiple points of comparison help ASES understand the information being reported via the various reports described in the Plan Vital Reporting Guide, since any one metric observed in isolation may lead to an incorrect conclusion.

For clinical, quality, PI and network reports, MCOs are instructed to report on a monthly, quarterly and annual basis. These metrics capture key access, PI and clinical information for the Plan Vital program.

For Financial Reports, MCOs are instructed to report either an accrual basis of reporting (i.e., on a reported basis) or on an incurred and paid basis. When examining financial measures, the data source of the metric measured and the basis of reporting for that schedule should be considered.

The overall approach can be visualized through a dashboard by displaying tiered metrics based on the overall impact to the organization to allow a high-level analysis of results, but with the ability to drill into more detailed data and metrics. The metrics for each oversight area are described in more detail in each of their respective sections.

Metrics are aligned into four categories:

- Demographic
- Tier 1 — top level metrics
- Tier 2 — summarized but more detailed metrics
- Tier 3 — detailed metrics

Demographic metrics give background information for oversight; examples include membership growth trends, membership mix and capitation per member per month (PMPM). The tiered approach to metrics allows additional research to drill into detail when a metric does not land where expected. Tier 1 metrics provide a high-level understanding of the MCO's operational and financial health. If Tier 1 metrics are not what was expected, look to Tier 2 metrics, then Tier 3 metrics until sufficient detail explains the likely reason for not meeting expectations. Each lower tier contains additional detail that supports the calculation of the higher tier.

Tier 1 Metrics

Tier 1 metrics are designed for executive management. They provide insight into MCO operations only at a high level. Areas of concern that are identified within Tier 1 metrics may trigger a drill down requirement for additional explanatory data to provide further detail. Recommended Tier 1 metrics include network access and appointment availability, PI, quality and clinical management, and financial.

Network Access and Appointment Availability Metrics

In Plan Vital, network access and network adequacy metrics were updated to reflect the island-wide coverage model. ASES established five key standards for MCOs to uphold throughout the life of the program and must assess compliance quarterly with Centers for Medicare and Medicaid Services (CMS). The reporting standards outlined meet the CMS requirements and therefore assist ASES with gathering federally required data.

Oversight Category	Metrics
Access	• Provider to enrollee ratios • Provider access per municipality • Required network providers
Time and Distance	• Time and distance and any required exceptions
Appointment Availability	• Urgent/non-urgent conditions, diagnostics and pharmacy

PI Metrics

Key metrics that track the identification, investigation and outcomes of FWA activities by ASES, Medicaid Fraud Control Unit (MFCU) and the MCOs.

Oversight Category	Metrics
Program Oversight and Contracting Process	• Documents ASES oversight of FWA program, procurements and MCO approval process for certain materials

Oversight Category	Metrics
FWA	• Reporting, identification and coordination with other agencies

Quality and Clinical Management Metrics

Key metrics that track utilization, performance and outcomes measures.

Oversight Category	Metrics
Utilization	• Service utilization and condition-specific information • Pregnancy and deliveries • Prior-authorization approvals and denials • Appeals and grievances
Quality Performance Measures	• Process and outcome based quality performance measures • Performance in the Health Care Improvement Program (HCIP), performance measures and complaints and grievances
Care Management	• Key care management activities

Financial Metrics

Oversight Category	Metrics
Solvency	• Risk-Based Capital (RBC) Score (Proxy) • Current Ratio • Defensive Interval
Reliability	• Days in Incurred but not Reported (IBNR)
Profitability	• Underwriting Gain as a percent of Revenue • Net Income as a percent of Revenue • Operating Income as a percent of Revenue
Encounter Data	• Encounter data completeness and timeliness
Statutory (Efficiency)	• Medical Loss Ratio (MLR) • Administrative Expense Ratio (AER) • Total Cost of Care (TCOC) PMPM

Tier 2 Metrics

Tier 2 metrics are designed for departmental reporting and primarily consist of key program indicators and summarized aggregate data, which identify key indicators for efficient oversight and monitoring. Once metrics are compared over time, to peers and to expectations, the data provides actionable information. Areas of concern that are identified within Tier 2 metrics may trigger a drill down requirement for additional explanatory data to provide further detail.

Tier 3 Metrics

Tier 3 metrics are designed for analyst level reporting and are comprised of specific utilization and MCO experience for a narrower look at MCO performance. Tier 3 metrics should be metrics routinely evaluated by ASES and used to inform Tier 1 and Tier 2 metrics. Once metrics are compared over time, to peers and to expectations, the data provides additional actionable information.

3

Financial Oversight

Financial Reporting and Monitoring

Managed care is expected to increase the quality of patient care while controlling costs. Financial metrics provide insight into the efficiency, type and volume of care given to Medicaid beneficiaries in managed care. Detailed financial metrics provide more than profitability results. When analyzed properly, they can show how the MCO operates and ensures compliance with statutory and contractual obligations; therefore, the metrics may serve as an indicator of potential issues or instability that could lead to contractual considerations.

Guiding principles of Medicaid managed care financial oversight include:

- **Reasonable profitability**: MCOs are expected to earn a modest underwriting gain (profit), between 0% and 3%, of capitation revenue. Losses jeopardize solvency and liquidity over time and may indicate a failure to manage care. Profitability in excess of 3% of capitation revenue may indicate improperly denied claims or withholding of care.
- **Efficient use of Medicaid funds**: MCOs are expected to incur reasonable and necessary costs to manage their Medicaid population and adhere to rules outlined in 42 Code of Federal Regulations (CFR) § 438 and to the provisions of their contract with ASES. Some of those rules and provisions include:
  - Measurement and reporting of a MLR as defined in 42 CFR § 438.8 and in the terms of the contract.
  - Adhering to the CMS cost principles of reasonable and necessary expenses. Reimbursable costs and expenses used in the capitation rate setting process should be allowable under cost principles defined by professional standards along with governmental standards outlined in 2 CFR § 200.400 through 2 CFR § 200.475.

- **Solvency:** For financial health and sustainability, MCOs should have assets in excess of liabilities. MCOs are also expected to accept a minimum level of risk in participating in Medicaid managed care. To do so, MCOs must contribute a minimum level of capital to the business. The National Association of Insurance Commissioners developed a metric known as RBC to measure if the insurer holds enough capital to cover its insurance risk. The RBC score serves as an early indicator of financial distress or excessive risk. Scores at or below 200 often require government intervention. The formula for RBC is complex and part of a common annual regulatory filing requirement, but a reasonable RBC proxy can be easily calculated as capital divided by half of the average monthly medical expense.

- **Liquidity:** Despite prepayment of monthly capitation, liquidity should be monitored to ensure MCOs are capable of timely payment to providers serving the Medicaid populations. The common metrics of liquidity include the current ratio and defensive interval. The current ratio is calculated as current assets divided by current liabilities. If the ratio falls below 1.0, by definition current liabilities will exceed current assets which could require a capital contribution or redistribution of non-current assets to current assets. The defensive interval measures the number of days of operating expense available in cash or cash-equivalents. Defensive intervals should exceed 30 days since one month of incurred claims is typically paid out over 90 days.

- **Reliability:** MCOs shall submit financial templates in an accurate, truthful, and complete manner according to the instructions and periodic schedule listed in the Plan Vital Reporting Guide. The templates also include a certification statement, requiring a signature from the author certifying the truthfulness, accuracy and completeness of reported data.

The Financial Reporting Templates, Plan Vital Reporting Guide and Communication Guide provide the foundation for oversight of financial, encounter and utilization metrics, as well as compliance with contractual, Puerto Rico and Federal reporting requirements.

Solvency and liquidity metrics are calculated from detail provided in the Unaudited Financial Statements, schedule A-Balance Sheet, while profitability is measured from detail provided within the B-Income Statement. Other worksheets provide supporting detail to show activity for summarized line items. For example, the B1-Administration Detail worksheet provides a breakdown of administrative expenses and categorizes them as health care quality improvement (HCQI) activities or general administrative expenses. HCQI activities are identified separately because they directly impact the calculation of MLR and show efforts and commitment to efficiently manage care, which may not be included in the medical expense line items. C-Profitability worksheets show profitability by region and rate cell on a quarterly basis. The IBNR reports contain lag tables (tab A, tab B and tab C) to support IBNR estimates while providing claims detail for comparison to encounter data.

The templates, and metrics derived by the data therein, provide information to assess profitability, efficient use of Medicaid funds, solvency, liquidity and reliability. In an effort to increase the reliability

of the information, the Plan Vital Model Contract requires MCOs to obtain an annual financial audit by a third party. A standard financial audit should provide ASES with an opinion on the reliability of the information. During an audit, procedures, typically based on the auditor's judgement and industry standards, are performed to obtain evidence to determine if the MCO's submission reflects a fair presentation of financial activity.

In addition, ASES may request MCOs to have agreed upon procedures performed by a third party to comply with 42 CFR § 438.602(e), which requires financial and encounter base data used in capitation rate setting to be audited at least every three years.

ASES may consider outlining agreed upon procedures that a third party auditor must follow to test the MCO's internal controls and help validate significant figures within the financial reporting package. This process may include a comparison and reconciliation of audited financial income statements to information provided in the fourth quarter financial statements. In addition, this process may require the auditor to trace certain values within the Financial Reports back to bank records or the MCO's enterprise data warehouse.

Examining financial metrics over time, among peer submissions, and against industry benchmarks contribute to the reliability of financial information. Requiring a third party to audit the results and outlining the agreed upon procedures should improve reliability of the information. A third party audit may be performed in parallel with traditional MCO oversight activities, such as examining key metrics, searching for data anomalies, and providing insight into leading performance indicators, in order to improve reliability of financial information.

Utilization Reporting and Monitoring

Utilization metrics not only inform financial oversight, but also provide insight into care quality. Medical costs are a summary of two components: unit cost and utilization. Utilization metrics should be monitored with quarterly submissions and compared to peers, national and Puerto Rico-specific benchmarks. Most utilization metrics follow the Healthcare Effectiveness Data and Information Set (HEDIS®) definitions and national standards set by the National Committee for Quality Assurance (NCQA).

Inpatient utilization metrics are captured in the Annual Statistical Report, the Executive Utilization Data Report and the Audited HEDIS Results Report. The data reported includes activity such as inpatient admission counts, readmission counts and days.

Metrics for outpatient services are captured as claims. Professional services are captured as primary or specialty care visits, and utilization for other services is captured in nursing home days and ambulance trips, for example.

To make utilization metrics comparable, they are often shown with a denominator of 1,000 members. Admissions, days, visits and claims are calculated per 1,000 members. To calculate the metric, the counts are multiplied by the number of months in the study period times 1,000 and then divided by the number of member months (MMs) in the study period.

National benchmarks for comparison include inpatient admits per 1,000 MMs, inpatient days per 1,000 and/or average length of stay (ALOS), emergency room (ER) visits per 1,000 MMs, and outpatient visits per 1,000 MMs. Data for national benchmarks provided in this guide is from NCQA's Quality Compass for Medicaid.

Comparison metrics can be calculated from the rate setting data. Examples include average cost per inpatient day, ER average cost per visit, outpatient cost per visit, primary care cost per visit and specialty care cost per visit. Detail can also be provided at the region and rate cell level where applicable.

Approach to Identifying and Managing Financial Benchmarks

For Financial Reports, MCOs are instructed to use an accrual basis of reporting for most schedules, meaning any over or under accruals are adjusted in the next reporting period (i.e., on a reported basis). Some schedules, like the claims lag reports, show expenditures on both an incurred and paid basis. The incurred basis, completely associated with dates of service, is used to set rates. When examining financial measures, the data source of the metric measured and the basis of reporting for that schedule should be considered. For example, a metric based on "as reported" experience should be interpreted realizing that it may include adjustments pertaining to other periods but adjusted during the period being reviewed.

The overall approach can be visualized through a dashboard by displaying metrics based on the overall impact to the organization to allow a high level analysis of results, but with the ability to drill into more detailed data and metrics.

As previously mentioned, metrics are aligned into four categories:

- Demographic
- Tier 1 — top level metrics
- Tier 2 — summarized but more detailed metrics
- Tier 3 — detailed metrics

Demographic metrics give background information for oversight; examples include membership growth trends, membership mix and capitation PMPM. Knowing these metrics allows the reviewer to

understand differences between MCOs. Growth trends or membership decline that exceed 5% of the previous reporting period may result in unmanaged care during a ramp-up period or inefficiency due to excess capacity during a runout period. Membership mix identifies the percentage of MMs reported as Aged, Blind and Disabled or Temporary Assistance for Needy Families and Other Related Children and Adults eligibility groups. Capitation PMPMs may be risk-adjusted and should reflect varying PMPMs based on acuity differences.

The tiered approach to metrics allows for additional research to drill into detail when a metric does not land where expected. Tier 1 metrics provide a high-level understanding of the MCO's operational and financial health. If Tier 1 metrics are not what was expected, look to Tier 2 metrics, then Tier 3 metrics until sufficient detail explains the likely reason for not meeting expectations. Each lower tier contains additional detail that supports the calculation of the higher tier.

For example, operating income as a percentage of revenue is calculated by dividing operating income by revenue. Operating income is made up of premium revenue less operating expenses. Operating expenses may be broken into major category of service (COS) expenses. The transactions for the major COS expenses are made up of units of utilization multiplied by a rate. An example of the relationship between metrics is shown in the table below.

Tier	Description	Formula
Tier 1	Operating Income as a percent of Revenue	(Revenue – Inpatient Expense – ER Expense – Outpatient Expense – Professional Expense – Pharmacy Expense – Other Expense – Care Coordination – Administrative Expenses + Recoveries) / Revenue
Tier 2	ER PMPM as a percent of TCOC	(ER Expense / MMs) / (TCOC PMPM)
Tier 3	ER visits per 1,000 members	ER Visits / (MMs / 1,000 * Number of Months Reported)

Tier 1 Metrics

Tier 1 metrics provide insight into MCO operations only at a high level. Recommended Tier 1 metrics include:

Oversight Category	Metrics
Solvency	• RBC Score (Proxy) • Current Ratio • Defensive Interval

Oversight Category	Metrics
Reliability	• Days in IBNR
Profitability	• Underwriting Gain as a percent of Revenue • Net Income as a percent of Revenue • Operating Income as a percent of Revenue
Encounter Data	• Encounter Data Completeness
Statutory (Efficiency)	• MLR • AER • TCOC PMPM

High-level solvency metrics, which are also statutory, include an RBC score, the current ratio and the defensive interval ratio. RBC is a complicated calculation, but a reasonable proxy can be substituted to measure the financial strength of the MCO by dividing total capital by one-half of the MCO's average monthly medical expense. The current ratio, current assets divided by current liabilities, shows if the MCO has enough liquidity to meet its short-term obligations. The defensive interval ratio calculates the number of days of average expense the MCO has in cash.

Days in IBNR provides insight into how conservative the MCO is in setting the self-reported liability. IBNR is measured at a point in time. The liability may fluctuate based on estimates made by the MCOs. By dividing IBNR by average daily medical expense, the number of days of expense included in IBNR becomes a benchmark to compare to future periods. Because IBNR is measured at a point in time, the change in IBNR between reporting periods is what directly affects medical expenses. For example, reductions in IBNR will be reflected on the income statement as a reduction in medical expense. Industry standards for IBNR range from 35 days to 75 days, depending on the frequency of claims payments and the overall percentage of pharmacy claims to total claims. Pharmacy claims will skew the number of days lower because pharmacy typically pays within 14 days. Inpatient claims will skew the number higher because they tend to be more expensive and often require manual review. In a mature program, days in IBNR should remain stable if operations are running smoothly. Thus, the resulting noise created by the change in IBNR should be minimal. ASES should monitor days in IBNR to ensure the MCOs are not manipulating profitability by shifting estimated medical expenses from one period to another.

Profitability metrics, including underwriting gain, net income as a percentage of revenue and operating income as a percentage of revenue show the MCOs profitability in various ways for various audiences. Actuaries and the rate setting team are most interested in underwriting gain (profit). MCO Chief Financial Officers (CFOs) and executives are most interested in net income. Accountants and financial professionals will prefer operating income because it removes one-time and non-operating items that skew net income.

Encounter data completeness represents the total amount of payments from accepted encounters divided by the total amount of payments for medical services. To be 100% complete, all reported medical expenses must be accounted for in the encounter data. The Medicaid managed care final rule requires actuaries to use encounter data to set capitation rates. The importance of encounter data and corresponding financial data are reflected in 42 CFR § 438.602(e) requiring periodic audits of encounter and financial data at least every three years. Consistent tracking of encounter data completeness will allow ASES to monitor the reliability of encounter data.

Statutorily-required reporting includes MLR as defined by 42 CFR § 438.8, and TCOC, used to measure risk-adjusted cost growth. A byproduct of MLR is the AER used to show the percentage of capitation revenue spent on administrative functions of the MCO.

Tier 2 Metrics

Tier 2 metrics primarily consist of summarized COS metrics. COS metrics are broken into the service categories: inpatient, ER, outpatient, professional, prescription drugs and other medical, which includes basic behavioral health (BH). Metrics are designed to capture PMPM estimates and a percentage of TCOC. Tier 2 metrics improve through a consistent use of a COS hierarchy.

Tier 3 Metrics

Tier 3 metrics are comprised of utilization metrics. Tier 3 metrics allow ASES to identify whether increases in expenses are caused by increases in the cost of services or increases in the frequency certain services are used.

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Claims and Encounter Data

Encounter Reporting and Monitoring

ASES must collect encounter data to follow requirements set forth by CMS. The 42 CFR § 438.818(a)(2) requires ASES to validate the completeness and accuracy of encounter data. Encounter data completeness is measured as the number of unique transactions submitted and accepted divided by the number of unique transactions which should have been submitted to ASES as an encounter. Unique transactions are often defined as claims (not claim lines) but should include any encounter a member has with a provider in which a covered service is delivered. In certain instances of bundled payments or sub-capitation, providers should still submit claims with an expectation to receive $0 paid to allow the MCO and ASES to measure utilization.

In addition, a reconciliation of encounter data to financials should be reviewed through the use of the lag tables with encounter data metrics.

MCOs should collect the results of the encounter data submissions and track the data by major COS type and date, which should loosely correspond to the claim type submitted. By breaking the encounter data into these categories, incomplete data is highlighted by major COS to inform rate setting. Sub-capitated encounters are reported separately for additional detail. Denied encounter submissions are reported to alert ASES staff of potential issues and may require follow-up reporting from the ASES to the MCO.

Encounter data files must be submitted by the MCOs in a timely manner. Benchmarks for encounter timeliness include 98% of all medical claim submissions no later than 30 calendar days from the claim adjudication date.

Encounters should have an acceptance rate of 95%, encounters are submitted to Medicaid on a monthly basis. Submitted encounters should account for at least 98% of paid claims amounts. Once the encounter process has been in place, the encounters acceptance rate should be increased. There is an expectation that encounters that do not pass Medicaid edits are corrected and resubmitted.

Claims Processing

Claims processing is directly related to collecting encounter data. The data included in the Claims Activity Report will assist in tracking the timeliness of provider payments and claims processing delays.

Monitoring claims processing activity, inventory and accuracy are key components of claims oversight and are directly related to high quality encounter data submissions.

MCO oversight of claims includes monitoring metrics that measure the success of claims passing through the MCO's claim processing system and resulting in timely resolution. This includes metrics that measure:

- Claims processing through automatic system edits
- The percentage of clean claims that are auto-adjudicated
- The percentage of claims needing manual intervention
- The timeliness and accuracy of payments and remittance advice
- Claims payment denials per 1000 members
- Provider appeals per 1000 members
- Overturn or uphold rates of provider appeals

Mercer recommends verifying MCO capabilities for storing data for data analytics and creating encounters, and reviewing MCO claims auditing processes to ensure they maintain or improve claims processing accuracy.

For Tier 1 metrics, timely payment of clean claims should lead to minimizing provider complaints. Mercer recommends monitoring the percentage of clean claims paid within 30 days, and the percentage of claims that are considered clean. Clean claims are those that require no additional information to properly adjudicate. Contractually, MCOs must pay 95% of clean claims within 30 days and 100% of clean claims within 50 days per Article 16 of the MCO contract. Ninety percent of unclean claims must be resolved and/or paid within 90 days of the initial receipt of a claim. Clean claims will likely pass through system edits beginning with the member and provider information matching to the MCO data and then claims details that match to national standards, contract requirements or authorization requirements. Claims need to be paid timely with data stored and with additional controls in place to ensure the accuracy of data for reporting, including encounter submissions.

Tier 2 oversight should be done by the Claims Managers to verify that systems are operating correctly, staff handle claims according to benefits and procedures and to oversee the timeliness of claims payment. Metrics for tier 2 will include the number of days to process clean and unclean claims, and the accuracy of manual claims processing. Claims Managers are responsible for oversight of claims staff to ensure claims are paid accurately, to provide the tools necessary for claim processing or additional training when necessary. Denials, appeals and the overturn rate of appeals will also provide

insight into the accuracy of the claims adjudication process. Claims managers should also review the top reasons for claim denials.

Tier 3 oversight will review metrics related to claim auditing. The claims audits should be a metric of approximately 2% to 5% of all claims processed either systematically or manually by a claims analyst. This will help to ensure that providers are paid appropriately. Metrics are typically set to 99% financial accuracy and 97% or better procedural accuracy based on the number of claims audited per analyst.

Oversight of MCOs may include claim and encounter operational reviews. Operational reviews consist of a survey with a request for information on the MCO processes for the three tiers listed above to obtain basic information on the MCO systems and data flow, basic policies and oversight within the organization for claims payment and creation, processing and recording the success of encounter submissions. Step two in the review is a desk review from the survey responses and development of questions for an onsite review. The onsite review consists of interviews with key staff to validate the responses, receive clarification and any additional information needed. The onsite review includes a system demonstration of previously selected encounters to validate the data in the MCO's claim system to verify the data integrity to what was received from the provider, paid by the MCO and subsequently submitted as encounters to the state. Once the on-site portion of the review is completed, the reviewer should create reports to provide findings and recommendations for improvement by the MCO.

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Provider Network Oversight and Monitoring

Provider network metrics provide insight into member access and MCO contracting operations of the Plan Vital program including but not limited to; network sufficiency, provider access, and appointment availability standards maintained in managed care. When analyzed properly, they can show how the MCO operates and ensures compliance with statutory and contractual obligations and allows ASES to identify key urban/non-urban and municipalities network shortages or access concerns. Therefore, the metrics may serve as an indicator of potential issues or instability that could lead to contractual considerations.

Reporting Templates and the Plan Vital Reporting Guide provide the foundation for oversight of network and access metrics, as well as compliance with contractual, Puerto Rico and Federal reporting requirements. The templates include a certification statement worksheet, requiring a signature from the author certifying the truthfulness, accuracy and completeness of reported data.

Network Certification and Oversight

At the launch of Plan Vital, ASES was required to certify each of the MCO's provider network and document any exceptions granted due to contracting or coverage limitations. Through MCO exception requests, MCO provider files, and MCO reporting of compliance with time and distance, ASES are required to continuously monitor and update CMS (per request) to demonstrate compliance.

Network Standards

At the launch of Plan Vital, ASES established five key network standards which must be maintained throughout of the life of the program. For the island-wide Vital program, ASES established network adequacy standards in compliance with 42 CFR § 438.68 that include time/distance standards based on population density, enrollee-to-provider ratios for specified provider types and a per municipality rule for specific provider types. ASES based the network requirements against historic trends and utilization. When evaluating the adequacy of the network and reasonableness of the requested exceptions, ASES considered current industry constraints.

Information on network adequacy and access are found in: Report 15 Network Provider List, Report 16 Geographic Access, and Report 17 Appointment Availability.

- Standard 1 — Provider to Enrollee Ratios
- Standard 2 — Provider Access Per Municipality
- Standard 3 — Required Network Providers
- Standard 4 — Time and Distance Requirements
- Standard 5 — Appointment Availability
- Exception requests to network standard

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Program Integrity Oversight and Monitoring

On December 20, 2019, Section 1108(g) of the Social Security Act, implemented by section 202 of the "Further Consolidated Appropriates Act, 2020 was signed into law. This ensured that oversight and monitoring of PI metrics is crucial for appropriate oversight, coordination and funding of the Plan Vital program.

PI activities are cross-agency activities in terms of enforcement and reporting but start with leadership at ASES and at Medicaid in establishing an environment of integrity. It also includes key oversight of MCO FWA activities, communication and coordination between the MCOs and ASES. When analyzed properly, certain metrics can show how effectively the MCO operates and ensures compliance with statutory and contractual obligations; therefore, the metrics may serve as an indicator of potential issues or instability that could lead to contractual considerations.

Reporting Templates and the Plan Vital Reporting Guide provide the foundation for oversight of PI, as well as compliance with contractual, Puerto Rico and Federal reporting requirements. The templates include a certification statement worksheet, requiring a signature from the author certifying the truthfulness, accuracy and completeness of reported data.

Along with the reporting templates, Mercer recommends quarterly and annual reviews of MCO activity to ensure compliance with 42 CFR § 438 Subpart H and to further document ASES, Medicaid and MCO efforts to stop FWA while ensuring compliance with Section 1108(g).

Section 1108(g)

Section 1108(g) includes a series of activities that will be required of the Puerto Rico Medicaid program in Federal Fiscal Year 2020 and FFY 2021. Puerto Rico has begun planning and is taking action on these requirements as the law includes penalties tied directly to reductions of the new Federal Medical Assistance Percentage for lack of compliance.

PI Requirements of Section 1108(g), section 202:

- Due June 20, 2020 — Designate an officer and report that designation to the CMS Regional Office (determine if Medicaid or ASES responsibility).
- Due December 20, 2020 — Develop and publish a contracting reform plan to combat FWA contracts that includes metrics for evaluating the success of the plan and schedule for publicly releasing status reports on the plan.
    - Identify and document process used by Puerto Rico to evaluate bids and award contracts under such plan (or waiver) and which contracts are not subject to competitive bidding or requests for proposals under such plan (or waiver).
    - Document oversight by CMS of contracts awarded under such plan (or waiver).
    - Include any recommendations relating to changes that the Comptroller General determines necessary to improve the PI of such plan (or waiver).
    - Audit PMPM payments to MCOs determined to be at high risk for FWA.

PI Oversight

Puerto Rico must continue to oversee and monitor PI on an ongoing basis as a joint effort between ASES and the Department of Medicaid. This includes establishing and implementing routine monitoring and the identification of compliance risks. Historically, CMS and Office of the Inspector General (OIG) have looked closely at Puerto Rico PI activities stemming from the Medicaid Integrity Group CAP in 2012, the CMS audit in 2016 and the new federal bill and associated PI activities in 2020.

Auditing with Medicaid and MFCU

ASES should ensure establishment of formal reviews of compliance with a set of standards used to develop baseline measurements. Puerto Rico must implement a formal baseline assessment of major FWA risk areas. Audit activities include operational guidelines, policies and procedures (P&Ps), memorandum of understandings (MOUs), or interagency agreements that govern the interaction between the State's PI efforts and programmatic oversight for each managed care program. Auditing methods should vary by desk reviews, onsite reviews, internal and external audits. ASES and Medicaid should establish work group with MFCU and OIG to identify key auditing areas for each year. Operational reviews — includes operational guidelines, P&Ps, MOUs, or interagency agreements that govern the interaction between the State's PI efforts and programmatic oversight for each managed care program.

Annual Plans

Each contract year, MCOs must submit and ASES must conduct an annual review of MCO Compliance Plan, in accordance with 42 CFR § 438.608, as specified Section 13.2 of the Plan Vital contract and annual review of MCO PI Plans as specified in Attachment 14 and Section 13.3 of the Plan Vital contract. The annual review of these plans should reflect known PI activities that occurred during the previous year and planned mitigation strategies for the upcoming year.

To comply, Mercer recommends routine reviews of MCO activity should take place with quarterly and annual reviews to ensure continued compliance. A monitoring checklist can be a helpful tool to ensure MCO compliance. Checklists used to monitor changes and progress in MCO PI initiatives should include the following elements.

MCO Requirement	Recommended Oversight Step	Notes
Compliance Plan, Written P&Ps	Review the MCO Annual Compliance Plan. Verify that all of the OIG's recommended seven elements of a successful Compliance Plan[1] are included. Review P&Ps related to FWA.	Perform annually. After the initial review, look for any changes to the Compliance Plan from prior years or for changes in P&Ps in documentation.
Compliance Officer/Committee and Competent Staffing	Verify the MCO is staffed with a Compliance Officer and Compliance Committee. Review Compliance Committee meeting minutes when available. Review organizational chart, noting certifications and qualifications of compliance and Special Investigations Unit (SIU) staff at least annually.	Require reporting of any changes in staff. While verifying competence of staff, look for credentials such as Certified Fraud Examiner and Accredited Healthcare Fraud Investigator.

[1] Health Care Compliance Program Tips. Retrieved from https://www.oig.hhs.gov/compliance/provider-compliance-training/files/Compliance101tips508.pdf

MCO Requirement	Recommended Oversight Step	Notes
Training	Verify the MCO provides initial and annual compliance training for staff, providers and members. Review at least annually, training programs held by the MCO and training logs.	Provider contracts should contain the requirement that providers receive training on the False Claims Act. Look for documentation and proof of attendance for employees, executives, Board of Director members and providers.
Effective Communication	Ensure the MCO has a tip line and a procedure to address referrals of FWA. Also, ensure the MCO has published whistleblower protections, likely in an employee handbook.	The organization should have separate procedures for handling complaints about provider/member overpayments and complaints about employees.
Discipline	Review policies annually for disciplinary guidelines related to compliance issues. Request updates on any activity related to FWA.	After the initial review, look for changes in documentation. MCOs should possess documented disciplinary procedures for compliance issues, for internal offenses and provider terminations, discipline and training.
Internal Controls/Monitoring	Verify the MCO has internal auditing and data mining. Provide management oversight. MCOs should have reports from data mining activity regularly reviewed by the Compliance Committee to identify potential cases of FWA.	Often, this process is subcontracted. Standard data queries should be established but additional queries may vary based on the priorities of internal audit and compliance.
Provider Auditing	Look at P&Ps for provider self-audits.	MCOs should have policies for recoupments initiated by provider self-audits. Best practices include self-audit training and forms a provider can complete if they identified overpayments.

MCO Requirement	Recommended Oversight Step	Notes
	Verify procedures for member service verification.	MCOs must have a procedure for contacting members to verify that services were provided and a process for situations when the member response does not match a particular claim.
Prompt Response to Offenses	Track cases of reported offenses and non-compliance. Review reports showing actions taken for internal and external offenses.	MCOs should have a system for monitoring ongoing cases and documenting responses. P&Ps should include a time limit for reviewing cases, as well as for reporting to the SIU. For example, all tips must be reviewed within 24 business hours and assigned to investigators within five business days.
Monitoring for Exclusions	Review MCO P&Ps to confirm the MCO has a process and data to show exclusion monitoring of all staff and providers.	MCOs should check the following lists prior to hiring/contracting and at least monthly. Lists include: • The OIG's List of Excluded Individuals/Entities[2] • System for Award Management (SAM)[3]
Reporting	Review MCO monthly, quarterly and annual FWA reports.	Reports should be reviewed by MCO management and show all cases reviewed, opened and closed.

Reporting

Information on the identification and monitoring by the MCOs on FWA are found in Report 3 FWA Report (quarterly submission). Other reports also contain pertinent information to inform PI activities.

[2] Search the Exclusions Database. Retrieved from https://exclusions.oig.hhs.gov/
[3] Search Records. Retrieved from https://sam.gov/SAM/pages/public/searchRecords/search.jsf

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Quality and Clinical Management Oversight and Monitoring

The MCO quality and clinical programs ensures that members receive services in a timely, effective and cost-efficient manner. Areas of focus include but not limited to: utilization management (UM) grievance and appeals, care management and physical health (PH)/BH integration. The metrics serve as an indicator of potential under or over utilization, issues with quality of care and insufficient identification and interventions for vulnerable and/or complex populations. The MCO quality management strategy (QMS), quality assurance and MCO quality assessment performance improvement (QAPI) plan(s) serve as overarching documents that align with the quality and clinical metrics monitored with the Commonwealth's Quality Management Strategy and identified health and quality goals.

Mercer recommends creating a routine report identifying the top ten diagnoses and services utilized, sourced by encounter data. The report will allow ASES to determine which metrics should be considered higher priority due to the impact of increasing cost and poorer long-term quality outcomes. Determining which diagnoses may be driving acute, high cost services will assist in targeting specific clinical measures. For example, a younger population may need more focus on maternal and neonatal health while an older population may focus on more chronic conditions such as diabetes and heart disease. In addition, a periodic review of the driving diagnoses and services of high cost will allow prioritization of measures to reflect current status, as drivers will change over time. For instance, substance abuse treatment for opioid utilization may drop over time as more controls are put in place to restrict prescribers and suppliers, so these metrics may be considered higher in importance now, but lessen over time.

Guiding principles of Medicaid managed care quality and clinical oversight include interdepartmental coordination throughout the oversight process to review areas of overlap, particularly in the areas of utilization and quality where issues noted in these areas have significant impacts to other operational areas such as finance and network management. An overview of the quality and clinical metrics include utilization, grievances, appeals and complaints, care management and the HCIP.

Utilization Metrics

In addition to the use of utilization metrics to monitor financial oversight as described earlier, these metrics provide insight into care quality and member access to medically necessary services.

Utilization metrics are categorized by service type or level of care and can be evaluated for trends in length of stay or particular demographic or diagnoses drivers. Trending these metrics are used to identify areas of opportunity such as:

- Over or under utilization
- Potentially preventable utilization
- Quality of care issues
- Poor transition of care between care settings
- Inadequate network availability or access
- Need for improved UM process
- Member engagement and education
- Missed opportunities for care management support

When a concern is identified as needing a more specific focus, such as quarter over quarter review for each MCO separately, comparing the data by MCO or provider or by service type may offer additional insight to issues.

Grievances, Appeals and Complaints

Tracking and trending of grievances, appeals and provider complaints allows insight into areas of concern that may warrant further investigation such as, poor quality of care, dissatisfaction with health plans or providers, opportunities to improve the UM process, opportunities to provide member or provider education, or may highlight denial and appeal practices that unnecessarily limit access to medically necessary services or unnecessarily increase provider burden.

Care Management

Care management metrics provide insight into the MCOs stratification process to identify complex and high risk members, or those with Social Determinants of Health needs, followed by appropriate intervention. Effective care management consistently identifies member risks and bridges gaps in health services and community resources, provides member education, positive reinforcement and links to appropriate supports to manage their health and social needs. Effective care management proactively works to break down barriers to needed care which may result in reducing preventable services such as low-acuity non-emergent (LANE) ER visits and re-admissions, and identifies systemic as well as individual member barriers to accessing care at the right place, at the right time and at the right intensity.

Quality and Appropriateness of Care

ASES monitors how well the MCOs are complying with contractual standards consistent with 42 CFR § 438.340(c)(i) through the following mechanisms:

- QAPI Program
- Puerto Rico-specific data collection and monitoring, and MCO reporting
- External Quality Review Organization (EQRO) reports
- CMS 416 report
- HCIP

All contracts include quality provisions as well as requirements for quality measurement, quality improvement and reporting. ASES receives monthly, quarterly and annual report submissions from the MCOs and evaluates whether the MCO has satisfactorily met contract requirements. Another major source of information through which ASES assess quality of care is through the requirement of a QAPI. The QAPI Program is aimed to increase the health outcomes of government health plan (GHP) enrollees through the provision of health services that are consistent and compliant with national guidelines, and NCQA HEDIS standards. The MCOs QAPI Program is submitted to the ASES for review and approval.

Quality Management Strategy and Evaluation

Every three years, ASES revises the QMS which supports Puerto Rico's goal to provide patient-centered quality services aimed at increasing the use of screening, prevention and appropriate delivery of care in a timely manner to all Medicaid, Children's Health Insurance Program and Medicare/Medicaid Dual Eligible enrollees through MCOs operating island-wide.

The QMS provides a framework to communicate Puerto Rico's vision of performance-driven objectives and monitoring strategies that address quality of care and timely access to services. It is a comprehensive approach that drives quality through assessment, initiatives, monitoring and outcome-based PI.

In 2019, ASES revised the QMS with specific goals and objectives that play a significant role in the development of Puerto Rico's QMS are:

- Goal 1: Improve preventive care screening, access of care and utilization of health services for all enrollees. With the objective to increase the utilization of preventive care screening services, access of care and utilization of health services annually.

- Goal 2: Improve quality of care and health services provided to all GHP enrollees through the Healthcare for the Homeless Network (HCHN) program. With the objective of increasing the number of initiatives to improve the health of all GHP enrollees with a high cost condition and chronic condition annually.

- Goal 3: Improve enrollee satisfaction with provided services and primary care experience. With the objective to reach the average score established by the Agency for Healthcare Research and Quality in the categories of composite items on personal doctor, all health care and MCO.

ASES recognizes that effective quality improvement must be methodical, ongoing and measureable. For the QMS, a mix of quantitative and qualitative measures were identified to monitor clinical quality, access and UM for the program.

Puerto Rico prefers to use nationally recognized measure sets whenever possible, including the NCQA HEDIS and the Medicaid Adult and Child Core Measurement Sets. Several tools have been developed to facilitate the implementation of the QMS. The HCIP is one of the tools developed by ASES to reach this goal. The HCIP Manual ties financial incentives for MCOs to improve the quality of the program.

ASES created quality measures and scored quality measures for the MCOs to track and report quarterly; these measures are listed below. The MCOs must develop initiatives to improve the health of the population for each scored measure for the health conditions identified in the HCIP. A second tool used is the reporting and review of annual HEDIS measures. In addition to the HCIP and HEDIS performance measures, the MCOs will submit enrollee and provider satisfaction survey data and analysis at least annually using Consumer Assessment of Healthcare Providers and Systems and the Experience of Care and Health Outcomes survey instruments.

The strategies and interventions addressed in this QMS are focused on the health promotion, prevention and improving the quality of life, care and services as referenced in Attachment 19 of the contract. The specific quality and scored measures required for each initiative are defined in detail within the HCIP Manual. The MCOs must develop initiatives to improve the health of the population for each health condition identified through the indicators listed in the manual.

QMS Initiatives	
Initiative	**Description**
Health People Initiative	• The Healthy People Initiative focuses on preventive screening for all enrollees, including populations identified with high cost or chronic conditions. The scored measure point distribution for the Healthy People Initiative is a total of 10 points.
High Cost Conditions Initiative	• The High Cost Conditions Initiative focuses on those enrollees with a high cost condition that may be part of the HCHN Program specified in Section 7.8.3 of the Contract. The MCOs are to propose and demonstrate cost saving initiatives, programs and value-based payment models for provider reimbursement to address HCHN enrollees. The scored measure point distribution for the High Cost Conditions Initiative is a total of 11 points.
Chronic Conditions Initiative	• The Chronic Conditions Initiative focuses on those enrollees with a chronic condition. Chronic conditions are often complex, generally long-term and persistent, and can lead to a gradual deterioration of health. The MCOs shall include in the quality plan, the use of best practices for care to improve the health of those with a chronic condition.
ER High Utilizers Initiative	• The ER High Utilizers Initiative is designed to identify high users of emergency services (including BH) for non-emergency situations and to allow for early interventions to ensure appropriate utilization of services and resources. The MCO will submit to ASES for approval, a work plan with detailed activities and interventions aimed at ER high utilizers.

QMS Initiatives	
Initiative	**Description**
Additional Strategies to Achieve Quality, Goals and Objectives	• Developing and maintaining collaborative agreements among public agency stakeholders to improve health education and health outcomes as well as manage vulnerable and at-risk enrollees. • Improve health information technology to ensure that information retrieval and reporting are timely, accurate and complete. • Improving the health of enrollees through the identification of social determinants of health and health disparities. • A method of monitoring, analyzing, evaluating and improving the delivery, quality and appropriateness of health care furnished to all enrollees (including over, under and inappropriate utilization of services) and including those with special health care needs.

8

Pharmacy Benefits

The unique relationship between the MCOs, the PBM, and pharmacy program administrator (PPA) in Puerto Rico creates a complex set of responsibilities for ASES. Since ASES contracts directly with the PBM but the MCOs have financial responsibility for pharmacy benefits, ASES must monitor demographic utilization and cost while also monitoring clinical, disease, rebate, claims and administrative management at a deeper level than if the MCOs were contracting with PBMs directly. Additionally, there are several pharmacy operations that necessitate greater oversight to comply with the federal requirements prescribed in Medicaid managed care regulations including Drug Utilization Review (DUR). Federal law requires Medicaid DUR programs to reduce clinical abuse and misuse of outpatient prescription drugs using retrospective and prospective drug data. The 2016 Medicaid Managed Care Rule formalized DUR program activities within the context of Medicaid managed care.

This section describes the oversight and monitoring of pharmacy services and will supplement other sections of the MCO Comprehensive Oversight Plan. The metrics in this section are organized under several oversight categories summarized in the table below. Each oversight category is discussed in greater detail in the following subsections, with respective metric tables. Where applicable, Mercer describes best practices or considerations on FWA in the notes within the tables.

Pharmacy Services Oversight and Monitoring Categories

Oversight Category	Description
1. Demographic — Utilization Measures	• Used to monitor overall program utilization trends
2. Demographic — Cost Measures	• Used to monitor overall program pharmacy cost trends
3. Demographic — Combined Utilization and Cost Measures	• Used to monitor both utilization and cost trends
4. Clinical Management	• Used to monitor prescribing patterns and pharmacy-specific requirements in the Medicaid managed care contract, several of which are requirements of federal Medicaid managed care regulations
5. Disease Management	• Used to measure health outcomes tied to pharmacy utilization
6. Rebate Management	• Used to evaluate rebate invoicing and collections

Pharmacy Services Oversight and Monitoring Categories	
Oversight Category	**Description**
7. Claims and Administration Management	• Used to measure the functionality of claims processing and administrative management

Demographic — Utilization Measures

Utilization is a key metric to evaluating a drug management program and its effectiveness. In the current Puerto Rico PBM contract, there are contractual requirements for drug utilization summaries. Mercer recommends collecting and monitoring utilization metrics (i.e., the generic dispensing rate [GDR] and total prescriptions PMPM) in total, by MCO and by pharmacy type. By collecting data at this level, Puerto Rico will track changes in generic and total utilization trends. The collection of this data will provide a solid basis for analyzing prescription utilization and effectiveness.

Demographic — Utilization Measures			
Metric	**Tier**	**Definition**	**Notes**
Total Prescriptions	1	Total number of prescriptions dispensed. Provide in total, by MCO and by pharmacy type.	Evaluate quarterly and annually. After the initial review, look for any changes to the total number of prescriptions from prior quarters and year.
GDR	1	Total Generic Prescriptions divided by Total Prescriptions.	Perform quarterly and annually. After the initial review, look for any changes to GDR from prior quarters and year.
GDR by MCO	2	Total Generic Prescriptions divided by Total Prescriptions for each MCO.	Perform quarterly and annually. After the initial review, look for any changes to GDR by MCO from prior quarter and year.
GDR by Pharmacy Type	2	GDR analysis by pharmacy type (independent, local chain, national chain, hospital pharmacies).	Perform quarterly and annually. After the initial review, look for any changes to GDR by pharmacy type from prior quarter and year.
Prescriptions PMPM	1	Average number of prescriptions PMPM.	Perform quarterly and annually. After the initial review, look for any changes to the average number of prescriptions PMPM from prior quarter and year.

Demographic — Utilization Measures			
Metric	**Tier**	**Definition**	**Notes**
Prescriptions PMPM by MCO	2	Average number of prescriptions PMPM by MCO.	Perform quarterly and annually. After the initial review, look for any changes to the average number of prescriptions PMPM by MCO from prior quarter and year.

Demographic — Cost Measures

Cost measures are also key metrics to evaluating a drug management program and its effectiveness. In addition to the utilization measures described above, the current Puerto Rico PBM contract has contractual requirements for cost reporting. Mercer recommends collecting and monitoring cost metrics in total, by drug type, and by MCO. Mercer also recommends reviewing paid amount PMPM to align with the measures used for MCO capitation rate development. By collecting data at this level, Puerto Rico will track changes in drug cost trends. This data provides a solid basis for analyzing prescription cost management.

Demographic — Cost Measures			
Metric	**Tier**	**Definition**	**Notes**
Paid Amount	1	Total paid amount of prescriptions.	Perform quarterly and annually. After the initial review, look for any changes to the total paid amount from prior quarters and year.
Paid Amount per Claim Summary	1	Paid amount per claim for all prescriptions. Include claim count, ingredient cost, dispensing fee, patient pay amount, Coordination of Benefits(COB) amount and total paid amount.	Perform quarterly and annually. After the initial review, look for any changes to these measures from prior quarters and year.
Generic Paid Amount	2	Total paid amount for generic prescriptions and percentage of total paid.	Perform quarterly and annually. After the initial review, look for any changes to the generic paid amount as percent of total paid from prior quarters and year.

Demographic — Cost Measures			
Metric	**Tier**	**Definition**	**Notes**
Brand Paid Amount	2	Total paid amount for brand prescriptions and percentage of total paid.	Perform quarterly and annually. After the initial review, look for any changes to the brand paid amount as percent of total paid from prior quarters and year.
Paid Amount PMPM	1	Average paid amount PMPM.	Perform quarterly and annually. After the initial review, look for any changes to the average paid amount PMPM from prior quarters and year.
Generic Paid Amount PMPM	2	Average paid amount PMPM.	Perform quarterly and annually. After the initial review, look for any changes to generic PMPM from prior quarters and year.
Brand Paid Amount PMPM	2	Average paid amount per brand prescription per month.	Perform quarterly and annually. After the initial review, look for any changes to brand PMPM from prior quarters and year.
Paid Amount PMPM by MCO	2	Average paid amount PMPM by MCO.	Perform quarterly and annually. After the initial review, look for any changes to the average paid amount PMPM by MCO from prior quarters and year.

Demographic — Combined Utilization and Cost Measures

The PBM contract requires timely PBM reports for drug utilization and cost summaries. This data should be used to analyze changes and trends in overall pharmacy benefit utilization. The detail provided in these reports should be used to identify trend drivers and opportunities for management strategies.

Demographic — Combined Utilization and Cost Measures			
Metric	**Tier**	**Definition**	**Notes**
Monthly Summary	1	Summary by rolling 12-month period. Include month, paid amount, claim count, paid per claim, utilizer count, paid per utilizer.	Perform quarterly. After the initial review, look for any changes to these measures from prior time periods.

Demographic — Combined Utilization and Cost Measures			
Metric	**Tier**	**Definition**	**Notes**
Percentage of Maintenance and Acute Medications	2	Summary of percentage of paid amount and claim count for maintenance medications versus acute medications.	Perform quarterly and annually. After the initial review, look for any changes to these measures from prior quarters and year.
Top 25 Drugs	2	List of top 25 drugs by claim count and top 25 drugs by paid amount. Include drug name, therapeutic class, claim count, paid amount for each table.	Perform quarterly and annually. After the initial review, look for any changes to these measures from prior quarters and year.
Top 10 Therapeutic Classes	2	List of top 10 therapeutic classes by claim count and paid amount. Include therapeutic class, claim count and paid amount for each table.	Perform quarterly and annually. After the initial review, look for any changes to top 10 therapeutic classes from prior quarters and year.
Top 10 Specialty Drugs	2	Top 10 specialty drugs by paid amount. Include drug name, therapeutic class, claim count, paid amount and utilizer count.	Evaluate quarterly and annually. After the initial review, look for any changes and compare top 10 specialty drugs from prior time periods.

Clinical Management

Mercer reviewed the pharmacy-specific requirements in the PBM and MCO contracts and established metrics to be monitored related to clinical management of the pharmacy benefit. Many of those contract requirements are prescribed by federal regulation, which is also noted where applicable. For example, federal regulations at 42 CFR § 438.3(s) describe pharmacy-specific items that must be included in Puerto Rico's MCO contract. Notably, those metrics that are tied to compliance with federal regulations are noted as requiring "100% compliance."

Clinical Management				
Metric	**Tier**	**Definition**	**Acceptable Ranges**	**Notes**
Formulary of Medications Covered Drugs (FMC) Adherence	2	Preferred drugs on the FMC should be prescribed whenever possible. Report in total and by therapeutic class the percentage of FMC preferred drugs dispensed. Provide for the program in total and by MCO.	Recommend establishing a baseline and target thresholds based on the baseline.	Report quarterly and annually. High prescription fill rates of non-preferred medications may have significant impacts on pharmacy costs.
Claim Rejection Codes Summary	2	Summary of claim reject code, description and number of transactions by code.	N/A.	Report quarterly and annually.
List of Medications by Exception (LME)	2	Summary of LME drugs requested and their approval rates by MCO.	N/A.	Report quarterly and annually.

Clinical Management				
Metric	**Tier**	**Definition**	**Acceptable Ranges**	**Notes**
Percent of Claims Where Prior Authorization (PA) for Prescriptions is Provided Within the Requisite Timeframes	3	PA is provided within 24 hours of the request or there is documentation of a need for an extension.	100% compliance required.	Report quarterly and annually. Federal regulations (42 CFR § 438.3[s][6]) require that a PA program for covered outpatient drugs must: 1. Provide a response to a PA request within 24 hours 2. Provide for the dispensing of at least a 72-hour supply of a drug in an emergency situation. PA delays impact access to treatment. High rates of PA delays (over 24 hours) may indicate systemic failures in the PA process and will cause care interruptions if left unaddressed.

Clinical Management				
Metric	**Tier**	**Definition**	**Acceptable Ranges**	**Notes**
Percent of Claims Where Prescriptions are filled by a Provider Outside of the Preferred Provider Network (PPN)	3	Prescriptions must be filled by a provider in the PPN unless there is countersignature by the enrollee's Primary Care Physician (PCP) or another assigned PCP.	100% compliance required.	Report quarterly and annually. High rates of prescriptions filled by providers outside of the PPN may be an indicator of FWA. There may also be federal compliance violations if those providers outside the PPN are not Medicaid enrolled providers. Federal regulations (42 CFR § 455.410) requires that all providers providing Medicaid services to be enrolled in their respective state/territory's Medicaid program.
Percent of Claims that do not Follow the Prescription Timeframe Limits	3	Prescription timeframe limits are as follows: • Thirty days for critical conditions • Thirty days for chronic or severe BH conditions • Six months for maintenance drugs that require PA (exception process for up to 12 months)	Target measures based on the baseline.	Report quarterly and annually. High rates of prescriptions filled past the time limits described in the contract may be an indicator of FWA.

Clinical Management				
Metric	**Tier**	**Definition**	**Acceptable Ranges**	**Notes**
Tracking Mechanism for Detecting FWA is Used to Appropriately Document, Investigate and Resolve FWA Allegations	2	Tracking mechanism have the ability to: 1. Accurately document potential FWA from multiple sources (providers, enrollees, internal MCO sources) 2. Require documentation of investigation and resolution of FWA complaints from those sources	N/A.	Report quarterly and annually. The MCO's FWA P&P should be reviewed to ensure there are creditable descriptions of how pharmacy FWA is documented, investigated and resolved.

Clinical Management				
Metric	**Tier**	**Definition**	**Acceptable Ranges**	**Notes**
DUR Reports Include the Requisite Components	2	Prospective DUR reports must include the following: • Potential and actual adverse effects • Therapeutic duplication • Drug-disease interactions and contraindications • Incorrect dosage, frequency or duration of treatment • Drug allergy • Clinical misuse or abuse • Drug-drug interactions • Medication appropriateness • Incorrect drug dosage, duration or overutilization and underutilization of drug treatment • Pregnancy alerts Retrospective DUR must include the following: • Therapeutic appropriateness • Adverse events • Appropriate use of generic products • Incorrect duration of treatment • Utilization • Inappropriate or medically unnecessary care • Gross overuse • Abuse • Fraud	100% compliance required.	DUR programs (whether operated by the state/territory or MCO) must comply with requirements in Section 1927(g) of the Social Security Act. Compliance with 1927(g) is partly reflected in the requisite components of the prospective and retrospective DUR reports. This is a requirement of 42 CFR § 438.3(s)(2). Retrospective DUR program must provide for ongoing periodic examination of claims data and other records at least quarterly to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care.

Disease Management

Disease management is a critical component of pharmacy monitoring plan. There are many diseases, such as diabetes or hypertension, which can be successfully managed with drugs. As a result, medication adherence has become critical to improve health outcomes as well as lower total costs. Two main quality metric organizations provide disease management matrices, the Pharmacy Quality Alliance (PQA) and the NCQA, which uses HEDIS. Puerto Rico currently has other metrics utilizing both of these organizations. PQA and HEDIS are both used in the CMS star ratings and have undergone extensive validation.

Medication adherence is a key area that Puerto Rico should monitor. The PQA develops robust medication-use measures. These measures focus on medication safety, medication adherence and appropriateness. The adherence measures examine individuals' prescription claims for specific classes of medication therapy. Proportion of Days Covered is the preferred method to measure medication adherence.

Disease Management Measures — PQA				
Metric	**Tier**	**Definition**	**Acceptable Ranges**	**Notes**
Concurrent Use of Prescription Opioids and Benzodiazepines	2	The percentage of individuals greater than or equal to 18 years with concurrent use of prescription opioids and benzodiazepines for greater than or equal to 30 cumulative days.	Should establish a baseline first.	This metric is already in use in other sections of the COMP.
Use of Opioids in High Doses in Persons Without Cancer	2	The percentage of individuals greater than or equal to 18 years of age who received prescriptions for opioids with an average daily dosage of greater than or equal to 90 morphine milligram equivalents over a period of greater than or equal to 90 days.	Should establish a baseline first.	This metric is already in use in other sections of the COMP.

Depending on priorities, Mercer would recommend the following HEDIS metrics from The NCQA. These metrics provide the ability to compare and contrast data using the same set of measures.

Disease Management Measures – HEDIS				
Metric	**Tier**	**Definition**	**Acceptable Ranges**	**Notes**
Asthma Medication Ratio	2	Asthma Medication Ratio: Assesses individuals 5–64 years of age who are identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	Compare to national HEDIS measures.	
Multiple Concurrent Antipsychotics in Children and Adolescents	2	Assesses the percentage of children and adolescents who were on two or more concurrent antipsychotic medications for an extended period during the year.	Should establish a baseline first.	This metric is already in use in other sections of the COMP.
Diabetes Screening for People With Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (SSD)	2	The percentage of members 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	TBD.	This metric is already in use in other sections of the COMP.

Disease Management Measures – HEDIS				
Metric	**Tier**	**Definition**	**Acceptable Ranges**	**Notes**
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	2	Assesses adults 19–64 years of age who have schizophrenia and were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	TBD.	This metric is already in use in other sections of the COMP.

Rebate Management

Puerto Rico's PPA invoices drug manufacturers for drug rebates on a quarterly basis. Beginning in 2021, ASES will begin its participation in the Federal Medicaid Drug Rebate Program (MDRP). The MDRP helps reduce the outpatient prescription drug costs for all medications dispensed to Medicaid members. The MDRP requires drug manufacturers to enter into a national rebate agreement with the federal government in exchange for Medicaid program coverage of the manufacturer's drugs. Manufacturers pay drug rebates on a quarterly basis, which is shared with the federal government to offset the overall cost of prescription drugs. By tracking the rebate amount under the current program or through the MDRP, Puerto Rico can accurately compare and track trends of the net outpatient drug costs and its cash flow. If Puerto Rico negotiates supplemental rebates in the future, the supplemental rebate collections and invoicing should be included in the rebate management oversight.

Rebate Management			
Metric	**Tier**	**Definition**	**Notes**
Rebate Amount Invoiced	1	Total amount invoiced to drug manufacturers for rebates. Include separate totals for rebates for retail pharmacy claims and provider administered drug (PAD) claims.	Perform quarterly and annually. After the initial review, look for any changes to the total rebate amount invoiced from prior periods.
Rebate Amount Collected	1	Total amount collected from drug manufacturers for rebates. Include separate totals for rebates for retail pharmacy claims and PAD claims.	Perform quarterly and annually. After the initial review, look for any changes to the rebate amount collected and compare to invoice amounts from prior periods.

Rebate Management			
Metric	**Tier**	**Definition**	**Notes**
Rebate Percentage	1	Total rebates collected as percentage of total paid amount in total and by retail pharmacy claims and PAD claims.	Perform quarterly and annually. After the initial review, look for any changes to rebate percentage of paid amount from prior periods.
Total Paid Amount and Claim Count for Non-Rebateable Claims	2	Total paid amount and claim count for claims ineligible for rebating such as 340B Claims. Calculate a percent of total claims and paid amount.	Perform quarterly and annually.
Past-Due Rebate Payments	2	Total rebate amount for past due balances from drug manufacturers reported by 45 days, 75 days and greater than 90 days delinquency. Provide information by drug manufacturers with payment delinquencies.	Evaluate quarterly.

Claims and Administration Management Measures

Pharmacy claims processing is a principal function of a pharmacy benefit management program and, therefore, its effectiveness should be measured. The data for these measures may be obtained by requiring the PBM or MCO to report the measures or through an independent audit of the claims processing function conducted by the MCO, PBM, or a third party. All measurements must be client-specific and not based on book-of-business reporting unless otherwise noted.

Network adequacy is represented in beneficiary access, which can be measured by the percentage of pharmacies in a certain region, pharmacy provider turnover, and average time required to process a prescription.

Claims and Administrative Management Measures				
Metric	**Tier**	**Definition**	**Acceptable Ranges**	**Notes**
System Availability	2	The percent of time the claims processing system will be available to retail pharmacies as measured by the number of hours the system is available, divided by the total number of hours within the reporting period excluding regularly scheduled maintenance or telecommunication failure outside vendor's control. Measured on vendor's book-of-business.	Greater than or equal to 99.5%.	Evaluate quarterly and annually.
Claims Accuracy	2	Percent of claims processed and paid accurately based on the applicable coverage, and pricing and benefit design. Calculated as: the number of retail claims and directly submitted paper claims adjudicated by vendor that do not contain a material adjudication error (i.e., any inaccuracy relating to the processing of the claim that results in an incorrect charge to ASES or its members), divided by the total number of all such claims adjudicated.	Greater than 99.98%.	Perform quarterly and annually. After the initial review, look for any changes to the processing percentages from prior years.

Claims and Administrative Management Measures				
Metric	**Tier**	**Definition**	**Acceptable Ranges**	**Notes**
Call Center Abandonment Rate	2	Percentage of calls that are not answered by vendor (caller hangs up before call is answered). Calculated as the number of incoming telephone calls to the service telephone line that are not answered divided by the number of calls received. Measurement excludes calls routed to interactive voice response (IVR) and includes calls abandoned within the first 20 seconds.	Less than or equal to 2%.	Evaluate quarterly and annually.
Call Center Average Speed of Answer	2	Vendor will provide a dedicated toll-free service telephone line for use by pharmacy providers. Percent of all calls answered within an average of 30 seconds. Calculated as the amount of time that elapses once a call is placed into the customer service queue to the time the call is answered by a live customer service representative. Measurement excludes calls routed to IVR system.	100% within an average of 30 seconds.	Perform quarterly and annually.

Claims and Administrative Management Measures				
Metric	**Tier**	**Definition**	**Acceptable Ranges**	**Notes**
Pharmacy Network Access	2	As measured by the number of beneficiaries with access to a retail network pharmacy within two miles urban, five miles suburban or fifteen miles rural of their home zip code (where a pharmacy exists within the specified standard), divided by the total number of beneficiaries.	Greater than or equal to 90% for urban and suburban. Greater than or equal to 70% for rural.	Perform annually. After the initial review, look for any changes to the percentage of in network pharmacies from prior years.

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Managed Care Organization Operational Reviews

Per federal regulations (42 CFR § 438.66), states are required to implement a formal monitoring system to evaluate MCO performance across the operational domains specified below and further defined in the Plan Vital Model contract. States are required to assess compliance in at least the following managed care program areas and may be implemented through a combination of operational reviews, routine reporting and other oversight activities:

- Administration and management
- Appeal and grievance systems
- Claims management
- Enrollee materials and customer services
- Finance, including MLR reporting
- Information systems, including encounter data reporting
- Marketing
- Medical management, including UM
- PI
- Provider network management including provider directories
- Quality improvement

Operational reviews of MCOs offers an enhanced level of oversight that allows for the real time opportunity to confirm that ongoing operational processes and procedures comply with requirements and can be used as a tool to follow up on problems uncovered through reporting issues uncovered through EQRO reviews, and follow up on recommended actions. In addition, a formal operational review demonstrates ASES' commitment to confirming MCO adherence to requirements and holds MCOs accountable for non-compliance.

Given the detailed level of monitoring taking place through the EQRO evaluations, a full operational review is not intended to duplicate activities that are already taking place. Operational reviews can be structured in a targeted manner that offers an opportunity to communicate directly with MCO leadership around identified issues, interview member/provider facing staff and ensure that acceptable procedures have been established to monitor the quality of care provided by the MCO. Mercer recommends that formal operational reviews be conducted every two years with targeted operational reviews used to address/resolve issues in the off years as needed.

Full operational reviews may include a combination of onsite and desk reviews and may include a focus in the areas outlined below in addition to follow up on identified performance issues. Note that full operational reviews are intended to be separate from EQRO reviews. Effective cross-departmental communication is a key component to streamlining focus areas for the operational reviews. Prior to each formal review, it is recommended that all departments discuss and identify potential issues and/or positive results uncovered through the various oversight activities by MCO. This communication process will help inform the structure and focus of each MCO review.

A critical follow up activity to each operational review is a formal Operational Review Report generated by ASES that is shared with the MCOs that outlines audit findings identified. This report also documents evidence that efforts were made by ASES to address issues.

Examples of Operational Review Categories and Activities	
Oversight Category	**Operational Review Activity**
Organizational Management	• Desk Review: Review of organizational chart and staffing plan (UM/care management/network), and identification of staffing needs. • Onsite Review: Interviews with MCO staff to determine if adequate training has been carried out as required in the contract.
Claims Management	• Desk Review: Review of claims processing reports and ad hoc processing requests. Tracking of claims file error submissions and resolutions. • Onsite Review: Onsite audits of claiming system based on trends identified through provider complaints and reviewing denial trends.

Examples of Operational Review Categories and Activities	
Oversight Category	**Operational Review Activity**
UM/Care Management	• Desk Review: Review of UM/care management P&Ps, as appropriate. • Onsite Review: Interview staff on UM/care management protocols as required and demonstration of UM system.
Quality Management	• Desk Review: Review of Quality Management Program P&Ps, as appropriate. • Onsite Review: Staff interviews to assess performance of quality management protocols.
Network	• Desk Review: May include review of sample executed contracts and reconciliation with network data. • Onsite Review: — Interview with provider services staff and network management team to determine if staffing levels and process are adequate to preserve the needs of the provider community. — Address network gaps and contracting compliance issues identified through network reporting and provider complaints.
Member Services	• Desk Review: Review of P&Ps and staffing information. • Onsite Review: Interview of member services staff and call center functions.

EQR

42 CFR § 438.350 requires Puerto Rico to contract with an EQRO who perform an annual EQR for each contracted MCO. Puerto Rico must further ensure that the EQRO has sufficient information to carry out the EQR; that the information be obtained from EQR related activities; and that the information provided to the EQRO be obtained through methods consistent with the protocols established by CMS. Quality, as it pertains to EQR, is defined in 42 CFR § 438.320 as "the degree to which an MCO or pre-paid inpatient health plan (PIHP)increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge."

These same federal regulations require that the annual EQR be summarized in a detailed technical report that aggregates, analyzes and evaluates information on the quality, timeliness and access to health care services that MCOs and PIHPs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the plans regarding health care quality, timeliness and access, and make recommendations for improvement as well as assess the degree to which any previous recommendations were addressed by the MCOs.

To meet these federal requirements, the Puerto Rico contracts an EQRO to conduct the annual EQR of Puerto Rico's Medicaid managed care (Plan Vital) plans and the Medicare Advantage Organizations contracted under the Medicare program.

EQR Activities	
Activity	**Description**
Compliance Review	• This review determines MCO compliance with its contract and with Puerto Rico and federal regulations in accordance with the requirements of 42 CFR § 438.204(g) (Standards for Access, Structure and Operation, and Measurement and Improvement).
Validation of Performance Measures	• Compliance audits of HEDIS of the MCO processes for calculation and reporting of HEDIS performance measures for current HEDIS specifications.
Validation of Performance Improvement Projects (PIPs)	• PIPs for the subject time period were reviewed for each plan to ensure that the projects were designed, conducted and reported in a methodologically sound manner, allowing real improvements in care and services and giving confidence in the reported improvements.

Enrollment Counselor

In accordance with 42 CFR § 438.810, and in addition to the aforementioned MCO oversight, ASES also collects information on a monthly basis from the Enrollment Counselor (Enrollment Broker) who provide certain essential choice counseling, educational and enrollment functions for enrollees on an ongoing basis, including, as enrollees are eligible and annually during Open Enrollment.

Key functions include call center services, choice counseling, web-based enrollment counselor activities and an online provider search portal. As well as providing counseling services to enrollees, the Enrollment Counselor must maintain call center performance measures comparable with MCO requirements, including the following: Answer Rate, Wait or Hold Times, Abandoned Calls, Follow-Up Calls, Call Center Outages and First Call Resolutions.

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Targeted Interventions

An effective oversight program leverages all aspects of information to identify trends in MCO specific or system-wide data and identify areas of concern. When vulnerabilities or violations are identified through routine monitoring and auditing, timely and consistent action to correct the issue is critical. As with other areas of MCO oversight, inter-departmental communication represents a key component to reconciling performance issues that would inform the appropriate type of targeted intervention. The following section outlines options for targeted intervention based on the severity of contract violations.

CAPs

As issues or concerns are uncovered in the various MCO monitoring activities, the use of timely feedback, followed by CAPs to identify performance issues acts as an effective means of demonstrating efforts being made on the part of the MCO to resolve the issues. ASES may issue a corrective action to an MCO for any identified area of non-compliance with the Plan Vital Model Contract or program standards. The CAP includes a summary of the finding in writing and requires the MCO to submit a formal CAP using the ASES approved template that establishes timelines and milestones that demonstrate the area of non-compliance is fully addressed. The CAP follows the same approval process noted below and should be evaluated quarterly for progress toward resolving the identified issues. A record of required CAPs should be tracked to ensure MCO-specific issues have been fully resolved and to identify potential systemic issues across MCOs. Per the Plan Vital Model Contract, MCOs must demonstrate progress toward correcting areas of non-compliance and must resolve audit findings or implement a CAP within 90 calendar days of the issuance of final report or be subject to further corrective action.

When CAPs are reviewed quarterly, the assigned ASES CAP evaluation lead will document updates/progress and provide feedback to MCOs. For ongoing monitoring, it is recommended that ASES implement an automated tracking system that documents responses received to address repeat performance concerns.

In addition, per federal regulations 42 CFR § Part 438, Subpart E specify the requirements for annual EQR of MCOs. Each contract year, MCOs are evaluated by the Commonwealth's EQRO, currently IPRO. The EQR Technical Report contains the results of the EQRO's analysis and evaluation of information on quality, timeliness, and access to the health care services that an MCO or their subcontractors, furnish to Medicaid recipients. CMS requires the final EQR technical reports to be published on the Commonwealth's website by April 30 of each year.

Each contract year, once the EQR Technical Report is received, ASES reviews the findings and identifies any areas of non-compliance and requires that MCOs submit a formal CAP to ASES within 45 days of receipt of the Technical Report findings. The MCOs must provide the CAPs using ASES' CAP template. These CAPs are reviewed and approved by ASES within 45 days of receipt. Rejected plans must be updated and re-submitted to ASES for approval.

Quarterly, MCOs must submit a formal update on the progress made toward all identified CAP areas, outline progress made, and identify any areas that are delayed with a detailed summary of the reason for delays and the actions the MCO is taking to ameliorate the delay. CAP quarterly updates are evaluated by ASES for compliance with timelines to ensure that critical areas of non-compliance are being addressed in a timely and effective manner.

Leveraging Sanctions and Contract Termination

In severe cases, ASES has the right to terminate all or part of the Plan Vital Model Contract or impose intermediate sanctions and/or fines, or suspend member enrollment. This type of action can be informed through findings from onsite surveys, enrollee or other complaints, financial status, or any other source as well as the failure to implement/correct the terms of a CAP (pursuant to Article 19 of the Plan Vital Model contract) to ASES' approval.

Appendix A

Key Performance Indicators and Communication Plan

The Communication Plan identifies KPI and how metrics are built into program oversight, including when and which stakeholders to notify. The Plan serves as a scenario map to help identify the root causes for variances, formulate questions to MCOs and to alert key stakeholders of potential reporting anomalies.

With each MCO report submission, ASES shall review of the recommended reports for completeness and accuracy. Incomplete or inaccurate reports should be returned to the MCO for correction and resubmission. The accountable ASES personnel review the reporting for discrepancies that may be attributed to data validity, unanswered variances or poor performance. A documented Communication Plan between ASES and each MCO can identify the receipt of the required report, sign off from ASES on the report or further questions regarding the submission. This tracking mechanism should include the date of the report receipt, the issue identified, the MCO response and, as needed, the MCO's planned intervention to meet the reporting parameters. An example of a Communication Plan is shown below. This plan will be tailored to the oversight procedures performed in the targeted areas, and key metrics identified by ASES so as to highlight relevant information and areas of concern as deemed appropriate.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Care Management	1	Percentage of members with chronic conditions: Attention Deficit/ Hyperactivity Disorder (ADHD)	Number of members with chronic condition diagnosis: ADHD divided by the total number of members.	Previous quarter averages, peers.	Population health concerns and/or adverse selection.	Active enrollees in care management.	Care Management, Quality Performance, Member Enrollment.
Care Management	1	Percentage of Members With Chronic Conditions: Asthma	Number of members with chronic condition diagnosis: Asthma divided by the total number of members.	Previous quarter averages, peers.	Population health concerns and/or adverse selection.	Active enrollees in care management.	Care Management, Quality Performance, Member Enrollment.
Care Management	1	Percentage of Members With Chronic Conditions: Chronic Depression	Number of members with chronic condition diagnosis: Chronic Depression divided by the total number of members.	Previous quarter averages, peers.	Population health concerns and/or adverse selection.	Active enrollees in care management.	Care Management, Quality Performance, Member Enrollment.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Care Management	1	Percentage of Members With Chronic Conditions: Chronic Obstructive Pulmonary Disease (COPD)	Number of members with chronic condition diagnosis: COPD divided by the total number of members.	Previous quarter averages, peers.	Population health concerns and/or adverse selection.	Active enrollees in care management.	Care Management, Quality Performance, Member Enrollment.
Care Management	1	Percentage of Members With Chronic Conditions: Diabetes	Number of members with chronic condition diagnosis: Diabetes divided by the total number of members.	Previous quarter averages, peers.	Population health concerns and/or adverse selection.	Active enrollees in care management.	Care Management, Quality Performance, Member Enrollment.
Care Management	1	Percentage of Members With Chronic Conditions: Hypertension	Number of members with chronic condition diagnosis: HTN divided by the total number of members.	Previous quarter averages, peers.	Population health concerns and/or adverse selection.	Active enrollees in care management.	Care Management, Quality Performance, Member Enrollment.
Care Management	1	Percentage of Members With Chronic Conditions: Severe Heart Failure	Number of members with chronic condition diagnosis: Severe Heart Failure divided by the total number of members.	Previous quarter averages, peers.	Population health concerns and/or adverse selection.	Active enrollees in care management.	Care Management, Quality Performance, Member Enrollment.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Care Management	2	Active Enrollees in BH Care Management	Total number of enrollees in BH care management at the end of each quarter per 1000.	Previous quarter averages, peers.	Higher volumes are desired.	Drill down to care management program types that have active enrollees.	Care Management, Quality Performance.
Care Management	2	Active Enrollees in PH Care Management	Total number of enrollees in PH care management at the end of the quarter per 1000.	Previous quarter averages, peers.	Higher volumes are desired.	Drill down to care management program types that have active enrollees.	Care Management, Quality Performance.
Care Management	2	High Risk Pregnancies	Percentage of total pregnancies identified as high risk for quarter: Total number of pregnancies identified as high risk divided by total pregnant women.	Previous quarter averages, peers.	Higher than expected values may indicate quality of care issues, and lead to higher than expected costs, and maternal infant mortality.	Early identification of high risk pregnant members.	Care Management, Quality Performance.
Care Management	2	Percent of Pregnant Women Enrolled in Care Management	Total number of pregnant women in care management divided total number of pregnant women for quarter.	Previous quarter averages, peers, total number of high risk pregnancies for quarter.	Higher percentages are desired.	Investigate low percentages — and why women may not be enrolling in care management when pregnant.	Care Management, Quality Performance.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Care Management	3	Average Caseload: Care Management Support Staff (BH)	Average Care Management support staff Caseload (BH).	Inconsistency in care management such as staffing turnover or ineffective outreach.	Drill down to care management program types that have active enrollees.	Inconsistency in care management such as staffing turnover or ineffective outreach.	Care Management, Quality Performance.
Care Management	3	Average Caseload: Care Management Support Staff (PH)	Average Care Management support staff Caseload (PH).	Previous quarter averages, peers.	Inconsistency in care management such as staffing turnover or ineffective outreach.	Drill down to care management program types that have active enrollees.	Care Management, Quality Performance.
Care Management	3	Average Caseload: Care Managers (BH)	Average Care Management Caseload (BH).	Inconsistency in care management such as staffing turnover or ineffective outreach.	Drill down to care management program types that have active enrollees.	Inconsistency in care management such as staffing turnover or ineffective outreach.	Care Management, Quality Performance.
Care Management	3	Average Caseload: Care Managers (PH)	Average Care Management Caseload (PH).	Previous quarter averages, peers.	Inconsistency in care management such as staffing turnover or ineffective outreach.	Drill down to care management program types that have active enrollees.	Care Management, Quality Performance.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Care Management	3	BH Care Management Terminations	Number of Care Management Terminations reported for quarter.	Lower volumes are desired. High rates may indicate dissatisfaction with Care Management programs.	Drill down to member demographics or care managers that have members terminating.	Lower volumes are desired.	Care Management, Quality Performance.
Care Management	3	BH Care Management — Opt Out Requests	Number of opt out requests reported for quarter.	Lower volumes are desired. High rates may indicate dissatisfaction with Care Management programs.	Drill down to member demographics or care managers that have members opting out.	Lower volumes are desired.	Care Management, Quality Performance.
Care Management	3	Percent of Cesarean Sections (C-Section)	Percent of births that are C-sections (number of C-section births divided by number of total births)	Previous quarter averages, peers.	Lower percentages are desired.	Review High Risk Pregnancy data for possible drivers.	Care Management, Quality Performance.
Care Management	3	PH Care Management Terminations	Number of Care Management Terminations reported for quarter.	Previous quarter averages, peers.	Lower volumes are desired. High rates may indicate dissatisfaction with Care Management programs.	Drill down to member demographics or care managers that have members terminating.	Care Management, Quality Performance.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Care Management	3	PH Care Management — Opt Out Requests	Number of opt out requests reported for quarter.	Previous quarter averages, peers.	Lower volumes are desired. High rates may indicate dissatisfaction with Care Management programs	Drill down to member demographics or care managers that have members opting out.	Care Management, Quality Performance.
Care Management	3	Preventive Care Visits for Children per 1000	Total number of preventive care visits in the quarter (ages 0-21) per 1000.	Previous quarter averages, peers.	Lack of member education, network inadequacies.	Compare to annual HEDIS data related to preventive care.	Care Management, Quality Performance.
Care Management	3	Vaccinations per 1000	Total number of children vaccinated in the quarter (Ages 0-21) per 1000.	Previous quarter averages, peers.	Lack of member education.	Compare to annual HEDIS data related to well-child visits.	Care Management, Quality Performance.
Claims and Encounter Data	1	Encounter Data Completeness	Encounters accepted divided by encounters incurred (or claims count).	Contractual Standard.	Using paid dollars will account for many encounters; however, encounters should be submitted for sub capitated events for which nothing is paid on a claim.	Encounter data completeness by claim type or COS.	Encounters, Compliance, Rate Setting Team.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Claims and Encounter Data	1	Percentage of Clean Claims Paid Within 30 Days	The clean claims finalized with notification of payment to the provider within 30 days of receipt of the claims.	Contractual Standard.	Contractor claims processing issues.	Current ratio to see if the plan has adequate liquidity.	Claims, Compliance.
Claims and Encounter Data	1	Percentage of Clean Claims Paid Within 50 Days	The clean claims finalized with notification of payment to the provider within 50 days of receipt of the claims.	Contractual Standard.	Contractor claims processing issues.	Current ratio to see if the plan has adequate liquidity.	Claims, Compliance.
Claims and Encounter Data	2	Claim Payment Denials per 1000 Members	The number of claim denials times 3000 divided by the number of MMs.	Peers, prior submissions.	Claim denials may be a method of delaying payment or may point to PI, operations, or training opportunities for research.	Current ratio.	
Claims and Encounter Data	2	Claim Processing Inventory — Days for Manual Claims	Average number of days for claims that require manual intervention to be processed.	Contractual Standard.	Claims processing issues or lack of staff.	Claims processing backlogs.	Claims, Compliance.
Claims and Encounter Data	2	Claims Greater than 30 Days, Greater than 50 Days and Greater than 51 Days in Inventory	The number of claims not processed that are from 0-30 days, 31–50 days or 51 days or more since the claim is received.	Prior monthly submission.	Claims processing issues.	Claims processing backlogs.	Claims, Compliance.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Claims and Encounter Data	2	Overturn Rate of Provider Appeals	The number of provider appeals overturned divided by the number of provider appeals.	Peers, prior submissions.	A high overturn rate may be delaying payments, withholding necessary care or should provide additional training.		Claims, Compliance, Quality.
Claims and Encounter Data	2	Percentage of Claims Auto Adjudicated	Percentage of claims that were received and processed systematically without any further MCO intervention.	Industry expectations; adjust based on data available in Puerto Rico.	Claims setup or processing issues.	Claims pended for manual review; claims audit results.	Claims, Compliance.
Claims and Encounter Data	2	Percentage Of Encounters Accepted	Encounters accepted divided by encounters submitted.	Contractual standard.	Rejections and denials should be reviewed, corrected and resubmitted to achieve 100% acceptance.	Unresolved rejections and denials.	Encounters, Compliance.
Claims and Encounter Data	2	Provider Appeals per 1000 Members	The number of provider appeals times 1000 divided by the number of members.	Peers, prior submissions.	A high number of appeals may indicate the MCO is withholding necessary care or provide additional staff training.		Claims, Compliance, Quality.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Claims and Encounter Data	3	Financial Accuracy of Claims Audited	Paid dollars of claims deemed accurate divided by paid dollars of claims audited.	Industry standard.	Processing issues, processor training needed or system setup issues.		Claims, Compliance.
Claims and Encounter Data	3	Percentage of Claims Audited	Percent of all claims processed, either manually or systematically in a given month.	Best practice.	Percentages may vary by auto-adjudicated and manually processed claims.		Claims
Claims and Encounter Data	3	Procedural Accuracy of Claims Audited	Number of claims deemed accurate divided by the number of claims audited.	Best practice.			Claims, Compliance, Quality.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Financial Oversight	1	AER	The sum of administrative expenses (less HCQI and fraud reduction) divided by operating revenue.	Rates, peers.	Excessive administrative expenses may happen if there is not enough membership to support administrative fixed costs, or if the organization is using a related-party administrative services agreement with margin built in. Less than minimum AER may indicate a lack of available resources to support administrative functions.	Determine if there is a related-party administrative services agreement. If so, identify pricing. Review administrative costs by category to see if any individual expense varies from expectations.	Contract Liaisons, Rate Setting Team.
Financial Oversight	1	Capitation Revenue	Medicaid revenue earned by the MCO for the rating period.	820 files, 834 files times capitation PMPM.	Timing and retroactivity.	Current Ratio, looking at receivables or payables specific to capitation.	Finance

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Financial Oversight	1	Current Ratio	Current assets divided by current liabilities.	Industry averages.	IBNR set too high, care mismanagement, rates are too low.	Percentage of members with chronic conditions, days in IBNR.	Finance, Actuarial, Care Management.
Financial Oversight	1	Defensive Interval Ratio	Cash and cash equivalents divided by the average expense per day.	Peers, industry averages.	IBNR set too high, care mismanagement, rates are too low.	Percentage of members with chronic conditions, days in IBNR. Average number of days to pay claims.	Finance, Actuarial, Care Management.
Financial Oversight	1	Encounter Data Completeness	Percentage of encounters submitted versus claims actually incurred or paid. May be percentage of actual encounters and percentage of actual dollars.	History, peers, industry averages.	Look at claim types for trends. Hospital claims tend to be slower than physician and pharmacy. Look at top 10 encounter denial reasons to see if problem is systemic.	Claim payment timeliness reporting.	Encounter Data Processing, Rate Setting Team.
Financial Oversight	1	MLR	Following definition from 42 CFR § 438.8: The sum of medical expenses plus HCQI activities divided by operating revenue.	Category of aid (COA) expectations.	MLR less than 92% may indicate improper denial of care. MLR in excess of 97% may indicate lack of care management.	Check PMPMs and percentage of TCOC for major COS.	Investigate further, Contract Liaison(s), Rate Setting Team.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Financial Oversight	1	MMs	A count of eligible members for each month of the rating year. Shifts in MMs create instability for MCOs due to changes in staffing levels and the ability to assess and manage patient populations.	Prior periods.	Shifts in membership are often driven by changes in the macro environment or by policy-related initiatives.	TCOC.	Contract Liaisons, Enrollment Brokers, Fiscal Personnel, Budget Personnel, Network Management.
Financial Oversight	1	Operating Income Ratio; Underwriting Gain Ratio	Income from operations divided by operating revenue. Operating revenue includes prospective PMPM capitation, maternity event payments, and earned withhold, less the provision for premium taxes and income taxes.	Peers, industry averages.	Ratios less than 0 may indicate lack of care management, over-accrual of expenses, or insufficient rates. Ratios above 4% may indicate denial of care, under accrued expenses, or excessive rates.	Check PMPMs and percentage of TCOC for major COS. Check MLR and AER. Check days in IBNR for accrued expenses.	Investigate further.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Financial Oversight	1	Risk-Based Capital Proxy	Equity or net assets divided by the average of one half of one month's medical expenses covered under capitation.	Industry standard.	Lack of funding or capital at startup, consistent losses, or sweeping funds to parent/sister organizations.	Current Ratio, Defensive Interval. Also, review equity trends, profitability trends and determine if capital contributions are required.	Compliance
Financial Oversight	1	TCOC PMPM	Total medical costs divided by MMs.	History, peers.	Member mix and acuity may skew the overall cost up or down.	Profitability percentages, major COS PMPMs.	Executive Leadership.
Financial Oversight	2	Days in IBNR	IBNR divided by the average daily medical expense.	History, peers.	If IBNR is high, the plan may be padding IBNR because of inadequate data or to remain conservative in reporting profit. If too low, the plan may be under reporting medical expenses.	Check PMPMs and percentage of TCOC for major COS.	Rate Setting Team.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Financial Oversight	2	ER Percent of TCOC	ER expenses divided by total medical expenses.	Peers, expected rates.	High rate of non-emergent use of ER.	Review ER days per 1,000, cost per day and high cost cases.	Care Management, Clinical Quality, Rate Setting Team.
Financial Oversight	2	ER PMPMs	ER expenses divided by MMs.	Peers, expected rates.	High rate of non-emergent use of ER.	Review ER days per 1,000, cost per day and high cost cases.	Care Management, Clinical Quality, Rate Setting Team.
Financial Oversight	2	Inpatient Percent of TCOC	Inpatient expenses divided by total medical expense.	Peers, expected rates.	High cost cases, such as transplants, higher than expected admission rates, and readmissions. Look for cost versus volume.	Review days/1,000, admits/1,000, readmission rate, ALOS cost per day and high cost cases.	Care Management, Clinical Quality, Rate Setting Team.
Financial Oversight	2	Inpatient PMPMs	Inpatient expenses divided by MMs.	Peers, expected rates.	High cost cases, such as transplants, higher than expected admission rates and readmissions. Look for cost versus volume.	Review days/1,000, admits/1,000, cost per day, readmission rate, ALOS and high cost cases.	Care Management, Clinical Quality, Rate Setting Team.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Financial Oversight	2	Other Expense Percent of TCOC	Other expenses divided by total medical expenses.	Peers, expected rates.	Each line item in this major COS can indicate unmanaged care. Durable medical equipment (DME) is often associated with FWA.	Nursing home days over 90, if applicable.	Care Management, Clinical Quality, Rate Setting Team.
Financial Oversight	2	Other Expense PMPMs	Other expenses divided by MMs.	Peers, expected rates.	Each line item in this major COS can indicate unmanaged care. DME is often associated with FWA.	Nursing home days, transportation units.	Care Management, Clinical Quality, PI, Rate Setting Team.
Financial Oversight	2	Other Professional Percent of TCOC	Other professional expenses divided by total medical expenses.	Peers, expected rates.	Unmanaged use of specialists. Compare to utilization statistics for primary care.	Specialty care cost per unit, visits per 1,000 (Report 14).	Care Management, Clinical Quality, Rate Setting Team.
Financial Oversight	2	Other Professional PMPMs	Other professional expenses divided by MMs.	Peers, expected rates.	Unmanaged use of specialists. Compare to utilization statistics for primary care.	Specialty care cost per unit, visits per 1,000 (Report 14).	Care Management, Clinical Quality, Rate Setting Team.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Financial Oversight	2	Outpatient Percent of TCOC	Outpatient expenses divided by total medical expenses.	Peers, expected rates.	High cost cases or higher than expected usage.	Outpatient cost per claim, claims per 1,000.	Care Management, Clinical Quality, Rate Setting Team.
Financial Oversight	2	Outpatient PMPMs	Outpatient expenses divided by MMs.	Peers, expected rates.	High cost cases or higher than expected usage.	Outpatient cost per claim, claims per 1,000.	Care Management, Clinical Quality, Rate Setting Team.
Financial Oversight	2	Prescription Drug Generic Usage	Generic drug prescription counts divided by total prescription counts.	National trends modified for preferred drug list (PDL).	Unmanaged usage, PDL with increased brand drugs for higher rebates.	Adherence to PDL.	Pharmacy
Financial Oversight	2	Prescription Drug percent of TCOC	Pharmacy expenses divided by total medical expenses.	Peers, expected rates.	High brand usage, the use of specialty drugs.	Top 10 drugs, pharmacy specialty percentage.	Pharmacy, Rate Setting Team.
Financial Oversight	2	Prescription Drug PMPMs	Pharmacy expenses divided by MMs.	Peers, expected rates.	High brand usage, the use of specialty drugs.	Top 10 drugs, pharmacy specialty percentage.	Pharmacy
Financial Oversight	2	Primary Care Physician percent of TCOC	Primary care expenses divided by total medical expenses.	Peers, expected rates.	High primary care costs are often a sign of better care management.	Primary care cost per unit, visits per 1,000 (Report 14).	Care Management, Clinical Quality, Rate Setting Team.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Financial Oversight	2	Primary Care PMPMs	Primary care expenses divided by MMs.	Peers, expected rates.	High primary care costs are often a sign of better care management. Check for cost per unit.	Primary care cost per unit, visits per 1,000.	Care Management, Clinical Quality, Rate Setting Team.
Financial Oversight	3	Average Dental Cost per Visit	Total cost for dental services rendered/Number of dental visits in the quarter	Previous quarter rates and compare MCOs.	Differences in provider contracting; differences in the severity of services		UM, Quality Performance.
Financial Oversight	3	BH ER Visits/1,000	ER visits with BH primary Dx per 1,000 MMs.	National averages.	Overuse, non-emergent care.	LANE.	Care Management, Clinical Quality, Network.
Financial Oversight	3	BH Visits per 1,000	BH visits per 1,000 MMs.	Compare to national averages, peers.	Higher or lower than expected usage.	Risk Scores or Acuity of population.	Care Management, Clinical Quality.
Financial Oversight	3	Dental Visits/1,000	Total number of dental services rendered per 1,000 MMs.	Previous quarter rates and compare MCOs.	Underutilization, lack of provider availability.		UM, Quality Performance.
Financial Oversight	3	ER Cost per Unit	ER costs/visits.	Compare to Rate Book averages, peers.	Overuse, non-emergent care. Incorrect provider set-up or expense classification.	LANE.	Care Management, Clinical Quality, Network.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Financial Oversight	3	ER Visits /1,000	ER visits per 1,000 MMs.	Compare to Rate Book averages, peers.	ER use for non-emergent care.	LANE.	Care Management, Clinical Quality.
Financial Oversight	3	Inpatient Admissions per 1,000	Admissions (or Discharges) per 1,000 MMs.	National averages. May vary by COA and acuity of population.	Review primary diagnosis.	PPAs.	Care Management, Clinical Quality.
Financial Oversight	3	Inpatient ALOS	Days per admission.	National averages. May vary by COA.	Review primary diagnosis.	PPAs.	Care Management, Clinical Quality.
Financial Oversight	3	Inpatient Cost per Day	Inpatient costs per day.	Compare to Rate Book averages, peers.	Longer or shorter than expected length of stay, unbundled costs.	PPAs.	Care Management, Clinical Quality, Network, PI.
Financial Oversight	3	Inpatient Days per 1,000	Days admitted per 1,000 MMs.	National averages. may vary by COA and acuity of population.	Longer or shorter than expected length of stay.	Potentially preventable admissions (PPAs).	Care Management, Clinical Quality, Rate Setting team.
Financial Oversight	3	Inpatient Maternity ALOS	Days per admission for maternity events.	National averages.	Complications with pregnancy.	Risk Scores or Acuity of population.	Care Management, Clinical Quality.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Financial Oversight	3	Inpatient Maternity Days per 1,000	Days admitted for maternity events per 1,000 MMs.	National averages.	Complications with pregnancy.	Risk Scores or Acuity of population.	Care Management, Clinical Quality.
Financial Oversight	3	Inpatient Maternity Discharges/1,000	Discharges for maternity hospitalizations per 1,000 MMs.	Previous quarter averages and peers.	Complications of pregnancy.	Review of rate of members enrolled in Case Management (CM). Rate of members considered high risk.	Finance, UM, Quality Performance.
Financial Oversight	3	Inpatient Surgery Admissions/ 1,000	Admissions (discharges) for surgery events per 1,000 MMs.	National averages.	Complications with surgery.	Risk Scores or Acuity of population.	Care Management, Clinical Quality.
Financial Oversight	3	Inpatient Surgery ALOS	Days per admission for surgery events.	National averages.	Complications with surgery.	Risk Scores or Acuity of population.	Care Management, Clinical Quality.
Financial Oversight	3	Inpatient Surgery Days/1,000	Days admitted for surgery events per 1,000 MMs.	National averages.	Complications with surgery.	Risk Scores or Acuity of population.	Care Management, Clinical Quality.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Financial Oversight	3	Outpatient Claims/1,000	Claims (Visits) per 1,000 MMs.	National averages. Look at COA.	Higher or lower than expected usage.	Risk Scores or Acuity of population.	Care Management, Clinical Quality.
Financial Oversight	3	Outpatient Cost per Claims	Outpatient costs/claims.	Compare to Rate Book averages, peers.	Provider rates higher or lower than peers. May require analysis of contract terms.	Risk Scores or Acuity of population.	Care Management, Clinical Quality, Network, PI.
Financial Oversight	3	Readmissions Rate	Readmissions/admissions.	National averages, peers. Look at COA.	Lack of primary care or transitional care.	Risk Scores or Acuity of population.	Care Management, Clinical Quality.
Pharmacy Oversight	1	GDR	Total Generic Prescriptions divided by Total Prescriptions.	Prior quarters and annually.			Pharmacy
Pharmacy Oversight	1	Monthly Summary	Summary by rolling 12-month period. Include month, paid amount, claim count, paid per claim, utilizer count, paid per utilizer.	Prior time periods.			UM, Finance, Actuarial, Pharmacy
Pharmacy Oversight	1	Paid Amount	Total paid amount of prescriptions.	Prior quarters and annually.			Pharmacy

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Pharmacy Oversight	1	Paid Amount per Claim Summary	Paid amount per claim for all prescriptions. Include claim count, ingredient cost, dispensing fee, patient pay amount, COB amount and total paid amount.	Prior quarters and annually.			Pharmacy
Pharmacy Oversight	1	Paid Amount PMPM	Average paid amount PMPM.	Prior quarters and annually.			Pharmacy, Actuarial, Finance
Pharmacy Oversight	1	Prescriptions PMPM	Average number of prescriptions PMPM.	Prior quarters and annually.			Pharmacy, Finance.
Pharmacy Oversight	1	Rebate Amount Collected	Total amount collected from drug manufacturers for rebates. Include separate totals for rebates for retail pharmacy claims and PAD claims.	Prior periods.	Rebate vendor not invoicing timely or drug manufacturers not submitting timely rebate payments.	Total amount of rebate invoiced to collected amount.	Finance, Pharmacy.
Pharmacy Oversight	1	Rebate Amount Invoiced	Total amount invoiced to drug manufacturers for rebates. Include separate totals for rebates for retail pharmacy claims and PAD claims	Prior quarters and annually.	Rebate vendor not invoicing timely or drug manufacturers not submitting timely rebate payments.	Total amount of rebate invoiced to collected amount.	Finance, Pharmacy.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Pharmacy Oversight	1	Rebate Percentage	Total rebates collected as percentage of total paid amount in total and by retail pharmacy claims and PAD claims.	Prior quarters and annually.			Pharmacy, Finance
Pharmacy Oversight	1	Total Prescriptions	Total number of prescriptions dispensed. Provide in total, by MCO and by pharmacy type.	Prior quarters and annually.			Pharmacy, Finance
Pharmacy Oversight	2	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Assesses adults 19–64 years of age who have schizophrenia and were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	Compare to national averages using Quality Compass data and peers.	Lack of appropriate care coordination.	Review of rate of members enrolled in CM.	Care Management, Quality Performance, Pharmacy.
Pharmacy Oversight	2	Asthma Medication Ratio	Asthma Medication Ratio: Assesses individuals 5-64 years of age who are identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	National HEDIS measures on quarterly and annual basis.	Members not adherent to drug therapy.		Care Management, UM, Pharmacy.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Pharmacy Oversight	2	Brand Paid Amount	Total paid amount for brand prescriptions and percent of total paid.	Prior quarters and annually.			Pharmacy
Pharmacy Oversight	2	Brand Paid Amount PMPM	Average paid amount per brand prescription per month.	Prior quarters and annually.			Pharmacy
Pharmacy Oversight	2	Call Center Abandonment Rate	Percentage of calls that are not answered by vendor (caller hangs up before call is answered). Calculated as the number of incoming telephone calls to the service telephone line that are not answered divided by the number of calls received. Measurement excludes calls routed to IVR and includes calls abandoned within the first 20 seconds.	Prior quarters and annually.	Service disruption in call center.		Pharmacy, Quality Performance

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Pharmacy Oversight	2	Call Center Average Speed of Answer	Vendor will provide a dedicated toll-free service telephone line for use by pharmacy providers. Percent of all calls answered within an average of 30 seconds. Calculated as the amount of time that elapses once a call is placed into the customer service queue to the time the call is answered by a live customer service representative. Measurement excludes calls routed to IVR system.	Prior quarters and annually.	Service disruption in call center.		Pharmacy, Quality Performance.
Pharmacy Oversight	2	Claim Rejection Codes Summary	Summary of claim reject code, description and number of transactions by code.	Prior quarters and annually.			Pharmacy

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Pharmacy Oversight	2	Claims Accuracy	Percent of claims processed and paid accurately based on the applicable coverage, and pricing and benefit design. Calculated as: the number of retail claims and directly submitted paper claims adjudicated by vendor that do not contain a material adjudication error (i.e., any inaccuracy relating to the processing of the claim that results in an incorrect charge to ASES or its members), divided by the total number of all such claims adjudicated.	Prior quarters and annually.	Unplanned system outages.		Pharmacy, Quality Performance

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Pharmacy Oversight	2	Concurrent use of Prescription Opioids and Benzodiazepines	The percentage of individuals greater than or equal to 18 years with concurrent use of prescription opioids and benzodiazepines for greater than or equal to 30 cumulative days.	Previous quarter rates and peers This PQA Standard measure is part of the Core Set of Adult Health Care Quality Measures. Future state may include national standards.	Recipients utilizing multiple providers and pharmacies.	Review in coordination with the additional measures related to opioid use.	Pharmacy, UM, Care Management.
Pharmacy Oversight	2	SSD	The percentage of members 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Compare to national averages using Quality Compass data and peers.	Lack of appropriate care coordination.	Review of rate of members enrolled in CM.	Care Management Quality Performance, Pharmacy.

Pharmacy Oversight	2	DUR Reports Include the Requisite Components	Prospective DUR reports must include the following: potential and actual adverse effects, therapeutic duplication, drug-disease interactions and contraindications, incorrect dosage (frequency or duration of treatment), drug allergy, clinical misuse or abuse, drug-drug interactions, medication appropriateness, Incorrect drug dosage duration or overutilization and underutilization of drug treatment and Pregnancy alerts. Retrospective DUR must include the following: therapeutic appropriateness, adverse events, appropriate use of generic products, incorrect duration of treatment, utilization, inappropriate or medically unnecessary care, gross overuse, abuse and fraud.	DUR reports should include all requisite components.		Pharmacy

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Pharmacy Oversight	2	FMC Adherence	Preferred drugs on the FMC should be prescribed whenever possible. Report in total and by therapeutic class the percentage of FMC preferred drugs dispensed. Provide for the program in total and by MCO.	Prior quarters and annually.	High prescription fill rates of non-preferred medications.		Pharmacy
Pharmacy Oversight	2	GDR by MCO	Total Generic Prescriptions divided by Total Prescriptions for each MCO.	Prior quarters and annually.			Pharmacy
Pharmacy Oversight	2	GDR by Pharmacy Type	GDR analysis by pharmacy type (independent, local chain, national chain, hospital pharmacies).	Prior quarters and annually.			Pharmacy
Pharmacy Oversight	2	Generic Paid Amount	Total paid amount for generic prescriptions and percent of total paid.	Prior quarters and annually.			
Pharmacy Oversight	2	Generic Paid Amount PMPM	Average paid amount per PMPM.	Prior quarters and annually.			Pharmacy
Pharmacy Oversight	2	LME	Summary of LME drugs requested and their approval rates by MCO.	Prior quarters and annually.			Pharmacy

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Pharmacy Oversight	2	Multiple Concurrent Antipsychotics in Children and Adolescents	Assesses the percentage of children and adolescents who were on two or more concurrent antipsychotic medications for an extended period during the year.	Compare to national averages using Quality Compass data and peers.	Recipients utilizing multiple providers and/or pharmacies.	Review of rate of members enrolled in CM.	Care Management, Quality Performance, Pharmacy.
Pharmacy Oversight	2	Paid Amount PMPM by MCO	Average paid amount PMPM by MCO.	Prior quarters and annually by MCO.			Pharmacy, Actuarial
Pharmacy Oversight	2	Past-Due Rebate Payments	Total rebate amount for past due balances from drug manufacturers reported by 45 days, 75 days and greater than 90 days delinquency. Provide information by drug manufacturers with payment delinquencies.	Prior quarters.	Rebate dispute process delays.		Pharmacy, Finance
Pharmacy Oversight	2	Percentage of Maintenance and Acute Medications	Summary of percentage of paid amount and claim count for maintenance medications versus acute medications.	Prior quarters and annually.			Pharmacy, UM, Care Management.
Pharmacy Oversight	2	Prescriptions PMPM by MCO	Average number of prescriptions PMPM by MCO.	Prior quarters and annually.			Pharmacy

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Pharmacy Oversight	2	System Availability	The percent of time the claims processing system will be available to retail pharmacies as measured by the number of hours the system is available, divided by the total number of hours within the reporting period excluding regularly scheduled maintenance or telecommunication failure outside vendor's control. Measured on vendor's book-of-business.	Prior quarters and annually.	Unplanned system outages		Pharmacy, Quality Performance.
Pharmacy Oversight	2	Top 10 Specialty Drugs	Top 10 specialty drugs by paid amount. Include drug name, therapeutic class, claim count, paid amount and utilizer count.	Prior quarters and annually.			Pharmacy
Pharmacy Oversight	2	Top 10 Therapeutic Classes	List of top 10 therapeutic classes by claim count and paid amount. Include therapeutic class, claim count and paid amount for each table.	Prior quarters and annually.			Pharmacy

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Pharmacy Oversight	2	Top 25 Drugs	List of top 25 drugs by claim count and top 25 drugs by paid amount. Include drug name, therapeutic class, claim count and paid amount for each table.	Prior quarters and annually.			Pharmacy
Pharmacy Oversight	2	Total Paid Amount and Claim Count for Non-Rebateable Claims (For Example, 340B Claims)	Total paid amount and claim count for claims ineligible for rebating. Calculate a percent of total claims and paid amount.	Prior quarters and annually.			Pharmacy
Pharmacy Oversight	2	Tracking Mechanism For Detecting FWA is Used to Appropriately Document, Investigate and Resolve FWA Allegations	Tracking mechanism has the ability to: 1. Accurately document potential FWA from multiple sources (providers, enrollees, internal MCO sources) 2. Require documentation of investigation and resolution of FWA complaints from those sources	N/A			PI, Pharmacy.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Pharmacy Oversight	2	Use Of Opioids In High Doses In Persons Without Cancer	The percentage of individuals greater than or equal to 18 years of age who received prescriptions for opioids with an average daily dosage of greater than or equal to 90 morphine milligram equivalents over a period of greater than or equal to 90 days.	Previous quarter rates and peers This PQA Standard measure is part of the Core Set of Adult Health Care Quality Measures. Future state may include national standards.	Recipients utilizing multiple physicians and pharmacies.	Review in coordination with the additional measures related to opioid use.	Pharmacy, UM, Care Management.
Pharmacy Oversight	3	Percent of Claims That do not Follow the Prescription Timeframe Limits	Prescription timeframe limits are as follows: • Thirty days for critical conditions • Thirty days for chronic or severe BH conditions • Six months for maintenance drugs that require PA (exception process for up to 12 months)	Baseline on quarterly and annual basis	High rates of prescriptions filled past the time limits described in the contract may be an indicator of FWA.	Review data at pharmacy and/or prescriber level to identify outliers.	Care Management, UM, Pharmacy.
Pharmacy Oversight	3	Percent of Claims Where Prescriptions are Filled by a Provider Outside of the PPN	Prescriptions must be filled by a provider in the PPN unless there is countersignature by the enrollee's PCP or another assigned PCP.	Prior quarters and annually.	High rates of prescriptions filled by providers outside of the PPN may be an indicator of FWA.		Clinical Quality, UM.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Pharmacy Oversight	3	Percent of Claims Where PA for Prescriptions is Provided Within the Requisite Timeframes	PA is provided within 24 hours of the request or there is documentation of a need for an extension.		High rates of PA delays (over 24 hours) may indicate systemic failures in the PA process and will cause care interruptions if left unaddressed.		Pharmacy, Clinical Quality.
PI	1	FWA Cases	The number of cases (member and provider) opened, closed, refereed to ASES and MFCU, OIG during the reporting period.	Prior periods.	Poor case identification, tracking or referral practices.		
PI	1	Overpayments	The amount of overpayments estimated, identified and recouped	Prior periods, peers.	Recoupments should be net of any appeal results.		
PI	1	Provider Terminations	The number, reason and dollar amount regarding providers who were terminated due to FWA reasons from the MCO's network.	Prior periods and suspensions.	Excessive terminations due to contracting issues. FWA activity.	Government Agency referrals (ASES, OIG, DOJ).	

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
PI	2	Appeals Overturn Rate	Ratio of approved appeals divided by processed determinations for appeals filed by members and providers. Development of trends and baseline for key reasons for appeals.	Prior periods.	Usage of denials to boost cash flow. Provider/member education opportunities.	Member grievances, provider grievances.	Finance, Compliance, Clinical Quality.
PI	2	Member Grievances	Review of volume of grievances filed by members. Development of trends and baseline for key reasons for grievances and appeals.	Cumulative number of grievance by type.	Slow payments or excessive denials.	Appeals overturn rate.	Finance, Compliance, Clinical Quality.
PI	2	Payment Error Rate Measurement (PERM) Rate	Payment errors divided by total payments.	Benchmark	May indicate FWA or opportunities for training internal claims processors.		
PI	2	Provider Grievances	Review of volume of grievances filed by providers. Development of trends and baseline for key reasons for grievances and appeals.	Cumulative number of grievance by type.	Slow payments or excessive denials.	Appeals overturn rate.	Finance, Compliance, Clinical Quality
PI	2	Provider Suspensions	The number, reason and dollar amount regarding providers who were suspended due to FWA reasons from the MCO's network.	Prior periods and terminations.	Allegations of FWA, or failure to meet credentialing guidelines.		Compliance, Clinical Quality.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
PI	3	Initial FWA Member Allegations	The number of initial member allegations by topic identified each quarter. Topics include: • Misuse of ID cards • Prescription forgeries • Poly-pharmacy abuse • Overutilization of services • Third party liability • Recipient Explanation of Medicaid Benefits falsifying	Cumulative number by description.	Failure to set up a compliance tip-line or monitor for common FWA activity.		Compliance, Finance.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
PI	3	Initial FWA Provider Allegations	The number of initial provider allegations by topic identified each quarter. Topics include: • Altering or falsifying documents • MCO audit results • Billing for non-covered services • Billing for services not rendered • Billing for services out of scope of practice • Overutilization patterns • Duplicative charge patterns • Kickbacks • System claims coding issues	Cumulative number by description.	Failure to set up a compliance tip-line or monitor for common FWA activity.		Compliance, Finance.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Provider Network	1	Network Exceptions	ASES may grant an exception in accordance with 42 CFR § 438.68(d)(1), and must monitor enrollee access to that provider type on an ongoing basis and include the findings to CMS in the managed care program Assessment Report required under 42 CFR § 438.66.	Prior periods.	Exceptions to each MCO have been granted throughout Plan Vital. Need to establish baseline for exceptions granted for first year of Plan Vital.	Provider enrollment file and National Provider List (NPL).	
Provider Network	1	Provider Access Per Municipality	MCOs are required to have primary care providers and psychologists available to enrollees in each municipality of the island to ensure geographical distribution of providers.	Prior periods.	Key municipalities, including Vieques and Culebra historically have poor access availability.	Provider enrollment file and NPL.	
Provider Network	1	Provider to Enrollee Ratio	Enrollee-to-provider ratio requirements must be maintained for primary care and hospital access. Provider types include primary care, family practice, pediatrics, gynecologists and hospitals.	Prior periods.	MCOs historically have met this requirement.	Provider enrollment file and NPL.	

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Provider Network	1	Required Network Providers	Certain key providers must be contracted by the MCO to support Plan Vital. Provider types include but are not limited to certified buprenorphine providers, emergency stabilization units, Federally Qualified Health Centers and certain Government Health Care Facilities.	Prior periods.	At the launch of Plan Vital, certain Government Health Care Facilities were not contracting with all MCOs. In particular, there were issues contracting with Centro Comprensivo de Cáncer.	Provider enrollment file and NPL.	

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Provider Network	1	Time and Distance	The MCOs must maintain time and distance requirements established by ASES for primary care, gynecologists, dentists, mental health (MH) providers, and certain high-volume specialists which are held to two primary standards for Puerto Rico (urban and non-urban) based on population density and geographical considerations.	Prior periods.	There is a shortage of certain specialist providers in Puerto Rico, for both urban and non-urban areas including but not limited to: adult specialty providers including dermatologists, gastroenterologists, podiatrists and rheumatologists, and pediatric specialty providers including allergy and immunologists, dermatologists, gastroenterologists, cardiologists, and orthopedic surgeons.	Provider enrollment file and NPL.	

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Provider Network	2	Appointment Standards	For the 25% network survey (by quarter), the MCOs are required to report if the contractor received any complaints or grievances from enrollees regarding access or appointment availability.	Prior periods.	Note reporting focuses on surveyed providers and may not reflect larger more systemic issues.		Planning, Customer Service.
Provider Network	2	Appointment Standards	Every quarter the MCOs are asked to review their provider network and survey Appointment Availability and Time (Appt. AV&T) by provider type.	Peers			
Provider Network	2	Appointment Standards	For the 25% network survey (by quarter), the MCOs are required to report if the contractor received any complaints or grievances from enrollees regarding access or appointment availability.	Peers			

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Provider Network	2	Appointment Standards — Diagnostic and/or Laboratory Services — HOLD	Diagnostic/Laboratory Services: • Diagnostic laboratory — 14 calendar days • Diagnostic imaging — 14 calendar days • Other testing appointments — 14 calendar days				
Provider Network	2	Appointment Standards — Non-Urgent Conditions — HOLD	Non-urgent conditions: • Routine physical exams — 30 calendar days • Routine physical exams less than 21 years of age — early and periodic screening and diagnosis treatment routine evaluations for primary care — 30 calendar days • Covered Services — 14 calendar days • Specialist Services — 30 calendar days • Dental Services — 60 calendar days • BH Services — 14 calendar days				

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Provider Network	2	Appointment Standards — Prescription Drugs — HOLD	Prescription drugs: • Prescription fills — in person (ready for pick up) — 40 minutes • Prescription fills — phoned — 90 minutes				
Provider Network	2	Appointment Standards — Urgent Conditions — HOLD	Urgent conditions: • Emergency Services — 24 hours • Urgent conditions outpatient — 48 hours • Urgent conditions laboratory — 2 hours • BH Crisis Services — clinical necessity				
Provider Network	2	Enrollee Complaints	For the 25% network survey (by quarter), the MCOs are required to report if the contractor received any complaints or grievances from enrollees regarding access or appointment availability.	Prior periods.	Note reporting focuses on surveyed providers and may not reflect larger more systemic issues.	Member grievances related to appointment availability.	Planning, Customer Service.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Quality Performance	1	HCIP Performance — High Cost Conditions Quarterly Performance Score	Total points scored (out of 12) on the High Cost Conditions Initiative in the HCIP.	Previous quarter averages and peers.	Lower than expected points earned indicate issues in meeting clinical and quality metrics and will impact withhold earnings.	Drill down to measures that are driving favorable or unfavorable performance.	Finance, Care Management, Quality Performance.
Quality Performance	1	HCIP Quarterly Performance	Total quarterly points earned within the defined HCIP scored metrics. MCO withhold payment is directly tied to the HCIP quarterly score.	Previous quarter averages and peers.	Lower than expected prevention intervention and/or inappropriate service utilization.	Evaluation of variance amongst MCOs by initiative (High Cost Conditions, Chronic Conditions, Healthy People and ER High Utilization).	Finance, UM, Quality Performance, Care Management.
Quality Performance	2	HCIP Performance — Chronic Conditions Quarterly Performance Score	Total points scored (out of 16) on the High Cost Conditions Initiative in the HCIP.	Previous quarter averages and peers.	Lower than expected points earned indicate issues in meeting clinical and quality metrics and will impact withhold earnings.	Drill down to measures that are driving favorable or unfavorable performance.	Finance, Care Management, Quality Performance.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Quality Performance	2	HCIP Performance — ER High Utilizers Quarterly Performance Score	Total points scored (out of 2) on the ER High Utilizers Initiative in the HCIP.	Previous quarter averages and peers.	Lower than expected points earned indicate issues in meeting clinical and quality metrics and will impact withhold earnings.	Drill down to measures that are driving favorable or unfavorable performance.	Finance, Care Management, Quality Performance
Quality Performance	2	HCIP Performance — Healthy People Quarterly Performance Score	Total points scored (out of 10) on the Healthy People Initiative in the HCIP.	Previous quarter averages and peers.	Lower than expected points earned indicate issues in meeting clinical and quality metrics and will impact withhold earnings.	Drill down to measures that are driving favorable or unfavorable performance.	Finance, Care Management, Quality Performance.
Quality Performance	2	PH Hospital 30-Day Readmission Percent	Percent of 30-day readmissions PH hospital for quarter.	Previous quarter averages and peers.	Lack of appropriate care coordination and poor discharge planning.	Drill down of trends by service and/or provider.	Finance, UM, Care Management.
Quality Performance	2	Provider Complaints — BH Provider	Total number of BH provider complaints received for the quarter.	Previous quarter averages and peers.	Higher than expected volume could indicate significant provider network issues with member impact.	Drill down to compliant type.	Care Management, Quality Performance, Network Management.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
Quality Performance	2	Provider Complaints — PH Provider	Total number of PH provider complaints received for the quarter.	Previous quarter averages and peers.	Higher than expected volume could indicate significant provider network issues with member impact.	Drill into the reasons and/or trends driving provider complaints and/or disputes.	Care Management, Quality Performance, Network Management.
Quality Performance	2	Provider Preventable Conditions	Number of Provider Preventable Conditions reported in the quarter.	When not zero, follow up to ensure Medicaid did not pay for the event and evaluate corrective actions required of the MCO.	Indicates quality of care or service issues.		Finance, Quality Performance.
Quality Performance	2	Psychiatric Hospital 30-Day Readmission Percent	Percent of 30-day readmissions psychiatric hospital for quarter.	Previous quarter averages and peers.	Lack of appropriate care coordination and poor discharge planning.	Drill down of trends by service and/or provider.	Finance, UM, Care Management.
UM	1	Appeals per 1000	Count of appeals for quarter per 1000 MMs.	Previous quarter averages and peers.	Higher than expected rates indicate quality of care or service issues.	Drill down of trends in processed appeal reasons for PH or BH.	Care Management, Quality Performance.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
UM	1	Concurrent use of Prescription Opioids and Benzodiazepines	The percentage of individuals greater than or equal to 18 years with concurrent use of prescription opioids and benzodiazepines for greater than or equal to 30 cumulative days.	Previous quarter rates and peers This PQA Standard measure is part of the Core Set of Adult Health Care Quality Measures. Future state may include national standards.	Recipients utilizing multiple providers and pharmacies.	Review in coordination with the additional measures related to opioid use.	Pharmacy, UM, Care Management.
UM	1	Initiation and/or Engagement of Alcohol and Other Drug Treatment for Opioids	Initiation of Alcohol and Other Drugs (AOD) Treatment: • Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis.	Compare to national averages using Quality Compass data and peers.	Insufficient provider capacity and monitoring. Insufficient care management resources.	Review in coordination with the additional measures related to opioid use. Compare findings with BH services findings.	Care Management, UM, Quality Performance,

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
UM	1	Live Births Weighing Less than 2,500 Grams	This measure assesses the proportion of eligible births that are low birth weight.	Previous quarter rates, peer and Center for Disease Control 2020 Child Core Set Specifications. Future state may include national standards.	Poor prenatal health care.	Review of rate of members enrolled in CM. Rate of members considered High Risk. Review HEDIS Timeliness of Prenatal Care measures.	UM, Quality Performance.
UM	1	Member Grievances per 1000	Count of member grievances for quarter per 1000 MMs.	Previous quarter averages and peers.	Higher than expected rates indicate quality of care or service issues.	Drill down of trends in member grievances by reason code.	Care Management, Quality Performance.
UM	1	Use of Opioids in High Doses in Persons Without Cancer Greater than 200 MME	The percentage of individuals greater than or equal to 18 years of age who received prescriptions for opioids with an average daily dosage of greater than or equal to 200 morphine milligram equivalents (MME) over a period of greater than or equal to 90 days.				

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
UM	1	Use of Opioids in High Doses in Persons Without Cancer Greater than 90 MME	The percentage of individuals greater than or equal to 18 years of age who received prescriptions for opioids with an average daily dosage of greater than or equal to 90 morphine milligram equivalents (MME) over a period of greater than or equal to 90 days.	Previous quarter rates and peers. This PQA Standard measure is part of the Core Set of Adult Health Care Quality Measures. Future state may include national standards.	Recipients utilizing multiple physicians and pharmacies.	Review in coordination with the additional measures related to opioid use.	Pharmacy, UM, Care Management.
UM	2	Appeal Overturn Rate	The rate of appeals that have been overturned/approved within the quarter.	Previous quarter averages and peers.	Higher than expected rates indicate quality of care or service issues.	Drill down of trends in appeals approved by service or provider.	Care Management, Quality Performance.
UM	2	BH Discharges per 1,000	Discharges for BH hospitalizations per 1,000 MMs.	Previous quarter averages and peers.	Lack of access to BH outpatient services, including crisis services or quality of BH care.	Drill down of trends by region, diagnosis and/or provider.	Finance, UM, Quality Performance.
UM	2	BH Hospitalizations ALOS	ALOS for BH hospitalizations.	Previous quarter rates and peers.	Possible under or over utilization.	Drill down of trends by service and/or provider.	Finance, UM, Quality Performance.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
UM	2	Inpatient Medical Discharges/1,000	Discharges for medical hospitalizations per 1,000 MMs.	Previous quarter averages and peers.	Possible under or over utilization.	Drill down of trends by service and/or provider.	Finance, UM, Quality Performance.
UM	2	Inpatient PH Hospitalization ALOS	ALOS for PH hospitalizations.	Previous quarter averages and peers.	Possible under or over utilization.	Drill down of trends by service and/or provider.	Finance, UM, Quality Performance.
UM	2	Percent of PAs Fully Approved	Total prior authorizations approved in full divided by total PA's processed	Previous quarter averages and peers.	Lower than expected approval percentages may increase provider complaints and warrant further investigation.	Drill down of trends by service and/or provider.	UM, Quality Performance, Network Management.
UM	2	Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Assesses the percentage of children and adolescents who were on two or more concurrent antipsychotic medications for an extended period during the year.	Compare to national averages using Quality Compass data and peers.	Recipients utilizing multiple providers and/or pharmacies.	Review of rate of members enrolled in CM.	Care Management, Quality Performance, Pharmacy.
UM	2	Use of Opioids from Multiple Pharmacies in Persons Without Cancer Greater than 90 MME	the number of members who obtained opioid prescriptions from multiple pharmacies in persons without cancer greater than 90 MME.				

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
UM	2	Use of Opioids from Multiple Prescribers AND Multiple Pharmacies in Persons Without Cancer Greater Than 90 MME	The number of members who obtained opioid prescriptions from multiple prescribers AND multiple pharmacies in persons without cancer greater than 90 MME.				
UM	2	Use Of Opioids from Multiple Prescribers in Persons Without Cancer Greater than 90 MME	The number of members who obtained opioid prescriptions from multiple prescribers in persons without cancer greater than 90 MME.				
UM	3	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Assesses adults 19–64 years of age who have schizophrenia and were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	Compare to national averages using Quality Compass data and peers.	Lack of appropriate care coordination.	Review of rate of members enrolled in CM.	Care Management, Quality Performance, Pharmacy.
UM	3	BH Total Outpatient Services per 1,000	BH total outpatient services per 1,000 MMs.	Compare to national averages using Quality Compass data and peers.	Possible under or over utilization.	Drill down of trends by service and/or provider.	Finance, UM, Quality Performance.

Type	Tier	Metric	Definition	Compare to	Common Causes for out of Range	Other Metrics to Review	Stakeholders to Notify
UM	3	Dental Services per 1,000	Dental services per 1,000 MMs.	Compare to national averages using Quality Compass data and peers.	Underutilization and/or lack of provider availability.	Drill down of trends by service and/or provider.	Finance, UM, Quality Performance.
UM	3	SSD	The percentage of members 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Compare to national averages using Quality Compass data and peers.	Lack of appropriate care coordination.	Review of rate of members enrolled in CM.	Care Management Quality Performance, Pharmacy.
UM	3	Inpatient Maternity Discharges per 1,000	Discharges for maternity hospitalizations per 1,000 MMs.	Previous quarter averages and peers.	Complications of pregnancy.	Review of rate of members enrolled in CM. Rate of members considered high risk.	Finance, UM, Quality Performance.

Appendix B
Key Comparison Metrics

For Key Utilization Comparison Metrics, please refer to NCQA's Quality Compass.

https://www.ncqa.org/hedis/measures/

Measure Name	Average Rate	Number	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Inpatient Utilization — General Hospital (GH)/Acute Care — Maternity ALOS (Total)	See https://www.ncqa.org/hedis/measures/	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass
Inpatient Utilization — GH/Acute Care — Maternity Days/1,000 MM (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass
Inpatient Utilization — GH/Acute Care — Maternity Discharges/1,000 MM (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass
Inpatient Utilization — GH/Acute Care — Medicine ALOS (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass
Inpatient Utilization — GH/Acute Care — Medicine Days/1,000 MM (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass
Inpatient Utilization — GH/Acute Care — Medicine Discharges/1,000 MM (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass

Measure Name	Average Rate	Number	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Inpatient Utilization — GH/Acute Care — Surgery ALOS (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass
Inpatient Utilization — GH/Acute Care — Surgery Days/1,000 MM (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass
Inpatient Utilization — GH/Acute Care — Surgery Discharges/1,000 MM (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass
Inpatient Utilization — GH/Acute Care — Total Inpatient ALOS (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass
Inpatient Utilization — GH/Acute Care — Total Inpatient Days/1,000 MM (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass
Inpatient Utilization — GH/Acute Care — Total Inpatient Discharges/1,000 MM (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass
Ambulatory Care — ER Visits/1,000 MM (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass
Ambulatory Care — Outpatient Visits/1,000 MM (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass

Measure Name	Average Rate	Number	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
MH Utilization — Inpatient (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass
MH Utilization — Intensive Outpatient or Partial Hospitalization (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass
MH Utilization — ER (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass
MH Utilization — Outpatient (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass
MH Utilization — Telehealth (Total)	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass	See Quality Compass

Appendix C
Program Integrity Checklist

Item #		Contract Requirement	Compliance Plan Section or Name of Policy	Page #	Notes for ASES and Medicaid Staff Only*
1		P&Ps			
	1.1	Written policies, procedures and standards of conduct that articulate the primary contractor and/or its MCO's commitment to comply with all Federal and State standards related to Medicaid MCO.			Written P&Ps should be written clearly and describe expectations of compliance in detail. These guidelines also need to be made readily available for all employees.
	1.2	Compliance Committee that is accountable to senior management.			
	1.3	Information on FWA coordinator and staff.			
	1.4	Detailed description of FWA detection controls.			
	1.5	Detailed description of FWA investigative process.			
	1.6	Explanation of process for referring FWA to the SIU within 30 business days.			
	1.7	Overpayment recovery and sanction process.			

Item #		Contract Requirement	Compliance Plan Section or Name of Policy	Page #	Notes for ASES and Medicaid Staff Only*
	1.8	Process for informing SIU of providers who dis-enroll (voluntarily or involuntarily) from the program during or after a FWA investigation.			
	1.9	Process to notify SIU of any provider disclosures during credentialing/re-credentialing.			
	1.10	Process to notify SIU of any adverse actions taken during the credentialing/re-credentialing process.			
	1.11	Certification statement that the Quarterly Compliance Report has been reviewed for accuracy by the Chief Executive Officer (CEO), the CFO or the Chief Operations Officer and the SIU Manager/Compliance Officer.			
	1.12	The provider agreements include notification of prohibition and sanctions for submitting false claims.			
	1.13	The primary contractor and MCO subcontracts			

Item #		Contract Requirement	Compliance Plan Section or Name of Policy	Page #	Notes for ASES and Medicaid Staff Only*
		include all the requirements.			
	1.14	The written standards for conduct, or the code of conduct, should clearly state and outline the organization's commitment to compliance, values, and quality treatment of customers, patients and employees.			Standards of conduct should detail your organization's commitment to ethical behavior, should also indicate that compliance is the responsibility of all employees, and describe how to report incidence of noncompliant or unethical behaviors.
	1.15	Standards of conduct training is given upon hire and at a minimum of annually thereafter. All employees should be required to certify that they have read, understand and agree to comply with the standards.			

Item #		Contract Requirement	Compliance Plan Section or Name of Policy	Page #	Notes for ASES and Medicaid Staff Only*
2		**Compliance Program Oversight/Corporate Staffing**			
	2.1	The designation of a Compliance Officer.			The Compliance Officer should report directly to the CEO or other senior management, have access to the Board and be responsible for the compliance program's structure and administration. Also, the Compliance Officer must be able to demonstrate that s/he has involvement in and detailed familiarity with the organization's operational and compliance activities.
	2.2	The Compliance Officer and Compliance Committee also have the authority to conduct certain functions related to the compliance program. Those authorities include interviewing employees, reviewing collective data, seeking advice from legal counsel, reporting potential FWA within the organization, conducting operations audits, recommending policy procedure process improvements and enforcing compliance program requirements at all levels of the organization.			A Compliance Officer and a Compliance Committee are two different entities; many programs have both. A Compliance Officer is a single employee who is solely responsible for the day-to-day workings of the compliance program and structure. The Compliance Committee is a multidisciplinary committee whose members have various backgrounds and expertise. Both the Compliance Officer and the Compliance Committee should report directly to and be accountable to the CEO or other senior management.
	2.3	The designation of a full-time FWA Coordinator			

Item #		Contract Requirement	Compliance Plan Section or Name of Policy	Page #	Notes for ASES and Medicaid Staff Only*
		dedicated to the Plan Vital program.			
	2.4	Employ or contract FWA staff in sufficient numbers that will prevent, detect, investigate and report suspected FWA.			
	2.5	There is a SIU independent of operations, including quality, with accessibility to the Board.			
3		**Training**			
	3.1	Information on training and education for the Compliance Officer and SIU staff.			
	3.2	Information on training and education for members.			
	3.3	Information on training and education for the rest of the MCO staff, including the Board.			Initial compliance training for new employees should occur at or near the date of hire and then annual refresher compliance training that highlights compliance program changes or other new documents.
	3.4	Training includes information about False Claims Act and Whistleblowers Protection Acts.			

Item #		Contract Requirement	Compliance Plan Section or Name of Policy	Page #	Notes for ASES and Medicaid Staff Only*
	3.5	Inclusion of the toll-free FWA Hotline number in the Member Handbook.			
	3.6	Information on training and education for providers.			
	3.7	Inclusion of the toll-free FWA Hotline number in the Provider Handbook (or Manual).			
4		**Opening Lines of Communication**			
	4.1	Requirements for all employees to be proactive and to report issues timely.			There should be an organization-wide open-door policy for employee access to all levels of management, but particularly for the Compliance Officer and the compliance department staff.
	4.2	A formal process for managers to communicate compliance issues and results to staff.			
	4.3	A process to allow anonymous reporting without fear of retaliation.			Several methods available for employees to report compliance issues (i.e., in-person reporting; reporting electronically, either by email or internet form; and reporting anonymously by drop box or toll-free FWA Hotline).
5		**Disciplinary Guidelines**			
	5.1	Enforcement of standards through well publicized disciplinary guidelines for internal staff.			Written policy that apply appropriate disciplinary sanctions on those who failed to comply with the applicable requirements and with written standards of conduct. These disciplinary policies should include sanctions

Item #		Contract Requirement	Compliance Plan Section or Name of Policy	Page #	Notes for ASES and Medicaid Staff Only*
					for noncompliance, for failure to detect noncompliance when routine observation or due diligence should have provided adequate clues, and for failure to report actual or suspected noncompliance. Disciplinary policies must be clearly written and describe expectations and consequences for noncompliant behaviors. They should be widely publicized and reviewed at least annually for the staff.
6		**Internal and External Monitoring and Auditing**			
	6.1	Provisions for internal monitoring and auditing.			Monitoring includes regular reviews performed as part of normal operations to confirm ongoing compliance. Monitoring occurs on a regular basis: for example, daily, weekly or monthly during normal operations, to see if procedures are working as intended. Auditing is a more comprehensive review than monitoring. Auditors review compliance against a set of standards such as compliance with statutes and regulations or compliance with the internal requirements used as base measures.
	6.2	A plan of how internal investigations should be conducted; a time limit for choosing an investigation; options for corrective action; when to have an investigation performed by an outside independent contractor;			

Item #		Contract Requirement	Compliance Plan Section or Name of Policy	Page #	Notes for ASES and Medicaid Staff Only*
		and how and when to refer an active noncompliance to SIU or law enforcement authorities.			
	6.3	Provisions for external monitoring and auditing: • Referral to SIU • Triage • Reporting • Data analysis • Sample section and size • Auditing protocol • Investigation protocol • Use of extrapolation • Peer review of the completed process • Provider appeal process of SIU findings • Determining the penalty for a found violation • CAP and monitoring			
	6.4	Performs a risk assessment.			Risk assessment should include areas of concern identified by State, beneficiaries, providers and identify risk levels (for example, high, medium, or low risk). High risk areas should be audited regularly.

Item #		Contract Requirement	Compliance Plan Section or Name of Policy	Page #	Notes for ASES and Medicaid Staff Only*
7		**Response to Offenses (Corrective Action)**			
	7.1	Provisions for prompt response to detected offenses and the development of corrective action initiatives.			When vulnerabilities or nonconforming issues are identified and/or reported as the result of a risk assessment, audit or monitoring, corrective action must be conducted in response to potential violations.
	7.2	Provisions for tracking the CAP until completion.			
	7.3	Written process for coordination with SIU or the Office of Attorney General before informing the provider of findings and recoupment.			
	7.4	Written process that outlines when supporting documentation should be submitted to SIU.			
8		**Member Verification**			
	8.1	Description of methods to verify member receipt of services.			Documentation should include the sampling methodology.
	8.2	Written process for verifying receipt of services as part of the complaint and grievance process.			Documentation should include the process for negative responses.
9		**Precluded Providers/Suspension of Payments**			
	9.1	Statement that Medicheck and OIG List			

Item #		Contract Requirement	Compliance Plan Section or Name of Policy	Page #	Notes for ASES and Medicaid Staff Only*
		of Excluded Individuals and Entities and SAM are used to as part of initial credentialing and then monthly to ensure providers are not excluded.			
	9.2	Statement that the Social Security Death Master File is checked monthly.			
	9.3	Process for terminating providers upon notification of termination/suspension by SIU.			

*Excerpts are taken from the CMS Affordable Care Act Provider Compliance Programs.

Appendix C

ASES Compliance Office Work Plan 2019–2020

GOBIERNO DE PUERTO RICO
Administración de Seguros de Salud

Health Insurance Administration (ASES) Compliance Office
Chief Compliance Officer - Madeline Figueroa Rivera, Esq.

Compliance Work Plan 2019-2020

Background

The main function of the Compliance Program in any health organization is to ensure full compliance with all requirements that guarantee patients care and wellbeing. The Compliance Program identify and analyzes the areas of risks, anticipates inappropriate behaviors, improves operational functions and monitors and strengthens business relationships with the health care service providers. All organizations aspire to improve the quality of health services, following closely the applicable rules, laws and processes required of them. The work of the compliance area is compulsory (as established by the *Patient Protection Affordable Care Act)* and governs ethical culture in health care.

ASES has a clear vison and works with a designed compliance plan. Our compliance plan is developed by focusing on areas that require detailed monitoring and reporting based on risk and exposure analysis, demonstrated by changes reflected in quantified and documented prior analyses.

The Compliance Work Plan is non-static and should be reviewed periodically to ensure monitoring of compliance issues affecting ASES internally and/or externally.

Purpose

This Work Plan is intended to define, among others, the evaluation, review, monitoring and audit activities to be carried out and the owners responsible for carrying them out. It also describes, elements needed to achieve plan implementation, such as: review of existing rules, risk analysis, staff training, calendars, reporting, internal presentations and external visits and interventions to business partners to ensure quality and adequacy of patients health care and compliance with all applicable regulations and contractual obligations.

Basic Compliance Elements

There are seven basic elements in the compliance area that frame the work plan to follow:

1. Implementation of written policies, procedures and standards of conduct.
2. Identification of a Compliance Officer to lead efforts and oversee the implementation of compliance standards and good practices.
3. Training and education in compliance issues and regulations.
4. Establish open, confidential and reliable communication lines.
5. Internal/external monitoring and audits.
6. Implement compliance standards through widely published disciplinary guides.
7. Provide prompt answers to any offense or violation of compliance rules detected and develop appropriate and timely corrective actions.

General Functions of Administracion de Seguros Salud de Puerto Rico (ASES) Compliance Area

Based upon the compliance basic elements herein mentioned, we can describe our general functions as:

a. Establish contractual mechanisms to ensure compliance with aspects that may affect access, quality and cost control of services and the protection of the rights of beneficiaries and providers.
b. Determine whether they offer the services in accordance with the provisions of the contracts signed with ASES, monitoring compliance with the contracts of:
    - Vital Plan Health Entities (managed care organizations [MCOs])
    - Platinum Medicare Plans (Medicare Advantage Organizations [MAOs])
    - Pharmacy Benefits Management (PBM)
    - Pharmacy Benefits and Rebates Administrator
c. Direct ASES contractual compliance activities.
d. Advise the Executive Director on the implementation of ASES policies and procedures in accordance and compliance with the contracts reached.
e. Ensure that MCOs contracted by ASES provide the statistical and narrative reports required to accurately know the degree of compliance with contractual clauses.
f. Monitor and evaluate corrective action plans presented by MCOs according to contractual requirements and in the light of the findings of investigations and audits conducted by the Compliance Area staff.
g. Collaborate in the planning, preparation, evaluation and analysis of requests for proposals.

h. Assist the Executive Office and Office of Legal Affairs during the negotiation, renewal and contract amendment processes.
i. Coordinate meetings with healthcare providers and other professions to address and follow up on situations presented by contracted medical groups or MCOs referred to by the ASES Executive Office or Provider Services Office.
j. Require from participating providers to provide the information that ASES needs, to follow strict compliance with the law and the contract signed, by using implemented reporting guidelines, reporting tools, and comprehensive oversight reports.
k. Initiate, together with the ASES Legal Office, the process of sanctions applicable to the MCOs contracted, for any persistent breach of contract under the contractual provisions.
l. Monitor the mandatory compliance of the MCOs with the Health Insurance Portability and Accountability Act (HIPAA) law and investigate and establish responsibilities of any security and privacy breaches of protected information.
m. Supervise and complement the efforts of the MCOs contracted, in relation to the prevention, detection and investigation of fraud, waste or abuse issues and coordinate the activities of other government related entities like Medicaid Office, Medicaid Fraud Control Units (MFCU) and the state and federal corresponding agencies.
n. Perform different types of interventions:
    - Audit MCOs contracted by ASES for breach of contract or applicable regulations.
    - Respond to special requests from ASES executive area, among other offices or other government related agencies.
    - Review and validate of Vital Plan data request in accordance with HIPAA Law and investigation of other security and privacy breaches of protected information.
    - Detect and investigate fraud, waste or abuse behaviors.
    - Conduct continuous review and approval of MCOs and MAOs marketing and promotional materials.

Functions aimed at monitoring MCO's.

On-going monitoring of MCOs will take place allowing ASES to maintain an open and continuous communication with the MCOs in order to:

a. Identify specific and general behavioral trends of the MCOs, to achieve the establishment of consonant measures with contracts, as well as, compliance with applicable federal and state regulations, including the prevention of fraud, waste and abuse.
b. Establish timely corrective action plans and targeted or specific interventions in the event of non-compliance with MCOs metrics, established to ensure quality of service.
c. Obtain and reconcile information on the operational functioning of MCOs with Puerto Rico Medicaid and ASES, through Puerto Rico Medicaid Management Information System, to ensure homogeneous visibility into the behavior of those contracted MCOs.

The design of the ASES Monitoring and Compliance Plan has proactively identified clear components covering basic compliance functions, including:

a. Developing standards and metrics to evaluate the MCOs.
b. Strengthening Plan Vital contract and its amendments that allow the review of areas and requirements and their relationship to compliance.
c. Collecting data through the delivery of redesigned and/or modified reports (new *lay-outs* and *templates; Comprehensive Oversight Monitoring Plan [COMP] tool).*
d. Establishing key guides to manage and report the information to be provided.
e. Reporting graphical and real-time reports and dashboards, which summarize compliance behavior, trends and violations, to be communicated to MCOs and its management levels, along with any recommendations and improvement plans in a clear and identifiable manner.
f. Monitoring the proper use and distribution of funds paid by ASES to MCOs and their health care providers, to achieve the improvement and stability of the health of Vital beneficiaries as the target.

Work Plan 2020-2021/Actual and Projected Activities

As per ASES commitment on implementing a clear and successful oversight Compliance Plan, we developed internal elements to facilitate the approach outlined. These elements are directed to support stability of the compliance area of ASES, including staff responsibilities and trainings, policies and procedures, including:

- Policies and Procedures inventory and redefinition
- Identification of mirrored policies from other areas of operation that reflect the related guideline, policy, and/or compliance procedure
- Redefinition of the responsibilities and objectives for each compliance area officer. Assignment of an MCO - specific compliance officer for a closer relationship and oversight of assigned MCO
- Reinforce ASES employees' trainings requirements in areas:
  - Fraud and Abuse
  - Cultural Diversity
  - Anti-Kickback
  - Self-Referrals
  - Quality and Accreditation Basics
  - Retaliation Policies
- Review ASES existing monitoring reports for updating them to identified historical versus actual compliance needs.
- Opened government inter-agencies reliable and confidential lines of communication (Memorandum of Understanding [MOU] with Puerto Rico Medicaid and MFCU).
- Implement a primary cause identification process and risk assessments road-map for compliance in sensitive areas, as well as, rule violations to identify trends and suspicious patterns.

Our external compliance monitoring plan activities includes the implementation and ongoing improvement of:

a. Development and Implementation of Work Tools
   - **Reporting Packages -** *layouts* and *templates* redefinition into new platforms (XML) and its revision by the corresponding work areas of the ASES, to standardize forms and submissions of data from all MCOs.

- **Contractor Reporting Guidelines -** a clear guide to show steps to follow including required timeframes was developed and implemented. MCOs presented information to ASES in timeframes requested. Consequences of not reporting consistently and appropriately were communicated to MCOs.
- **COMP –** the MCO performance review tool that includes real time information provided by MCOs, using the tools and *layouts designed* and contained in the *Reporting Package* supplied to the MCOs by ASES. The COMP tool is divided into metric levels ranging from, metrics that must be routinely evaluated up to a third level that measures specific or exceptional data. COMP tool trainings began on October 1, 2020 for ASES middle management staff and MCO applicable staff.
- The COMP tool divides MCO behavior monitoring into six (6) key fields:
  - Evaluation and monitoring of the providers network relations areas (accessibility, availability and adequacy, and evaluation of full contracting and credentialing status of providers)
  - Evaluation and monitoring of Integrity and Compliance Programs - comparing programs based on reported data, and the proper identification of possible cases and suspicious behaviors of fraud, waste and abuse. Monitoring ensures the integrity and correct management of federal Medicaid programs and funds
  - Evaluation and monitoring of quality and clinical programs in relation to national and state standards
  - Evaluation and monitoring of the Finance data, measuring solvency, efficiency and profitability of the MCOs
  - Evaluation and monitoring of claims and encounters, oversight of complaints, timeliness, completeness, accuracy of processing and payment of claims
  - Evaluation and monitoring of PBM, evaluation of the operation of the PBM, the costs of prescriptions and drug treatments, trends in use and exceptions to standards and, costs of branded versus generic drugs and their financial impact.

b. Development and identification by risk assessment analysis of the following areas and its subsequent design of audit processes:
   - Management of the high-risk program; chronic conditions and special coverage conditions.
   - Evaluation and standardization of quality incentive programs.

- "*Directed Payments*" Oversight:
  - Adjustments of 70% Medicare payments to providers.
  - Payment phases to capitated physicians (10% increase adjustment to Primary Medical Groups and mental health providers, excluding 70% Medicare adjustment).
  - Payments to hospitals. Uniform adjustments to hospital rates payment refund by 78% Medicare. Approved by Centers for Medicare and Medicaid Services, July 2020, period from January 2020 to September 2021.

c. Interagency work between MFCU, Medicaid Integrity Program and ASES
   - Review and validation of the interagency MOU. (42 CFR § 438.608 and section 13.3 Vital Plan Contract)
   - Quarterly inter-agency: Medicaid, ASES and MFCU meetings implemented; first meeting on August 21, 2020.

Appendix D

Draft ASES Contracting Procedures

PUERTO RICO HEALTH INSURANCE ADMINISTRATION (ASES) PROFESIONAL SERVICES CONTRACTING PROCEDURES

STEP 1: Professional Service Proposal Evaluation

1. For the Professional Services contracting process each ASES unit/office/department administers the contracts regarding the expertise area.
2. Each department present to the Executive Director Office all the service proposals of each possible contractor.
3. The Executive Director and his staff review each proposal, according to the recommended budget of each contract and the scope of work requested.
4. The Executive Director prepare a report to be presented to the Contracting Committee designated by the Board of Directors and schedule a meeting with them to evaluate each contracting proposals and their discussed the recommendations that will be presented to the ASES' Board of Directors. The Contracting Committee evaluate each proposal, the necessity of it, the amount for each service and the maximum amount for the contract year.
5. In an ordinary or extraordinary meeting, the Board of Directors, review the Contracting Committee Recommendations and approve or decline each contract. If the committee does not agree with the proposal, they discussed with the Board of Director and recommend changes or ask for a different alternative of possible contractors.
6. Once the Board of Directors agrees with the proposal and its services the Executive Office send the approved proposals to ASES's Finance Department and Legal Department to prepare the documentation required to be submitted to Government Budget Management Office and Governor Secretary Office, according the Memorandum OSG-2019-001 & Circular Letter 168-19 of OMB.

STEP 2: Finances Department

1. ASES's Finance Office review all the services proposals to will submit in the Government Contract Processing Platform (PCo). This platform is creating by the OMB for obtain the required budget approval from the Office of Budget Management and the contract approval from Governor Secretary Office.

2. Once the Finances Department compile the application form and certifications requires, then they send the documentation to the Legal Department for include others legal certifications and final evaluation. The documents must include the following:
    a. Certification of the Finances Department director, certifying that ASES has the budget for the contract.
    b. Certification from the Human Resources director, certifying that the contract does not constitute an ASES employee job position.
    c. Certification from the Executive Director. **This certification is signed by the ED after the Legal Department Evaluation.*
    d. Certification from the Legal Department director, certifying that the contract will comply with all government legal rules. * *This certification is signed by de legal director after the evaluation from the legal department.*

STEP 3: Legal Department Evaluation/Procedures

1. Legal Advisors review the proposal, and its approval from the Board of Directors and Executive Director.
2. Finances Department hands over the legal department the OGP/PCo approval application for evaluation.
3. Leal Advisors ask the contractors to deliver to Legal department the following certifications that must include the PCo/OGP application:
    a. Contractor Certification Requirement: this must notify if the contractor will be having subcontractors.
    b. Certification under de Government Ethics Code: this must certify that there are no conflict of interest with Government of PR regarding the contract and the services that contractor will provide to ASES.
    c. Sworn Statement under Act 2-2018; the contractor must certify under oath that neither he/she or its company, employers and subcontractor have been convicted for fraud or corruption, neither by state nor federal laws.
    d. Evidence of being active under the System for Award Management (SAM).
4. Once the Contractor deliver the mentioned certifications, the legal director signs the certification confirming that the contract will comply with all government legal contracting rules.
5. The PCo/OGP application is sent to the Executive Director so he can sign the certification required by the OGP and Government Secretary Office.

Step 4: Submission of PCo/OGP Application:

1. The Executive Director office send over to Finances Department the completed application so it can be submitted.
2. Once the Finances Department receive the budget approval for the contract it will send over the approval certification to the Legal Department.
3. Finances Department send over the Legal Department a chart with all the approved contracts, its amounts for the fiscal year and the budget item account number.

Step 5: Contract Preparation:

1. Once Legal Department receive the OGP approval each legal advisor will work on the contract.
2. Legal advisors ask to the contractors for all the documents and governmental certifications as indicated on the checklist attached to this document.
3. Legal advisors will prepare the contract and the Business Associate Agreement (BAA).
4. Once all the documents and government certifications are received, Legal department will contact the contractor so they can sign the BAA and contract.
5. Once signed, legal administrative assistant will work on the pre-registry of the Puerto Rico's Comptroller's Office and Executive Director signature.
6. Once the contract is signed by both parties (ASES and Contractor) the administrative assistant will complete the Comptroller Office contract registration.
7. Finances Department send over the Legal Department the official approval letter of each contract.

DOCUMENTS AND GOVERNMENT CERTIFICATIONS CHECKLIST

	SI	NO	PENDIENTE
Propuesta, Resumé			
Registro Único de Licitadores (Administración de Servicios Generales). Si entrega el RUL, no es necesario presentar los documentos restantes.			
Certificación de radicación de planillas de contribución sobre ingresos emitida por el Departamento de Hacienda que confirme radicación por los últimos cinco (5) años previo al contrato. (**Modelo SC-6088**). De no haber rendido planilla en cualquiera de los cinco (5) años deberá acompañar también el **Modelo SC 2781** que indica las razones para no rendir planilla. Del Modelo SC-6088 indicar "***Información no disponible someta evidencia*"**, el contratista deberá someter copia de la primera página de la planilla con sello de recibido en Hacienda. Del contratista ser individuo, se requiere el Modelo SC 2888 (Corrección Manual de la Certificación de Radicación de Planilla) **(Vigencia establecida en la certificación o fecha de emisión no mayor de 60 días de antelación a la fecha de contratación).**			
Certificación de no-deuda por contribuciones emitida por el Departamento de Hacienda o de que existe un plan de pago, el cual se está cumpliendo. (Formulario SC-6096) **(Vigencia establecida en la certificación o fecha de emisión no mayor de 60 días de antelación a la fecha de contratación).**			
Certificación Negativa de Deuda sobre la Propiedad Inmueble **(Vigencia establecida en la certificación o fecha de emisión no mayor de 60 días de antelación a la fecha de contratación).**			
Certificación de Radicación de Planillas Contribución Propiedad Mueble para los últimos (5) cinco periodos contributivos y emitida por el Centro de Recaudaciones de Ingresos Municipales (CRIM). De			

la certificación indicar que no se rindió para algún año no se podrá formalizar el contrato hasta que se aclare la situación contributiva. Si el contratista, no posee propiedad mueble y no figura radicando planilla en el sistema de CRIM, deberá presentar una **declaración jurada** que contenga la información requerida en la Carta Circular (CC 1300-21-06) del 28 de febrero de 2006. La misma debe contener lo siguiente: 1. Que los ingresos son derivados y pagados por servicios profesionales (explicar naturaleza de los mismos). 2. Que durante los últimos cinco (5) años, o desde que comenzó a brindar los servicios profesionales (explicar años), no ha tenido negocio ni propiedad mueble o tributable al 1ro de enero de cada año. 3. Que por dicha razón no viene obligado a rendir planilla de propiedad mueble como lo dispone el Artículo 6.03 de la Ley 83 de agosto de 1991, según enmendada, conocida como Ley de Contribución sobre la Propiedad Municipal. Que por tal motivo no tiene expediente contributivo en el sistema mecanizado del CRIM por la radicación de planillas de propiedad mueble para los últimos (5) años, o desde que comenzó a brindar los servicios profesionales. **(Vigencia establecida en la certificación o fecha de emisión no mayor de 60 días de antelación a la fecha de contratación).**			
Certificación negativa de Deuda Por Todos los Conceptos que indicará que el contratista no tiene deudas por ninguno de los conceptos con el CRIM y otra Certificación Negativa de Deudas por Contribuciones Muebles. Se puede obtener en las oficinas regionales del CRIM luego de adquirir el correspondiente sello. En los casos que el contratista no tenga propiedad mueble o inmueble no se emitirá certificación de deuda sino una Certificación negativa de Propiedad Mueble o de Propiedad Inmueble.			

4. **(Vigencia establecida en la certificación o fecha de emisión no mayor de 60 días de antelación a la fecha de contratación).**			
Certificación Negativa de Caso de Pensión Alimentaria o Certificación de Estado de Cuenta emitido por la Administración para el Sustento de Menores (ASUME) vigente a la fecha de la otorgación del contrato. Esta indica que el peticionario no tiene deuda **de** pensión alimentaria, o de tener deuda que está acogido a un plan de pago y si se encuentra al día en sus pagos. **(Vigencia establecida en la certificación o fecha de emisión no mayor de 60 días de antelación a la fecha de contratación).** En caso de sociedades, aplica a todos los socios residentes en Puerto Rico.			
Declaración Jurada del contratista, según exigida por la Ley 2 de 2018, "Código Anticorrupción para el Nuevo Puerto Rico", que no ha sido convicto o se ha declarado culpable de cualquiera de los delitos enumerados en la Sección 6.8 de la Ley 8 del 2017, según enmendada. **(Vigencia 1 año)**			
Nueva Certificación de Información del Contratista o Subcontratista. ***(Ver modelo, Anejo I)*** **(Vigencia establecida en la certificación o fecha de emisión no mayor de 60 días de antelación a la fecha de contratación).**			
Nueva Certificación Ley de Ética Gubernamental.			
Carta que indique las agencias o dependencias gubernamentales con las cuales tenga contrato o esté en proceso de negociación. **(No mayor de 60 días de antelación a la fecha de contratación).**			
{**OPCIONAL**} Relevo de Retención en el Origen emitido por Departamento de Hacienda, a los efectos de reducir o eliminar la cantidad de retención dispuesta por ley (7% a individuos residentes ó 29% a no residentes y a corporaciones foráneas). **(Vigencia establecida en la certificación o fecha de emisión no mayor de 60 días de antelación a la fecha de contratación).**			

Certificado de Registro de Comerciante (Copia del Modelo SC 2918) **si es agente retenedor deberá entregar lo siguiente:** 1. Certificación de Radicación de Planillas del Impuesto de Ventas y Uso (Modelo SC2942) 2. Certificación de Deuda del Impuesto sobre Ventas y Uso (Modelo SC 2927) **(Vigencia establecida en la certificación o fecha de emisión no mayor de 60 días de antelación a la fecha de contratación).** **NOTA:** Todo contratista que aparezca con deudas contributivas, únicamente se podrá otorgar un contrato haciéndose la salvedad en el propio contrato de que se le descontará la partida adeudada y se le enviará el pago a la agencia correspondiente para que se le liquide la misma.			
Normas a seguir en caso de subcontratación. Para subcontratar a un tercero, deberá solicitar autorización de ASES: a) Por escrito b) Identificar al subcontratista c) Especificar las tareas en las cuales intervendrá el subcontratista d) Divulgar la remuneración que recibirá el subcontratista por los trabajos realizados, y el margen de ganancia, si alguno, que tendrá el contratista con relación a las tarifas pagadas al subcontratista. **Si el(la) subcontratista va a dedicar un 25% o más de su tiempo a las tareas asignadas en el contrato otorgado entre ASES y contratista, el(la) subcontratista deberá presentar TODOS los documentos y certificaciones aquí solicitadas por ASES al contratista. El(la) contratista deberá proveer todos estos documentos en la solicitud de subcontratación.*			

Autorizado por la Comisión Estatal de Elecciones CEE-SA-19-166

Certificación a los efectos de que ha sido adiestrado en HIPAA en los aspectos administrativos, físicos y técnicos según establecido en el 45 CFR §§ 164.308, 164.310, 164.312, 164.316, al momento de la firma de su contrato con ASES y cuando añada recursos a su plantilla de empleados(a) o contratistas (subcontratistas) para trabajar en las tareas pactadas mediante contrato con ASES. ***(Ver Anejo III)***			
Evidencia de registro en System for Award Management (SAM), conforme al Memorando OSG-2019-001 y Carta Circular 168-19 de OGP, en https://www.sam.gov/SAM/.			

ENGLISH VERSION:

	Yes	No	Comments
Service Proposal			
Certification of having filed income tax returns in the past five years from the Treasury Department of Puerto Rico (Model SC 6088). (Valid for 1 year)			
Certification from Puerto Rico Treasury Department attesting that there is no outstanding debt or, if a debt exists, that it is subject to payment plan (or pending administrative review under applicable law or regulations) (Model SC 6096). (Valid for 1 year)			
Certification from Puerto Rico Center for the Collection of Municipal Revenues ("CRIM" for its Spanish acronym) certifying that there is no outstanding debt or, if a debt exists, that it is subject to payment plan (or pending administrative review under applicable law or regulations). (Valid for 90 days)			
Certifications of no outstanding alimony or child support debts from ASUME by its Spanish acronym, if applicable. (Valid for 30 days)			

Sworn statement of Act 2-2018, "*Código Anticorrupción para el Nuevo Puerto Rico*".			
Certification of no outstanding debt, or copy of valid Insurance Policy from the Puerto Rico State Insurance Fund Corporation (Corporación del Fondo del Seguro del Estado)			
Certification from Puerto Rico Department of Labor and Human Resources of compliance with unemployment insurance, temporary disability insurance and/or chauffeur's social security, if applicable.			
Certifications from the State Department of Puerto Rico of the entity's authority to do business in Puerto Rico. (Existence and Good Standing)			
Corporate Resolution identifying the authorized representative to appear on behalf of the entity.			
A letter certifying whether the entity has contracts with other agencies or instrumentalities of Puerto Rico			
New Contract Certification Requirement (**See model, Attachment I**)			
Retention waiver issued by the Treasury Department, in order to reduce or eliminate the tax retention. If no waiver is presented, ASES shall deduct the percent amount required by law from payments to be made to Contractors for services rendered.			
Merchant's Certification (Model SC 2918) Certification of filing Sale and Use Tax, if classified as Retainer Agent (IVU for its Spanish acronym) (Model SC 2942)			
Certification of updated municipal patents, if applicable.			
New Conflict of Interest Certification (See Attachment)			
Subcontract Proceedings. (See Attachment of Guidelines) To subcontract a third party, you must request ASES for authorization: 1. Made in writing 2. Identifying the Subcontractor			

Autorizado por la Comisión Estatal de Elecciones CEE-SA-19-166

3. Specifying the tasks in which the Subcontractor will intervene 4. Disclose the remuneration that the Subcontractor will receive for the work carried out, and the profit margin, if any, that the Contractor will have in relation to the subcontractor's paid fees. **If the Subcontractor is to dedicate 25% or more of its time to the tasks assigned in the contract between ASES and the Contractor, the Subcontractor must submit all the documents and certification here required from the Contractor for government contracting. The Contractor will be responsible for providing these documents and certifications from the Subcontractor to ASES when requesting authorization from ASES to subcontract.*			
Evidence of been registered in the System for Award Management(SAM), according to the Memorandum OSG-2019-001 and the Circular Letter 168-19 de OGP, in https://www.sam.gov/SAM/.			

Appendix E

CMS Quarterly Report 4-27-20

GOVERNMENT OF PUERTO RICO

Hon. Wanda Vázquez Garced
Governor

Department of Health
Office of the Secretary of Health

April 27, 2020

Mr. Nicole McKnight
Program Management – Branch Manager
Medicaid & CHIP Operations Group
CMS, Region II
Via email: Nicole.McKnight@cms.hhs.gov

Mrs. Ivelisse Salce
Health Insurance Administrator
Medicaid & CHIP Operations Group
CMS, Region II
Via email: Ivelisse.Salce@cms.hhs.gov

Dear Mrs. McKnight and Mrs. Salce:

The executive staff and leadership at the Puerto Rico Medicaid Program (Medicaid) and Puerto Rico Health Insurance Administration (Administración de Seguros de Salud (ASES)) have initiated the steps necessary to comply with the requirements of section 1108(g) of the Social Security Act, implemented by section 202 of the "Further Consolidated Appropriates Act, 2020". Together we are working together to continue to strengthen the Medicaid program to meet the health care needs of our most vulnerable citizens.

In the following report, we describe the progress to date and activities planned for the coming months. It is our intent to provide a quarterly status report so the Centers for Medicare & Medicaid Services (CMS) are assured of our continued forward progress and provide any feedback or course correction along the way. This ongoing dialogue will support the completion of the report to Congress due on October 30, 2020.

We appreciate the technical support from the New York CMS Regional Office and welcome the opportunity to discuss Puerto Rico's efforts in meeting the requirements and to provide any requested clarity regarding the activities described herein.

Cordially,

Lorenzo González-Feliciano, MD, MBA, DHA
Secretary of Health

c: Luz E. Cruz-Romero, Executive Director Medicaid Program
Jorge E. Galva-Rodríguez, Executive Director PRHIA (ASES)

Enclosure: Executive Summary

Executive Summary

ASES and Medicaid are working together to analyze, adopt, plan and implement all of the requirements of section 1108(g) of the Social Security Act, implemented by section 202 of the "Further Consolidated Appropriates Act, 2020" signed into law on December 20, 2019, and provides funding for Puerto Rico's Medicaid program.

The federal funding is critical to the health and well-being of our citizens, and we are fully committed to building the infrastructure, services, monitoring and reporting required.

The law includes a series of activities required of the Puerto Rico Medicaid program, known as the Government Health Plan "Plan Vital", in federal fiscal years (FFY) 2020 and 2021.

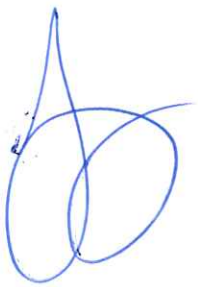
This report serves as a summary of ASES/Medicaid activities underway or planned to satisfy the requirements of the law and to ensure the robust and highly functioning Medicaid program the citizens deserve.

The following table includes:

- The specific language in the law.
- A summary of the approach Puerto Rico will employ to achieve compliance.
- The key activities already completed during the reporting period.
- The planned next steps.

The following table is structured:

1. Directed Payment Arrangement for Physician Services.
2. Program Integrity Lead.
3. Payment Error Rate Measurement (PERM) Requirements.
4. Contracting Reform Plan.
5. Medicaid Eligibility Quality Control Unit.
6. Financial Reporting CMS-37 and CMS-64.
7. Reporting on Medicaid and Children's Health Insurance Program (CHIP) Scorecard Measures.
8. Annual Report.



The combined team at Medicaid and ASES are proud of the efforts made during this calendar quarter and are pleased to report key highlights of the hard work underway:

- Completed a cost analysis and documentation necessary to seek CMS approval to implement a minimum fee schedule at 70% of the Medicare fee schedule for licensed professionals eligible to receive payment for professional services under Puerto Rico's Medicaid program.
- Signed a comprehensive memorandum of understanding (MOU) between Medicaid and ASES to collaborate and combat Fraud, Waste and Abuse (FWA).
- Hired the Program Integrity Lead and in process of hiring additional staff and working with Puerto Rico's government to establish position/roles.
- Designed and began implementing a Comprehensive Oversight and Monitoring Plan (COMP), which addresses the requirements of both section 1108(g) of the Social Security Act and 42 CFR 438.66. [attached]
- Began analysis of contracting reform requirements and local requirements.
- Began planning and procuring support to meet PERM and Medicaid eligibility quality control (MEQC) requirements.

Completed and planned activities table as of April 1, 2020:

Requirement	Approach to Meet Requirement	Completed Activities	Planned Activities
(1) DIRECTED PAYMENT ARRANGEMENT FOR PHYSICIAN SERVICES **Additional funding in the amount of $200,000,000 per fiscal year is available when Puerto Rico's State Plan establishes minimum reimbursement amounts utilizing a directed payment arrangement for physician services covered under the Medicare Part B schedule as addressed in further detail below.**	• ASES plans to implement this directed payment in the contract and per member per month (PMPM) payments as of April 1, 2020. • ASES will require the managed care organizations (MCOs) to reimburse physician services at a minimum 70% of the Medicare Part B fee schedule effective April 1, 2020.	• Developed draft Directed Payment preprint per Section 438.6(c). • Completed the following financial analyses: – Calculated financial impact of direct payment arrangement. – Calculated PMPM increase to capitation rates effective April to June 2020. – Submitted direct payment arrangement to CMS for approval. • Drafted memo on contract and rate changes for MCOs. • Drafted revised contract language for Plan Vital contract.	• Complete rate certification amendment and contract amendment for April through June 2020 period for CMS submission by May 2020. • Incorporate the minimum fee schedule in the rate certification for July 2020 through June 2021.
(2) PROGRAM INTEGRITY LEAD **Due 6/20/2020** **Not later than six months after the date of enactment of this paragraph, the agency responsible for the administration of Puerto Rico's Medicaid program under title**	• Medicaid will take the steps necessary to create an official position within the government of Puerto Rico. • In the interim, Medicaid has temporarily filled this role with an individual who is classified as a contractor.	• Medicaid has consulted on this requirement with CMS about the need to create a permanent position within government. • The Puerto Rico Medicaid Program (PRMP) began to develop the Program Integrity	• Update CMS on the creation of governmental position to meet this requirement.

Requirement	Approach to Meet Requirement	Completed Activities	Planned Activities
XIX shall designate an officer (other than the director of such agency) to serve as the Program Integrity Lead for such a program.	• Using the 42 CFR sub part 455 the Program Integrity Director developed procedures as well as the internal policies and is currently in the process of hiring more professionals with proven experience in the healthcare area.	Unit in October 1, 2019. At that time, the Medicaid Program hired the Program Integrity Director. This leadership position reports directly to the Medicaid Program Executive Director and the Puerto Rico Secretary of Health. • ASES will hire a Chief Compliance Office, which will be in charge of the Compliance Department at ASES. This person will serve as a counterpart to the Integrity Lead at Medicaid and will work closely with Integrity Lead with a focus on contract compliance. ASES will provide administrative back up on cases reviewed by the Program Integrity Lead. A job offer has been made and accepted and is pending central government approval.	
(3) PERM REQUIREMENT **Due: 6/20/2021** **Not later than 18 months after the date of enactment of this**	• ASES and Medicaid will develop a plan and associated measures to comply with federal PERM requirements.	• ASES has procured a vendor for this work and is awaiting final approval from the Governor's office and the	• Provide a draft outline of a plan for developing PERM in the next quarterly update.

Requirement	Approach to Meet Requirement	Completed Activities	Planned Activities
paragraph, Puerto Rico shall publish a plan, developed by Puerto Rico in coordination with the Administrator of CMS and approved by the Administrator, for how Puerto Rico will develop measures to satisfy the PERM requirements under subpart Q of part 431 of title 42, Code of Federal Regulations (or any successor regulation).	• ASES and Medicaid are in the process of procuring a vendor to complete this requirement.	Office of Management and Budget (OMB). • Medicaid is also in the procurement process. • The agencies will coordinate efforts to ensure no duplication occurs among vendors and project work.	
(4) CONTRACTING REFORM **Due 12/20/2020** **Not later than 12 months after the date of enactment of this paragraph, Puerto Rico shall publish a contracting reform plan to combat fraudulent, wasteful, or abusive contracts under Puerto Rico's Medicaid program under title XIX that includes — "(I) metrics for evaluating the success of the plan;" and "(II) a schedule for publicly releasing status reports on the plan."**	• The Puerto Rico Medicaid Program under Department of Health (DOH) is a public agency subject to all contracting rules and regulations established by the Central Government. There are many local laws that address contracting reform and these requirements and federal requirements will be cross-walked. • ASES/Medicaid are in the process of developing a contracting reform plan to combat FWA. This includes procuring a third-party	• In December 2019, Medicaid established a competitive process (e.g., request for proposal (RFP) and request for questions (RFQ)), for all contracts in the Medicaid program. This will apply to all contracts including the operational, professional services and nonprofessional services. • Completed initial review of contracting activities including vendors, enrollment counselors, pharmacy benefits manager (PBM) and MCOs. • ASES and Medicaid are actively looking to enroll an	• ASES and Medicaid expect a draft contracting reform plan to be ready in the next six months. • ASES will review its contracts with PBM and Pharmacy Program Administrator in order to ensure maximum contractual savings and efficiency during the conversion to participation in the Medicaid Drug Rebate Program. • ASES will review its enrollment counselor contract to identify possible efficiencies. • ASES and Medicaid will develop a matrix for period

Requirement	Approach to Meet Requirement	Completed Activities	Planned Activities
	evaluator to audit the respective processes.	independent auditing firm in order to audit MCO contractual compliance, recoupments and other issues.	review of all consultant/trade/business associate contracts. This will ensure a regular review of contracts and adjustments as market contracting processes change.
(5) MEQC **Due: 6/20/2021** **Not later than 18 months after the date of enactment of this paragraph, Puerto Rico shall publish a plan, developed by Puerto Rico in coordination with the Administrator of CMS and approved by the Administrator, for how Puerto Rico will comply with the Medicaid eligibility quality control (MEQC) requirements of subpart P of part 431 of title 42, Code of Federal Regulations (or any successor regulation).**	• An MEQC unit is already in place at Medicaid and will be evaluated against regulatory guidance by CMS to determine the gaps. • ASES and Medicaid will work together to develop a plan and associated measures to comply with federal MEQC requirements.	• In November 2019, Medicaid reached out to CMS pertaining to PERM requirements. At the time, Mr. Todd Chandler indicated that there were no compliance issues. • ASES has procured a vendor to assist with this effort as needed and is awaiting final approval from the Governor's office and OMB.	• ASES will provide a draft outline of a plan for further developing MEQC in the next quarterly update.
(6) Federal Medicaid budget (CMS-37) **Due 3/31/21** ***[Beginning with the first quarter beginning on or after the date***	• The Puerto Rico Medicaid Program is already in compliance with Sec. 1902. [42 U.S.C. 1396a] (rr)(1)(A) and (B).	• Medicaid has begun updating procedures to reflect the changes required by the Public Law 116-94 enacted by Congress, including a narrative	• Finalization of updated procedures to reflect the changes required by the Public Law 116-94 enacted by Congress, including a narrative

Requirement	Approach to Meet Requirement	Completed Activities	Planned Activities
that is one year after the date of the enactment of this subsection) **For each quarter with respect to which Puerto Rico is required under subparagraph (A) to ensure that information described in such subparagraph is available, Puerto Rico shall submit to the Administrator of the CMS a report on such information for such quarter, which may include the submission of a quarterly Form CMS-37.**	• With regard to Sec. 1902. [42 U.S.C. 1396a] (rr)(1)(A)(i) – Puerto Rico has established and maintained a system for tracking any amounts paid by the Federal Government to Puerto Rico with respect to the State Plan of Puerto Rico. The system includes the use of the quarterly Form CMS-64. As part of such a system, the Medicaid Office submits quarterly the CMS-64 report through the Medicaid Budget and Expenditure System (MBES). • With regard to Sec. 1902. [42 U.S.C. 1396a] (rr)(1)(A)(ii) – The total amount that Puerto Rico expects to spend during the quarter under the State Plan of Puerto Rico, and a description of how Puerto Rico expects to spend such amount is reported on Form CMS-37 through the MBES. • All policies and procedures established for the preparation of the CMS-64	report that will be submitted with the CMS-37 and CMS-64.	report that will be submitted with the CMS-37 and CMS-64.

Requirement	Approach to Meet Requirement	Completed Activities	Planned Activities
	and CMS-37 reports are documented in relative sections of the Finance Division Manual under the custody of the Finance Director of the Puerto Rico Medicaid Program.		
(7) REPORTING ON MEDICAID AND CHIP SCORECARD MEASURES. Due 12/20/2020 **Beginning 12 months after the date of enactment of this subsection, Puerto Rico shall begin to report to the Administrator of CMS on selected measures included in the Medicaid and CHIP Scorecard developed by CMS.**	• ASES and Medicaid have developed a comprehensive approach to oversight and monitoring. Both agencies are leveraging vendors to help evaluate data and quality information, develop benchmarks and to line up MCO and Medicaid Management information System (MMIS) information with the Medicaid and CHIP scorecard. • Both agencies expect to have a robust oversight and monitoring program by Q3 of 2020.	• ASES developed and began implementation of a Comprehensive Oversight and Monitoring Plan (COMP) of Plan Vital MCOs, which aligns with 42 CFR 438.66 and the Medicaid/CHIP scorecard. – The COMP is a tiered oversight metrics approach to monitor key performance indicator (KPI) related to five main areas: Finance, Quality, Network, Program Integrity and program materials. – ASES is hosting weekly calls with MCOs to provide technical assistance with reporting and date submissions. – In February, ASES issued a normative letter outlining	• Finalization and implementation of COMP. • Beginning implementation of MMIS oversight and monitoring and associated KPIs.

Requirement	Approach to Meet Requirement	Completed Activities	Planned Activities
		compliance of data submission requirements to each MCO. • ASES and Medicaid have been working closely with the MMIS team in order to: – Develop mutually acceptable KPI and dashboard. – Decide and design reports allowing a meaningful review of financial performance, quality of care and access to care for Vital beneficiaries. – Allow for complete interoperability between ASES and the Single State Agency to insure that KPIs, dashboards and reports are based on the same or compatible information and allow a seamless understanding of the joint ASES-Medicaid operation.	
(8) ANNUAL REPORT **Due 10/30/2020** **Not later than the date that is 30 days after the end of each**	• On May 1, 2019, the Government of Puerto Rico submitted a letter to Congress to ask for additional federal	• Initial discussions and meetings with ASES, Medicaid, and Financial Oversight Management Board (FOMB).	• ASES and Medicaid will work together, with key contractors, and the FOMB to

Requirement	Approach to Meet Requirement	Completed Activities	Planned Activities
fiscal year (beginning with fiscal year 2020 and ending with fiscal year 2021), Puerto Rico shall submit a report, employing the most up-to-date information available, that describes how Puerto Rico has used such Medicaid cap increase, or such increase in the Federal medical assistance percentage, as applicable, to increase access to health care under the State Medicaid Plan of such territory under title XIX. **Such report may include:** **(i) the extent to which such territory has: (I) increased payments to health care providers; (II) increased covered benefits; (III) expanded health care provider networks; or (IV) improved in any other manner the carrying out of such plan (or waiver); and** **(ii) any other information as determined necessary by such territory.**	funds for the Puerto Rico Medicaid Program. In that letter, the Government also included five "Critical Sustainability Measures to Provide Essential Health Services to Puerto Rico's Medicaid Recipients". • Initiative #1: Provide Life-Saving Hepatitis-C Drugs to Puerto Rico's Medicaid Beneficiaries. • Initiative #2: Provide Medicare Part B Premium Coverage for Dual Eligible. • Initiative #3: Adjust the Puerto Rico Poverty Level to Increase Fairness of Medicaid Eligibility. • Each of these initiatives are part of the planned approach to utilizing funds to enhance the Medicaid program.	• Regarding Hepatitis C, as of March 17, 2020, the Puerto Rico Medicaid Program filed a State Plan Amendment (SPA) to CMS for approval (PR-2-0001). The purpose of this SPA is to cover the Antiviral Action Drug, Glecaprevir/Pibrentasvir (Mavyret) and to describe the scope of the benefit. • Regarding Medicare Part B, as of March 16, Puerto Rico has the first call with CMS subject matter experts to receive guidance. • Regarding the Puerto Rico Poverty Level, Puerto Rico completed an initial analysis and is waiting for the actuarial certification to determine the new percentage. The certification will be needed to determine the federal budget impact for the FFY 2020 and 2021.	develop an understandable and credible fiscal report. • Regarding Medicare Part B, Puerto Rico will file the required SPAs for CMS' consideration and approval. We expect to implement this measure on July 1, 2020. • Regarding the Puerto Rico Poverty level, Puerto Rico will file the required SPAs for CMS' consideration and approval. We expect to implement this measure on July 1, 2020.

Appendix F

CMS Quarterly Report 8-21-20

GOVERMENT OF PUERTO RICO

Department of Health
Medicaid Program

August 21, 2020

Mrs. Nicole McKnight
Program Management – Branch Manager
Medicaid & CHIP Operations Group
CMS, Region II
Via email: nicole.mcknight@cms.hhs.gov

Mrs. Ivelisse Salce
Health Insurance Administrator
Medicaid & CHIP Operations Group
CMS, Region II
Via email: ivelisse.salce@cms.hhs.gov

Dear Mrs. McKnight and Mrs. Salce:

The executive staff and leadership at the Puerto Rico Department of Health (Medicaid) and Puerto Rico Health Insurance Administration (Administración de Seguros de Salud (ASES)) are pleased to present this second quarterly report on the progress and activities related to the requirements of section 1108(g) of the Social Security Act, implemented by section 202 of the "Further Consolidated Appropriates Act, 2020."

In the following report, we describe the progress to date (including updates from the May 1, 2020 first quarter report) and activities planned for the coming months. This report serves the best interest to provide a quarterly status report to CMS Region II to track our progress and to provide any feedback or course correction along the way. This ongoing dialogue will support the completion of the report to Congress due on October 30, 2020. We appreciate the technical support from the New York CMS Regional Office and welcome the opportunity to discuss Puerto Rico's efforts in meeting the requirements and to provide any requested clarity regarding the activities described herein.

Cordially,

Luz E. Cruz-Romero
Executive Director
Medicaid Program

Jorge E. Galva-Rodríguez
Executive Director
PR Health Insurance Administration

Executive Summary

ASES and Medicaid continue to work together to analyze, adopt, plan and implement all of the requirements of section 1108(g) of the Social Security Act, implemented by section 202 of the "Further Consolidated Appropriates Act, 2020."The federal funding associated with the requirements detailed in this and future reports is critical to the health and well-being of our citizens, and we remain fully committed to building the infrastructure, services, monitoring and reporting required.

This report serves as a summary of ASES/Medicaid activities underway during this reporting period May through July 2020 and does not include all the activities reported in our initial report for the first quarter period.

The following table includes:

- The specific language in the law.
- A summary of the approach Puerto Rico will employ to achieve compliance.
- The key activities already completed during the reporting period.
- The planned next steps.

The following table is structured:

1. Directed Payment Arrangement for Physician Services.
2. Program Integrity Lead.
3. Payment Error Rate Measurement (PERM) Requirements.
4. Contracting Reform Plan.
5. Medicaid Eligibility Quality Control Unit.
6. Financial Reporting CMS-37 and CMS-64.
7. Reporting on Medicaid and Children's Health Insurance Program (CHIP) Scorecard Measures.
8. Annual Report.

The combined team at Medicaid and ASES are proud of the efforts made during this calendar quarter, and are pleased to report key highlights of the hard work underway:

- Completed and submitted analysis and documentation necessary to seek CMS approval to implement a minimum fee schedule at 70% of the Medicare fee schedule for licensed professionals eligible to receive payment for professional services under Puerto Rico's Medicaid program. In doing so, Puerto Rico has completed the requirement in law and secured the additional $200 million per year for Fiscal Years 2020 and 2021.
- Medicaid took all necessary steps to create an official position within the Puerto Rico Government for the Program Integrity Lead.
- Medicaid procured a vendor, which is in the final stages of Fiscal Oversight Management Board (FOMB) approval, to address PERM and Medicaid eligibility quality control (MEQC) requirements.

- ASES updated the Comprehensive Oversight and Monitoring Plan (COMP), which addresses the requirements of section 1108(g) of the Social Security Act, 42 CFR 438.66, and CMS Medicaid and CHIP (MAC) Scorecard measures.

Completed and planned activities table as of August 1, 2020:

Requirement	Approach to Meet Requirement	Completed Activities	Planned Activities
(1) DIRECTED PAYMENT ARRANGEMENT FOR PHYSICIAN SERVICES **Additional funding in the amount of $200,000,000 per fiscal year is available when Puerto Rico's State Plan establishes minimum reimbursement amounts utilizing a directed payment arrangement for physician services covered under the Medicare Part B schedule as addressed in further detail below.**	• ASES plans to implement this directed payment in the contract and per member per month (PMPM) payments as of April 1, 2020. • ASES will require the managed care organizations (MCOs) to reimburse physician services at a minimum 70% of the Medicare Part B fee schedule effective April 1, 2020.	• ASES submitted the directed payment preprint to CMS on March 31, 2020. • ASES received CMS approval for the period of April 2020 through September 2021 on June 8, 2020. • ASES received FOMB approval for rate changes and is waiting for approval of the contract.	• ASES will complete a rate certification on or before August 15, 2020. • ASES will complete a Plan Vital contract amendment to incorporate the directed payment and submit to CMS for review and approval on or before August 15, 2020.
(2) PROGRAM INTEGRITY LEAD **Due June 20, 2020** **Not later than six months after the date of enactment of this paragraph, the agency responsible for the administration of Puerto Rico's Medicaid program under title XIX shall designate an officer (other than the director of such agency) to serve as the Program Integrity Lead for such a program.**	• Medicaid will take the steps necessary to create an official position within the government of Puerto Rico. • The Program Integrity Director developed internal procedures and policies based on 42 CFR part 455 and is currently in the process of hiring more professionals with proven experience in the healthcare area.	• Medicaid finalized the creation of the Program Integrity Lead position within the Government of Puerto Rico to meet this requirement. • A contractor has filled this position since October 2018. The contractor has now accepted the newly created permanent position within the government. This transition will occur in the early part of August and can occur without disruption of current activities underway. • ASES hired a Chief Compliance Officer, who is in charge of the Compliance Department. This person is the counterpart to the Program Integrity Lead at	• ASES will add finance schedules to its reporting requirements to gather claims audits for PERM. • ASES will train compliance staff on the use of the compliance checklist, MCO checklist and COMP reporting. • ASES will leverage the information from the completed risk assessment with Medicaid and Medicaid Fraud Control Unit (MFCU) to track and monitor PI activities in a cohesive manner.

Requirement	Approach to Meet Requirement	Completed Activities	Planned Activities

		Medicaid with a focus on contract compliance. The Chief Compliance Officer's résumé is Attachment A to this report.
		• ASES is currently developing a risk assessment with Medicaid and DOJ to identify fraud, waste and abuse (FWA) concerns and associated risk factors, including but not limited to:
		  ○ Vendor and contractor contracts.
		  ○ Credentialing requirements and provider contracts.
		  ○ Development of monthly provider payment reviews.
		  ○ MCO transition.
		• ASES ensured key Program Integrity (PI) metrics were part of the COMP to track various PI related measures, including but not limited to federal statutes, MCO contract requirements, FWA cases, investigations, provider terminations/exclusions, grievances/appeals and PERM. The updated COMP is Attachment B to this report.	

(3) PERM REQUIREMENT **Due: June 20, 2021**	• ASES and Medicaid will develop a plan with associated measures to	• Medicaid completed the procurement process and has selected a vendor to support the	• The agencies will coordinate efforts to ensure no duplication

Requirement	Approach to Meet Requirement	Completed Activities	Planned Activities
Not later than 18 months after the date of enactment of this paragraph, Puerto Rico shall publish a plan, developed by Puerto Rico in coordination with the Administrator of CMS and approved by the Administrator, for how Puerto Rico will develop measures to satisfy the PERM requirements under subpart Q of part 431 of title 42, Code of Federal Regulations (or any successor regulation).	comply with federal PERM requirements. • ASES and Medicaid are in the process of procuring a vendor to complete this requirement.	PERM plan development; this vendor contract is pending FOMB approval. The contract approval request is Attachment C to this report. • ASES has identified a vendor to complete elements of the PERM requirement that are unique to the agency, as needed.	occurs across vendors and project work. • ASES will add claims and encounter schedules to its reporting requirements to gather MCO claims audit information for PERM reporting.
(4) CONTRACTING REFORM **Due: December 20, 2020** **Not later than 12 months after the date of enactment of this paragraph, Puerto Rico shall publish a contracting reform plan to combat fraudulent, wasteful, or abusive contracts under Puerto Rico's Medicaid program under title XIX that includes — "(I) metrics for evaluating the success of the plan;" and "(II) a schedule for publicly releasing status reports on the plan."**	• The Puerto Rico Medicaid Program under Department of Health (DOH) is a public agency subject to all contracting rules and regulations established by the Central Government. There are many local laws that address contracting reform and these requirements and federal requirements will be cross-walked. • ASES and Medicaid are in the process of developing a contracting reform plan to combat FWA. This includes procuring a third-party evaluator to audit the respective processes.	• The Government Accountability Office (GAO) continues to meet with ASES and Medicaid to review of the contracting processes. • ASES and Medicaid have begun independent reviews of contracting practices to inform a comprehensive plan. • Medicaid completed the procurement process and has selected a vendor to support the contracting reform plan development. As noted above, this contract approval request is included as Attachment C to this report. • ASES recently completed a procurement for a new enrollment counselor. The revised contract implemented cost savings opportunities and	• ASES and Medicaid expect a draft contracting reform plan to be ready by the end of August 2020. • The analysis and contracting reform plan must meet all federal and local requirements. Puerto Rico has a comprehensive set of applicable local laws. Included as Attachment D is a compendium of the most relevant laws for CMS's reference. This list is not exhaustive. More information is available upon request. • ASES will review its contracts with the Pharmacy Benefits Manager and Pharmacy Program Administrator to ensure maximum contractual savings and efficiency in the conversion to participation in the Medicaid Drug Rebate Program.

Requirement	Approach to Meet Requirement	Completed Activities	Planned Activities
		strengthened oversight and management language by ASES. • ASES developed a work plan for periodic review of all consultant/trade/business associate contracts and compliance activities. The work plan is included as Attachment E.	
(5) MEQC **Due: June 20, 2021** **Not later than 18 months after the date of enactment of this paragraph, Puerto Rico shall publish a plan, developed by Puerto Rico in coordination with the Administrator of CMS and approved by the Administrator for how Puerto Rico will comply with the MEQC requirements of subpart P of part 431 of title 42, Code of Federal Regulations (or any successor regulation).**	• An MEQC unit is already in place at Medicaid and will be evaluated against regulatory guidance by CMS to determine if any gaps exist. • ASES and Medicaid will work together to develop a plan with associated measures to comply with federal MEQC requirements.	• Medicaid completed the procurement process and has selected a vendor to support the MEQC plan development, this is pending FOMB approval. As noted above, this contract approval request is included as Attachment C to this report. • ASES has identified a vendor to complete elements of the MEQC requirement that are unique to the agency, as needed.	• Medicaid will provide a draft outline of the MEQC plan in the next quarterly update.
(6) Federal Medicaid budget (CMS-37) **Due: March 31, 2021** ***(Beginning with the first quarter beginning on or after the date that is one year after the date of the enactment of this subsection)*** **For each quarter with respect to which Puerto Rico is required under subparagraph (A) to ensure that**	• The Puerto Rico Medicaid Program is already in compliance with Sec. 1902. [42 U.S.C. 1396a] (rr)(1)(A) and (B). • With regard to Sec. 1902. [42 U.S.C. 1396a] (rr)(1)(A)(i) – Puerto Rico has established and maintained a system for tracking any amounts paid by the Federal Government to Puerto Rico with	• Medicaid updated procedures to reflect the changes required by federal Public Law 116-94, including a narrative report that will be submitted with the CMS-37 and CMS-64. • On July 27, 2020, CMS verbally confirmed Medicaid is in compliance with CMS-37 and CMS-64 reporting requirements.	• No planned updates.

Requirement	Approach to Meet Requirement	Completed Activities	Planned Activities
information described in such subparagraph is available, Puerto Rico shall submit to the Administrator of the CMS a report on such information for such quarter, which may include the submission of a quarterly Form CMS-37.	respect to the State Plan of Puerto Rico. The system includes the use of the quarterly Form CMS-64. As part of such a system, the Medicaid Office submits quarterly the CMS-64 report through the Medicaid Budget and Expenditure System (MBES). • With regard to Sec. 1902. [42 U.S.C. 1396a] (rr)(1)(A)(ii) – The total amount Puerto Rico expects to spend during the quarter under the State Plan of Puerto Rico, and a description of how Puerto Rico expects to spend such amount is reported on Form CMS-37 through the MBES. • All policies and procedures established for the preparation of the CMS-64 and CMS-37 reports are documented in relative sections of the Finance Division Manual under the custody of the Finance Director of the Puerto Rico Medicaid Program.		
(7) REPORTING ON MEDICAID AND CHIP (MAC) SCORECARD MEASURES. **Due: December 20, 2020** **Beginning 12 months after the date of enactment of this subsection, Puerto Rico shall begin to report to the Administrator of CMS on selected measures included in the**	• ASES and Medicaid have developed a comprehensive approach to oversight and monitoring. Both agencies are leveraging vendors to help evaluate data and quality information, develop benchmarks and to line up MCO and Medicaid	• In May 2020, ASES implemented the first stage of its COMP for Plan Vital MCOs. The COMP aligns with 42 CFR 438.66 and the Medicaid/CHIP scorecard. The COMP has been updated since the last submission to CMS to include KPIs for pharmacy data.	• Where possible, ASES and Medicaid will update COMP and other reporting vehicles to address SHSP metrics, a component of the CMS MAC Scorecard, not currently captured today.

Requirement	Approach to Meet Requirement	Completed Activities	Planned Activities
Medicaid and CHIP Scorecard developed by CMS.	Management information System (MMIS) information with the Medicaid and CHIP scorecard. • Both agencies expect to have a robust oversight and monitoring program by Q3 of 2020.	The revised version is included as Attachment B. • ASES completed a crosswalk of State Health System Performance (SHSP) metrics. As of the date of this report, ASES currently captures 77% of the CMS MAC Scorecard measures. long-term services and supports and does not apply to the PR Medicaid program. • ASES and Medicaid are coordinating efforts to ensure reporting for the program integrity metrics for State Administrative Accountability.	• ASES and Medicaid will continue to coordinate PI information to ensure scorecard metric improvement targets are reasonable and achievable. • ASES and Medicaid will collaboratively address metrics, which fail to meet benchmarks or improvement targets to determine appropriate corrective actions. • ASES and Medicaid continue to work closely with the MMIS team to: ○ Develop mutually acceptable KPIs and dashboards. ○ Design reports allowing a meaningful review of financial performance, quality of care and access to care for Plan Vital beneficiaries. ○ Allow for complete interoperability between ASES and Medicaid to ensure that KPIs, dashboards and reports are based on the same or compatible information and allow a seamless understanding of the joint ASES-Medicaid operation.
(8) ANNUAL REPORT **Due: October 30, 2020**	• On May 1, 2019, the Government of Puerto Rico submitted a letter	• Medicaid and ASES are currently working on the annual report.	• Medicaid and ASES will continue to work on the annual report.

Requirement	Approach to Meet Requirement	Completed Activities	Planned Activities
Not later than the date that is 30 days after the end of each fiscal year (beginning with fiscal year 2020 and ending with fiscal year 2021), Puerto Rico shall submit a report, employing the most up-to-date information available, that describes how Puerto Rico has used such Medicaid cap increase, or such increase in the Federal medical assistance percentage, as applicable, to increase access to health care under the State Medicaid Plan of such territory under title XIX. **Such report may include:** **(i) the extent to which such territory has: (I) increased payments to health care providers; (II) increased covered benefits; (III) expanded health care provider networks; or (IV) improved in any other manner the carrying out of such plan (or waiver); and** **(ii) any other information as determined necessary by such territory.**	to Congress to ask for additional federal funds for the Puerto Rico Medicaid Program. In that letter, the Government also included five "Critical Sustainability Measures to Provide Essential Health Services to Puerto Rico's Medicaid Recipients". • Initiative #1: Provide Life-Saving Hepatitis-C Drugs to Puerto Rico's Medicaid Beneficiaries. • Initiative #2: Provide Medicare Part B Premium Coverage for Dual Eligible. • Initiative #3: Adjust the Puerto Rico's Poverty Level to Increase Fairness of Medicaid Eligibility. • Each of these initiatives are part of the planned approach to utilizing funds to enhance the Medicaid program.		

Appendix G

Medicaid Go Forward Plan

Go Forward Plan to Meet Congressional Requirements

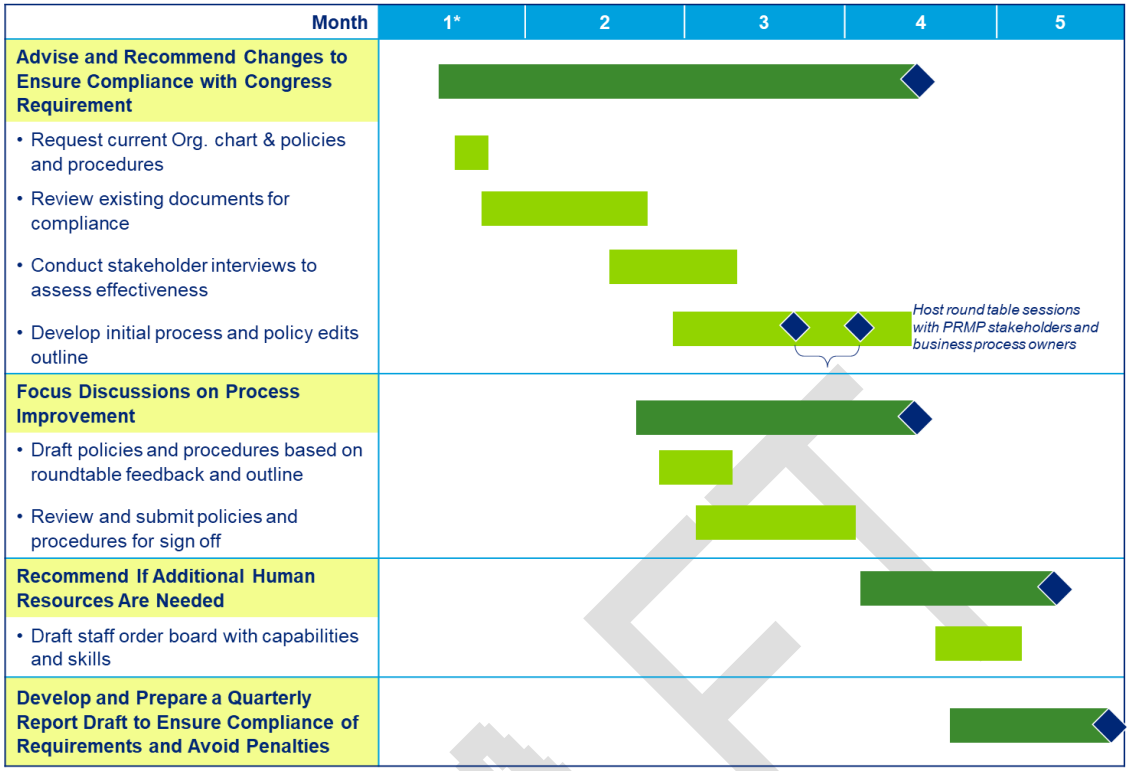
This document provides information on the next steps or "Go Forward Plan" for each of the thirteen (13) requirements mandated by PL 116-94. As demonstrated herein, the Puerto Rico Department of Health (PRDOH) and the Puerto Rico Health Insurance Administration (PRHIA) herein after referred as Puerto Rico, are working collaboratively with the goal of meeting each of the mandated requirements of Congress. These two government agencies are responsible for the administration of the Medicaid Program in Puerto Rico. PRDOH as the Single State Agency Grantee, among other duties determines eligibility, receives the grant, and also submits the required reports to the Centers for Medicare and Medicaid Services (CMS). PRHIA among other duties, enrolls the Medicaid beneficiaries to the MCO plans under contract and has the responsibility of the MCO contract oversight.

Requirement 1: Review Program Integrity Office Policies/ Procedures/ Staffing

Requirement: Not later than 6 months after the date of the enactment of this paragraph, the agency responsible for the Administration of Puerto Rico´s Medicaid Program under Title XIX shall designate an officer (other than the Director of Such Agency) to serve as the Program Integrity Lead for the such Program. Advise and recommend changes to policies and procedures and scope of work to ensure compliance with Congress Requirement. Recommend if additional Human Resources are needed to strengthen the Medicaid Integrity Office. The selected vendor should develop and prepare a quarterly report draft to ensure compliance of the requirements and avoid penalties as stated in the law.

As referenced in Section 3 of this FY20 Annual Report, Puerto Rico has appointed and successfully onboarded the Program Integrity Lead Officer. To meet the remaining requirements, Puerto Rico will compare its Program Integrity policies, processes, procedures, and staffing against CMS guidelines to identify gaps and areas where efficiencies can be gained.

- **Process improvement** focuses on whether improvements could make the existing processes more efficient.
- **Program Integrity Maturity** focuses on whether policies and procedures should be revised or changed to have a greater impact on preventing, detecting, and responding to fraud, waste, abuse, and improper payments.

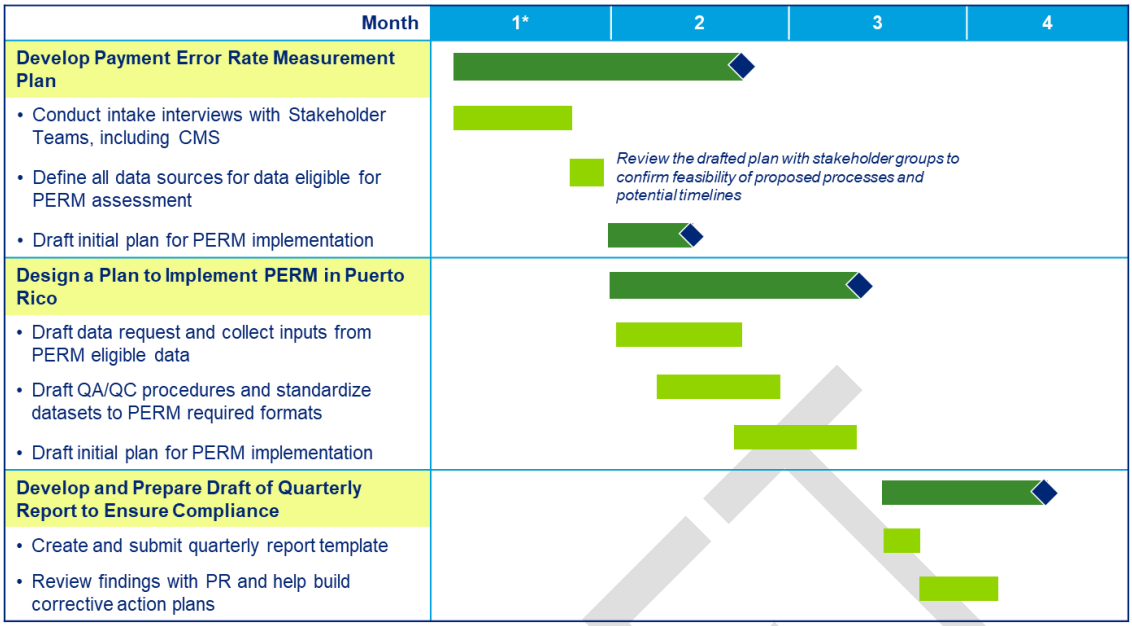


Requirement 2: Develop Payment Error Rate Measurement (PERM) Plan

Requirement: Not later than 18 months after the date of the enactment of this paragraph, Puerto Rico shall publish a plan developed by Puerto Rico in coordination with the Administrator of CMS, and approved by the Administrator, for how Puerto Rico will develop measures to satisfy the payment error rate measurement (PERM) requirements under subpart of part 431 of Title 42 CFR or any successor regulation).

Puerto Rico will evaluate and refine their payment review process and ensure compliance with PERM Audit specifications and draft a plan to achieve compliance with Payment Error Rate Measurement (PERM) requirements as outlined by CMS. Specific attention will be aimed at developing the measures required to enable Puerto Rico to meet all PERM requirements and successfully complete a PERM level audit.

The plan includes processes to select samples of Medicaid and CHIP encounters, the evaluation of the encounter universe and reconciliation to the quarterly CMS-64 reports, the development of metrics to identify and mitigate potential compliance issues.

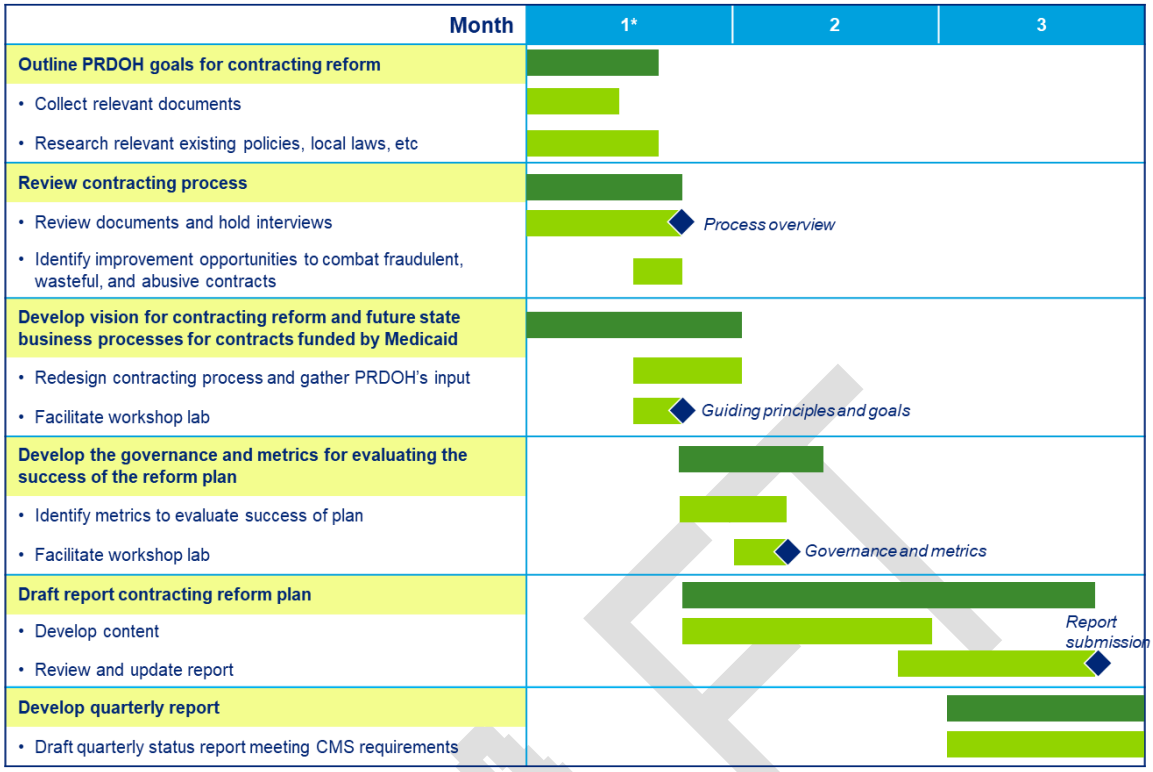


Requirement 3: Develop Contract Reform Plan

Requirement: Not later than 12 months after the date of the enactment of this paragraph, Puerto Rico shall publish a contract reform plan to combat fraudulent, wasteful or abusive contracts under Puerto Rico's Medicaid Program under Title XIX. that includes new contract business processes, metrics for evaluating the success of the plan; and a draft of the quarterly report to ensure compliance of the requirements and avoid penalties as stated in the law. Advice regarding the development of the Plan to comply with the Contract reform as required by Federal and Puerto Rico Law, rules, regulations and federal policy established by CMS and Government Agencies best practices. The plan should include metrics for evaluating the success of the plan. Document recommended new contract business processes.

As referenced in earlier sections of this FY20 Annual Report, Puerto Rico has documented current processes and practices in place detailing partnership with enforcement agencies, Managed Care Organizations (MCOs), and Pharmacy Benefit Managers (PBMs) to combat fraud, waste, and abuse with respect to oversight and general compliance of contracts. Puerto Rico has also completed a crosswalk between the local laws that address contracting reform and contracting rules and regulations established by the Central Government.

To further address this congressional requirement, Puerto Rico will develop a contracting reform plan to enhance its procurement and contracting function. Leadership from PRDOH and PRHIA will work collaboratively to develop the vision, guiding principles, governance structure and key metrics to measure the success of the contracting reform plan.

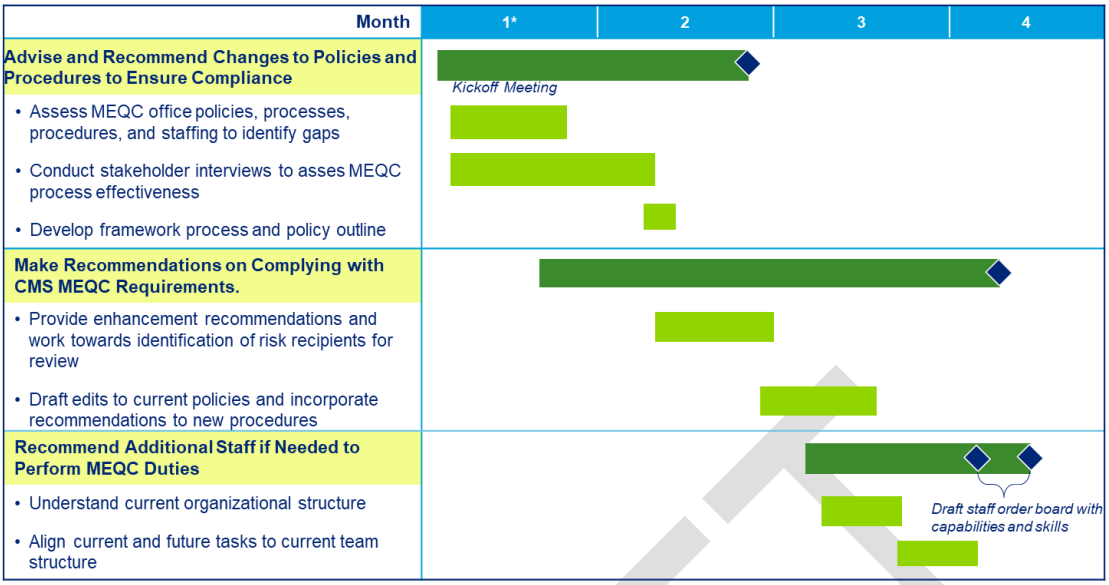


Requirement 4: Review Medicaid Eligibility Quality Control (MEQC) Policy/Procedures/ Staffing

Requirement: Not later than 18 months after the date of enactment of this paragraph, Puerto Rico shall publish a plan, developed by Puerto Rico in coordination with the Administrator of the Centers for Medicare & Medicaid Services and approved by the Administrator, for how Puerto Rico will comply with the Medicaid eligibility quality control (MEQC) requirements of subpart P of part 431 of title 42, Code of Federal Regulations (or any successor regulation). Advise and recommend changes to policies and procedures and scope of work to ensure compliance of the Congress Requirements. Make recommendations on how to fully comply with CMS MEQC requirements. Recommend additional staff if needed to perform MEQC duties.

A component of complying with PERM regulations includes compliance with MEQC. Puerto Rico currently has an MEQC office but will work in close collaboration with CMS to validate the requirements set forth and align on expectations and create the plan that will help satisfy the MEQC requirements. Specific attention will be aimed at reviewing the processes and procedures currently performed in order to validate their compliance with regulations. The evaluation is focused on quality check enhancement processes, and work towards identification of higher risk recipients for review.

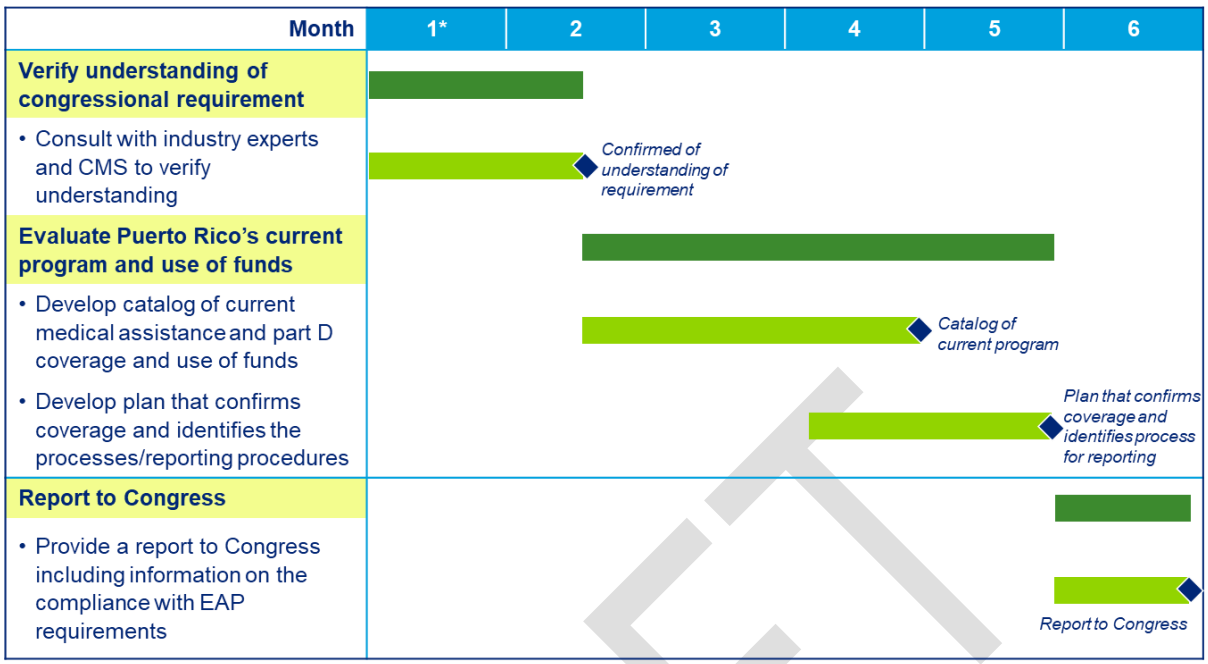
As part of the MEQC compliance plan and contingent on availability of data, Puerto Rico will analyze the Medicaid eligibility data to identify high-risk factors within a recipient population. This approach for review of the Medicaid eligible population provides Puerto Rico with trends in behavior patterns to flag errors, inform the eligibility rules and conditions, and when necessary revise the program eligibility checks to eliminate future errors. This approach assists Puerto Rico in detecting and preventing intentional program violations by both members and case workers, and flag unintentional agency errors.



Requirement 5: Evaluate Dual Eligible Special Needs Plan

Requirement: Treatment of Funding Under Enhanced Allotment Program – Section 1935 (e) of the Social Security Act (42 USc1396 u -5e as amended). From §1396u-5. Special provisions relating to Medicare prescription drug benefit (e) Treatment Of Territories. –The Secretary shall determine that a plan is described in this paragraph if the plan -(A) provides medical assistance […] of covered part D drugs […] to low-income part D eligible individuals;(B) provides assurances that additional amounts received by the State that are attributable to the operation of this subsection shall be used only for such assistance […] and that no more than 10 percent […] shall be used for such administrative expenses; and (C) meets such other criteria as the Secretary may establish.

Puerto Rico will meet with CMS to validate the requirements set forth and align on expectations. Puerto Rico will provide an assessment of its current dual eligible SNPs to verify that the requirements for use of the EAP funds are met. To conduct this assessment, Puerto Rico will catalog current medical assistance and part D coverage and use of funds related to the dual eligible population. This catalog will include documenting the current coverage provided, the allocation process of funds related to the dual eligible population, comparison of coverage to peer states, and identification of gaps between the requirement and current process. Puerto Rico will develop a plan that confirms the medical assistance coverage, identifies the processes and reporting procedures to report on the allocation of funds to the Part D subsection and portion of administrative expenses. Should changes to the SNPs be necessary to comply with the requirements of the Act, Puerto Rico will identify and implement such changes in a timely manner.

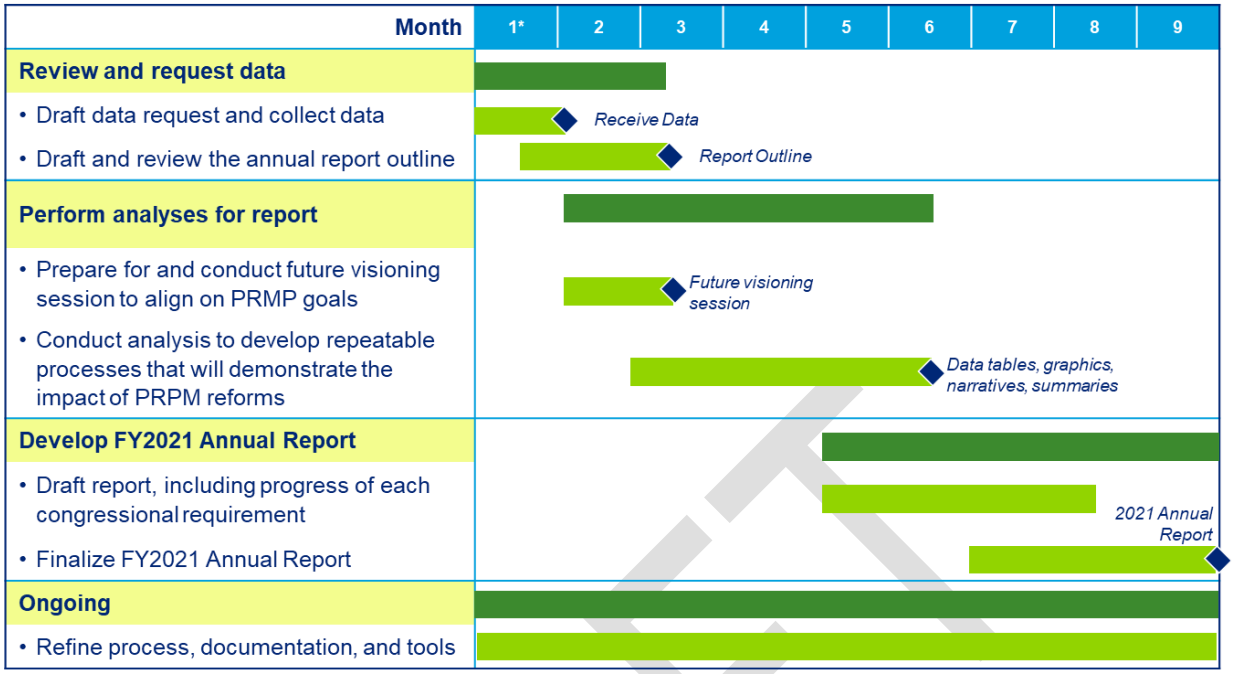


Requirement 6: Develop Annual Report

Requirement: In general not later than the date that is 30 days after the end of each fiscal year […] such territory shall submit […] a report […] that describes how such territory has used such Medicaid cap increase, or such applicable, to increase access to health care […] Such report may include-"(i) the extent to which such territory has, with respect to such plan (or waiver)-"(I) increased payments to health care providers; "(II) increased covered benefits; "(III) expanded health care provider networks; or "(IV) improved in any other manner the carrying out of such plan (or waiver); and "(ii) any other information as determined necessary by such territory.

In preparation for the FY2021 Annual Report, Puerto Rico will define a plan to continue to satisfy congressional requirements while identifying additional buildouts to supplement the report and provide a holistic view of improvements to the Medicaid program. Such supplements to the annual report will include updates on the progress made for each congressional requirement, as well as a combination of visuals, analyses, and narratives to describe the changes to the Medicaid program. The following may be incorporated into future reports: a breakdown of initiative funding that reconciles to the total funding received; an evaluation of the improvements to access to care and network adequacy through sources such as CAHPS results and provider retention reports; a comparison of changes to provider reimbursements by reviewing historical trends as well as known future changes.

The aforementioned analyses, summaries, and visuals will be accompanied by a comparison of peer Medicaid programs to identify leading practices. To the extent possible, depending on data availability among other uncertainties, these reports and evaluations will be automated and conducted in a repeatable process to ensure a consistent format across years for more efficient reporting and reviewing.



Requirement 7: Develop Report on Contracting Oversight and Approval

Requirement: ...the Comptroller General of the United States shall issue and submit … a report on contracting oversight and approval with respect to Puerto Rico's State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver such plan). Such report shall examine- (i) the process used by Puerto Rico to evaluate bids and award contracts under such plan (or waiver); (II) which contracts are not subject to competitive bidding or requests for proposals under such plan (or waiver); and (iii) oversight by the Centers for Medicare & Medicaid Services of contracts awarded under such plan (or waiver); and (b) include any recommendations for Congress, the Secretary of Health and Human Services, or Puerto Rico relating to changes that the Comptroller General determines necessary to improve the program integrity of such plan (or waiver).

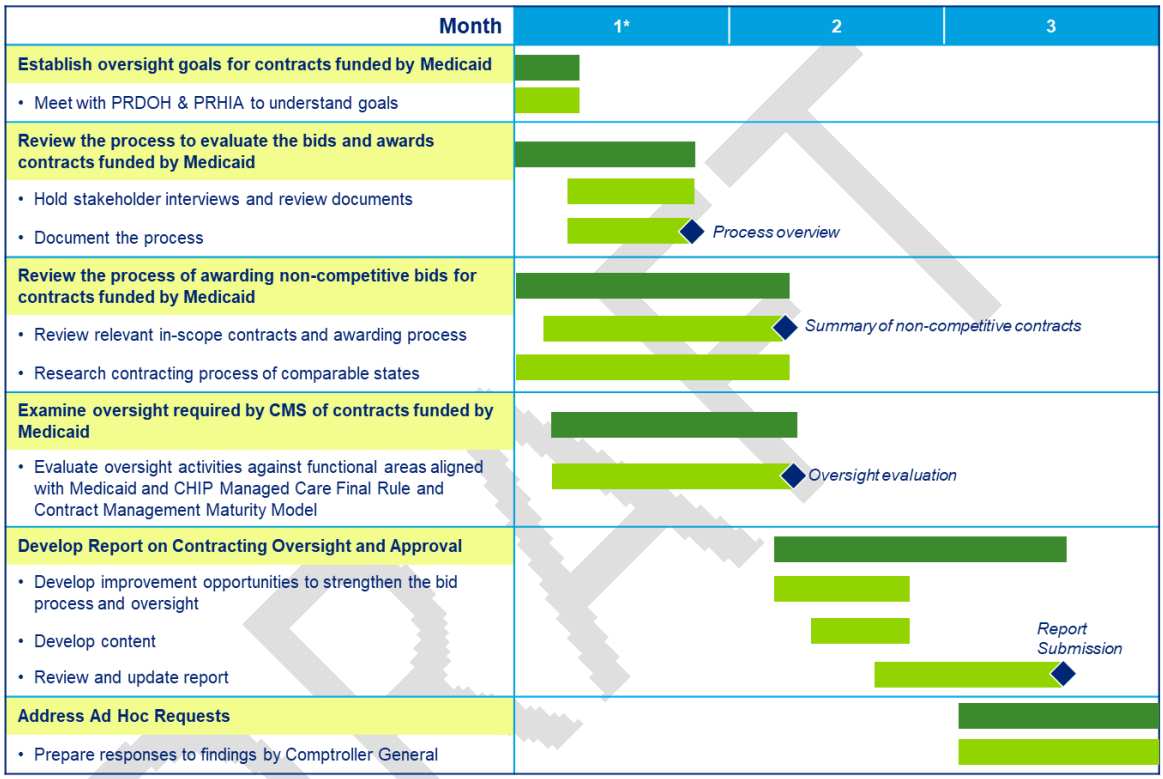
As stated in the FY2020 Annual Report to Congress, Puerto Rico has documented the process steps for proposal evaluations, departmental responsibilities, and a contracting consideration checklist. To continue addressing the remaining requirements, Puerto Rico will develop an overview of the process for evaluating bids and awarding contracts that utilize Federal Medicaid funding.

Puerto Rico will also assess the subset of contracts that utilize Medicaid funding and are not subject to competitive bidding and provide an overview of the awarding process, outlining compliance with current laws and regulations. To supplement this review, Puerto Rico will research leading practices from comparable states and identify opportunities for improvement will be performed.

To examine oversight by CMS, Puerto Rico has identified six areas of oversight as part of the Comprehensive Oversight Monitoring Plan (COMP) to monitor managed care organization activities including contractual obligations, federal requirements, and overall financial health. These areas partially align with the functional areas described in Medicaid and CHIP Managed Care Final Rule established by CMS. Puerto Rico will expand the review of the oversight and compliance activities against the functional areas described the Final Rule. In addition, Puerto Rico will leverage the Contract Management Maturity

Model (CMMM), introduced by the National Contract Management Association in 2005, to measure the maturity of the contract management processes to further provide improvement opportunities. To complete this examination of contract oversight, leadership and staff will be interviewed, documents such as policies, procedures, training materials, and report publications will be reviewed, and business processes may be observed.

Puerto Rico may be required to respond to findings and recommendations made by the Comptroller General requesting changes determined necessary to improve the Medicaid program's integrity.



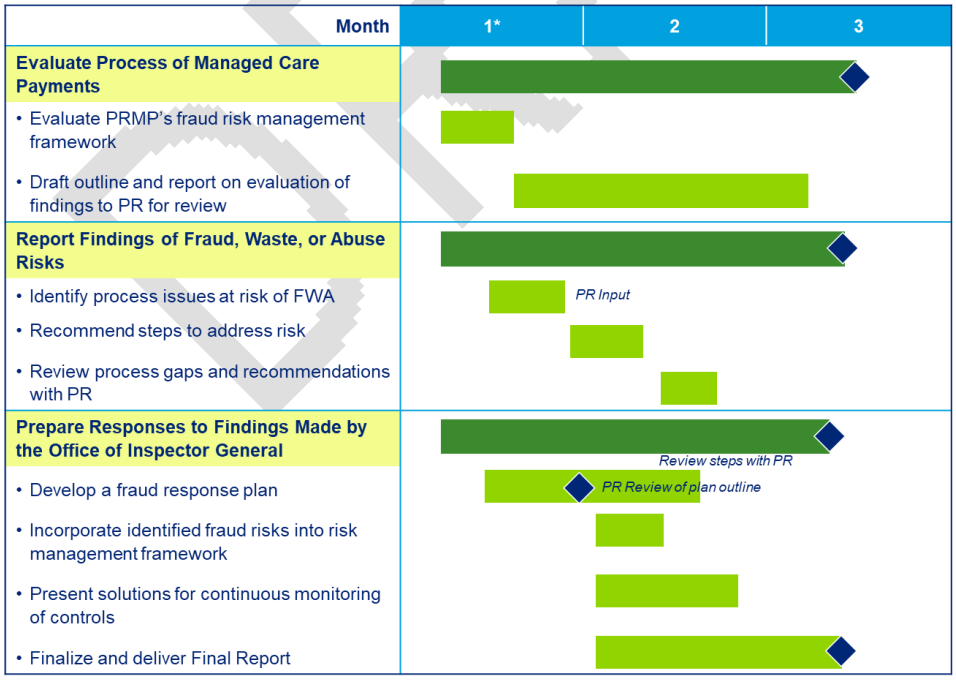
Requirement 8: Evaluate Current Process of Managed Care Payments

Requirement: Not later than the date that is 1 year after the date of enactment of this Act, the Inspector General shall develop and submit to Congress—(A) a report identifying payments made under Puerto Rico's Medicaid program to managed care organizations that the Inspector General determines to be at high risk for waste, fraud, or abuse; and (B) a plan for auditing and investigating such payments.

Puerto Rico will build on its current accomplishments to take a deeper dive and identify any additional gaps, areas for improvement and or payment types to be targeted in future audits. To do this Puerto Rico will:

- Evaluate the current report against the congressional requirements to identify gaps; including the assessment and report completed
- Evaluate existing fraud risk management framework to detect potential gaps in controls in the processes
- Recommend enhancements of existing controls or mitigating controls for implementation, based on gaps detected
- Enable continuous monitoring of controls using technology and/or perform forensic data analytics of transactions at the process level
- Develop a fraud response plan to address cases of alleged or confirmed fraud
- Incorporate identified fraud risks and schemes into fraud risk management framework based on findings

This assessment and evaluation will enable Puerto Rico to draft the MCO Payments Review plan to include possible findings made by the Office of the Inspector General.



Requirement 9: Develop Scorecard Reporting Measures

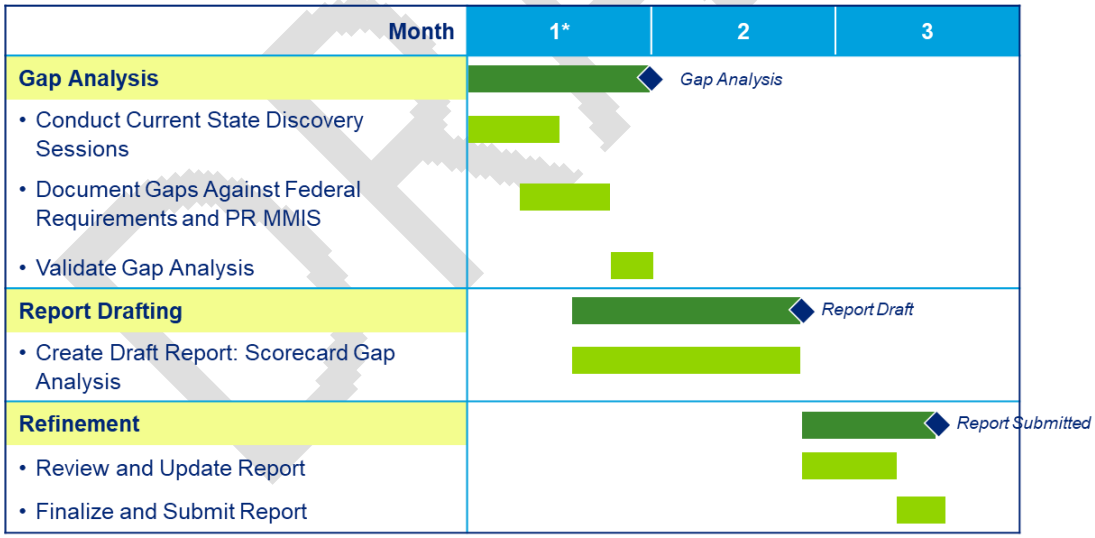
Congressional Requirement

Requirement: Advise and recommend policies and procedures and scope of work to ensure compliance of the Congress Requirement. This is a new requirement and currently Puerto Rico does not have the scorecard measures. Evaluate requirement established by Congress. If needed, design and prepare if a template for the report.

Requirement 9 activities build on the work that Puerto Rico has done to date. As mentioned in this FY20 Annual Report, Puerto Rico has started to capture some of the CMS Medicaid & CHIP (MAC) Scorecard Measures. Requirement 9 is therefore focused on an assessment of the current overall state of data relevant to scorecard measures including data sources, processes for generating the scorecard measures, and an analysis of the remaining reporting gaps and development of template to report on the scorecard measures being included in the pilot reporting phase discussed in Requirement 12.

To conduct the gap analysis, series of work sessions will be held to assess the sources of data that the CMS MAC Scorecard Measures would be generated from included the Medicaid Management Information System (MMIS).

Puerto Rico will draft a Scorecard Gap Analysis Report to conduct a gap analysis between the current state and the federal scorecard requirements. The report will also analyze which scorecard measures are most viable to begin reporting by congressional deadline per requirement 12. The report will also describe the sample templates of the reports for the scorecard measures to be included in the pilot reporting phase as discussed further in Requirement 12, Implementation of scorecard measures

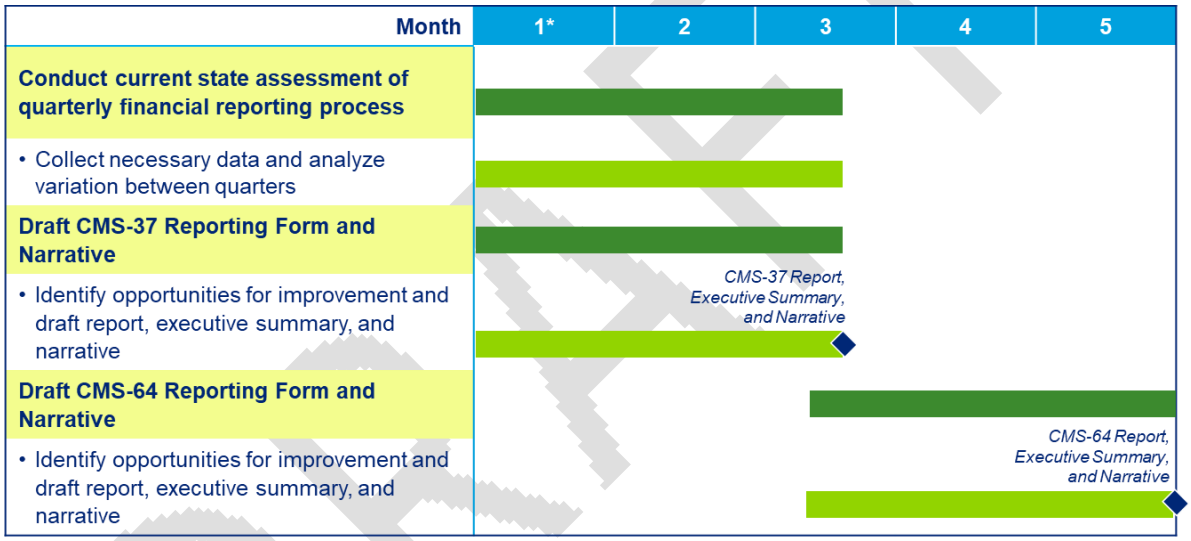


Requirement 10: Develop Financial Executive Summary for CMS 37/64 Reporting

Requirement: (A) In general- Puerto Rico shall establish and maintain a system, which may include the use of a quarterly Form CMS-64, for tracking any amounts paid by the Federal Government to Puerto Rico with respect to the State plan of Puerto Rico (or a waiver of such plan).[…] Puerto Rico shall ensure that information is available […] on the following: "(I) In the case of a quarter other than the first quarter of such fiscal year-" (I) the total amount expended by Puerto Rico during any previous quarter of such fiscal year under the State plan of Puerto Rico (or a waiver of such plan); and "(II) a description

of how such amount was so expended. "(ii) The total amount that Puerto Rico expects to expend during the quarter under the Sate plan of Puerto Rico (or a waiver of such plan) and a description of how Puerto Rico expects to expend such amount. "(B) Report To CMS.- For each quarter with respect to which Puerto Rico under subparagraph (A) to ensure that information described in such subparagraph is available, Puerto Rico shall submit to the Administrator of the Centers for Medicare & Medicaid Services a report on such information for such quarter, which may include the submission of a quarterly Form CMS-37.

While CMS has already confirmed that Puerto Rico is in compliance with this requirement, Puerto Rico will continue to evaluate and enhance the CMS-37 and CMS-64 reports and include additional information as it becomes available. For example, future versions of the CMS-37 report may include a listing of funding estimates for initiatives that Puerto Rico is undertaking which may include improvements such as access to care, eligibility expansion to serve more clients, and/or provider network expansions for each region. Similarly, future versions of the CMS-64 report may include actual expenditures for the initiatives that Puerto Rico is undertaking. Puerto Rico will work to identify opportunities to automate these reporting forms, as well as the narrative reports to supplement the forms.

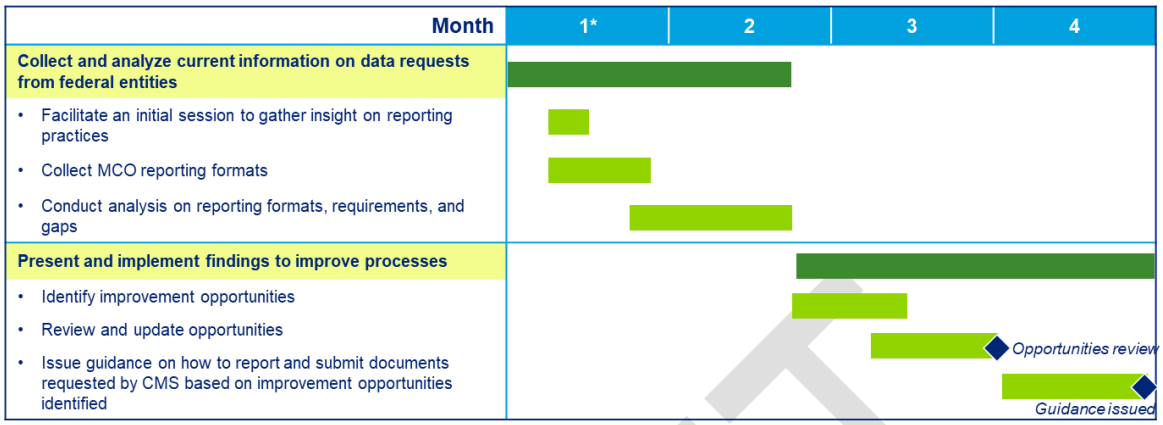


Requirement 11: Evaluate Current Contract Requirements and CMS Reporting

Requirement: Puerto Rico shall, upon request, submit to the Administrator of the Center for Medicare & Medicaid Services all documentation requested with respect to contracts awarded under the State plan of Puerto Rico (or waiver of such plan).

Since CMS and other federal entities may occasionally require information on an ad-hoc basis, Puerto Rico will build upon the work accomplished under requirements 3 and 7 to develop opportunities to streamline and improve responsiveness and data integrity and improve its ability to respond readily to future requests anticipated of CMS and other federal entities. Puerto Rico will review samples of the current contracts and MCOs'/PBMs' documentation across the oversight functional areas described in requirement 7, and gather insight on program monitoring goals, current techniques and reporting practices, and lessons learned from responding to recent data requests from federal agencies. Puerto Rico will then develop opportunities to improve reporting and monitoring guidelines, tools and/or systems to better align to reporting needs, so that Puerto Rico can respond

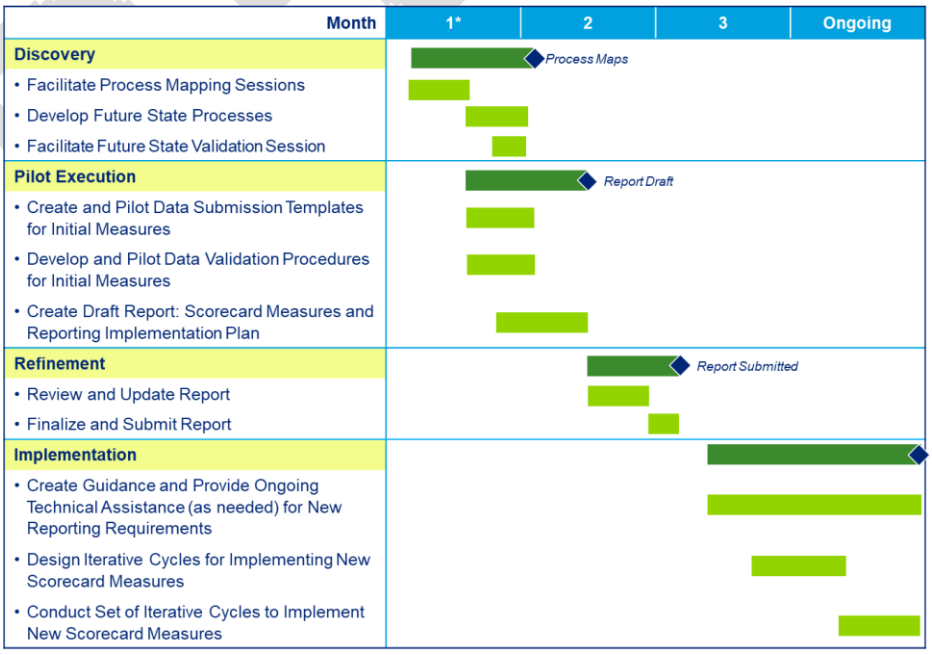
readily and fully to future requests of CMS and other federal entities with respect to contracts awarded under the Medicaid State Plan.



Requirement 12: Implement Scorecard Reporting System

Requirement: Beginning 12 months after the date of enactment of this subsection, Puerto Rico shall begin to report to the Administrator of the Center for Medicare & Medicaid Services on selected measures included in the Medicaid and Chip Scorecard developed by the Center for Medicare & Medicaid Services.

Following review of the current status of Scorecard data (as described in Requirement 9), Puerto Rico will identify opportunities for process redesign, resulting in current and future state process maps. Data submission templates and processes and procedures will be developed for the request, submission, and validation for pilot Scorecard measures. Puerto Rico will develop a report that includes the measures to be included in the pilot reporting phase and an implementation plan that describes how the remaining measures can be gradually phased in for future reporting.



Requirement 13: Develop Policies and Procedures for Penalties

Requirement: In general- for each fiscal quarter during the period beginning on January 1, 2020 and ending on September 30, 2021: (I) for every clause under sub paragraph (A) with respect on which Puerto Rico does not fully satisfy the requirements described in the clause (including requirement imposed under the terms of a plan described in the clause) in the fiscal quarter, the Federal medical assistance percentage applicable to Puerto Rico under section 1905 (ff) shall be reduced by the number of percentage points determined for the clause and fiscal quarter under subclause (II). (II) The number of percentage points determined under for this subclause with respect to a clause under subparagraph (A) and a fiscal quarter shall be the number of percentage points (not to exceed 2.5 percentage points equal to: (aa) 0.25 percentage points; multiplied by (bb) the total number of consecutive fiscal quarters for which Puerto Rico has not fully satisfied the requirements described in such clause.

Currently, Puerto Rico meets monthly with CMS to give them an update on status to-date and discuss progress on various requirements. Puerto Rico also provides quarterly reports summarizing the status toward each requirement. Puerto Rico will continue these monthly meetings with CMS monthly and the quarterly status reporting to track progress toward each of the Congressional Requirements. To supplement the monthly meetings with CMS, moving forward, Puerto Rico will provide a written status report for each monthly meeting. This will allow CMS to have written documentation of the status and better track progress toward compliance.

Puerto Rico will establish a tracking system that will include written status report updates to continuously document the status of each requirement. The written status report will also include documentation of any known risks or issues. By setting up a tracking system and maintaining communication between Puerto Rico and CMS, Puerto Rico will be able to maintain compliance and avoid any financial penalties.