

# Report in Response to

**P.L. 116-94: Further Consolidated Appropriations Act,  
2020:(133 STAT 3109), Division N, Title 1, Subtitle B,  
§202(f)(2)**

## Report on Contract Oversight and Approval

**Government of Puerto Rico  
Office of the Governor**

**December 20, 2020**



**GOVERNMENT OF PUERTO RICO**

**Office of the Governor**

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# 1. EXECUTIVE SUMMARY

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## 1.1 Congressional Requirement

On December 16, 2019, the U.S. Congress came to a bipartisan agreement on 12 appropriation packages. On December 17, 2019, the House passed H.R. 1865 with a vote of 297-120 and this bill became Public Law (P.L.) 116-94 on December 20, 2019.

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 progress towards compliance with the conditions and requirements set forth in **P.L. 116-94: Division N, Title 1, Subtitle B, (133 STAT 3109) - §202(f)(2) – Report on Contracting Oversight and Approval**. The requirement within the law reads as follows:

*"Report on Contracting Oversight and Approval (pursuant to P.L. 116-9 Sec. 202 (f)(2) – Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall issue, and submit to the Chair and Ranking Member of the Committee on Energy and Commerce of the House of Representatives and the Chair and Ranking Member of the Committee on Finance of the Senate, 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-*

*a. 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);*
  - iii. oversight by the Centers for Medicare & Medicaid Services of contracts awarded under such plan (or waiver);*
- 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)."*

This report provides the Government of Puerto Rico's response to comply with the specific requirement listed above.

For the purposes of this report submission and related reports, this requirement is hereinafter referred to in our documents as **Requirement 7: Contracting Oversight and Approval**<sup>1</sup>.

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<sup>1</sup>P.L. 116-94: Further Consolidated Appropriations Act, 2020:(133 STAT 3109), Division N, Title 1, Subtitle B, §202(f)(2)

## 1.2 Puerto Rico's Current Efforts for Contract Oversight and Approval

We adhere to territorial laws for contracting and procurement. In order to provide further contracting transparency and increase competition on the Island, we are working towards improving the non-competitive awarding process. We have taken our first steps through the incorporation of the recently approved solicitation process with Puerto Rico General Services Administration (PR GSA, or Administración de Servicios Generales in Spanish) and other recent governmental mandates.

PRDOH and PRHIA are in the process of improving comprehensive oversight at various levels of the program. In addition to the new Program Integrity Lead within the Medicaid Program Integrity Unit (PIU), we hired a new Chief Compliance Officer for PRHIA in Summer 2020, who is a counterpart to the Program Integrity Lead and focuses on contract compliance. We have since designed and began implementing a comprehensive plan and compliance work plan for oversight and monitoring of our contracted managed care organizations (MCOs), and started deploying several new compliance tools. With these tools, we are focusing our efforts on a more consistent and thorough information review process to validate metrics and information received from the MCOs.

We have been making improvements to the Medicaid Management Information System (PR MMIS), especially with the launch of the Provider Enrollment Portal to screen and enroll providers in the Medicaid program.

## 1.3 Puerto Rico's Response to Congressional Requirement

To meet the Congressional mandate Puerto Rico has taken the following actions:

- As it relates to responding to *“any changes that the Comptroller General determines necessary to improve the program integrity of such plan (or waiver)”*, as of December 20, 2020, the deadline for the submission of this report to Congress, the GAO, led by the Comptroller General, has only provided us with some questions related to our contracting processes which we have responded on November 13, 2020. Upon receipt of the final assessment report from the GAO, we will add an addendum to this report with our response to any changes that Comptroller General deems necessary to improve the program integrity of our contracting processes.
- The U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) conducted a risk assessment for the Puerto Rico Medicaid program controls and processes, titled **‘A-02-20-01011 Risk Assessment Puerto Rico Medicaid Program’**, to comply with P.L. 116-94.<sup>2</sup> This assessment outlines risk areas and other high-risk factors that could contribute to improper Medicaid program payments. The OIG determined audits of Puerto Rico's Medicaid program are warranted and the results will set their priorities for performing future audits of the Medicaid program in Puerto Rico. We reviewed the draft brief in October 2020 and the final report in December 2020. Puerto Rico is responding to OIG's assessment throughout this report for the following risk areas: *Program Integrity, Provider Enrollment, Overpayment Reporting, Contracting, Other High-Risk Factors, and Program Management*.

<sup>2</sup> Office of Inspector General, Department of Health & Human Services. (December 11, 2020). A-02-20-01011 Risk Assessment Puerto Rico Medicaid Program. Retrieved from <https://oig.hhs.gov/oas/reports/region2/22001011.asp>.

- Building on our response to OIG’s assessment and the GAO’s inquiries, Puerto Rico conducted its own assessment of its contracting and oversight processes to respond to the **Contracting Oversight and Approval** requirements. We are pleased to present this report to Congress related to our contracting oversight and approval processes with respect to Puerto Rico’s State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.). We conducted 26 interviews across our Medicaid Enterprise, reviewed over 250 documents, researched leading practices and spoke with other Medicaid programs to identify opportunities to help enhance our contract oversight processes.

We have organized our assessment in the following sections:

- **Differences in Medicaid Program Funding between Puerto Rico and the Other States and Territories (refer to Section 2):** There are significant differences in Medicaid program funding between states and territories, either due to an annual cap on the federal Medicaid spending in territories and a set federal Medicaid matching rate for territories in statute. This limited funding limits our ability to dedicate resources to improving program integrity and contract reform processes. For example, Puerto Rico sometimes has only one employee evaluating an RFP because staff are busy maintaining operations. While Puerto Rico remains committed to meeting all the Congressional requirements that have been added as part of Public Law 116-94, we are concerned that without parity in the Medicaid program or, at a minimum, additional administrative funding, we may not be able to enact long-term plans and changes that are essential to maintaining Puerto Rico’s Medicaid program. **Section 2** of this report highlights additional details related to these funding disparities, and we sincerely request Congress to consider providing the requisite federal Medicaid funding needed to fully implement the opportunities identified in these reports.
- **An Introduction to the Puerto Rico Medicaid Enterprise (refer to Section 3):** It is worth considering the unique nature of our Medicaid program given the number of departments and agencies involved. The PRDOH is the Single State Agency (SSA) for administering our State Medicaid Program. For purposes of the Medicaid program administration, PRDOH is the State Medicaid Agency (SMA). The Medicaid Program is administered by PRDOH and the Puerto Rico Health Insurance Administration (PRHIA), which collectively is referred to as the Medicaid Enterprise. We have detailed all the agencies involved and that collaborate with our Medicaid Enterprise in **Section 3** of this report.
- **Current State for Contracts and Bids Funded by Medicaid in Puerto Rico:** We first describe the types of contracted services procured by the Medicaid Enterprise, which are funded by Medicaid. As Governor Wanda Vázquez Garced recently stated, “It is imperative that the rules on procurement of goods and services in government be rigorously applied in order to protect the interests and money of the people”<sup>3</sup>; therefore, we describe our territorial laws for contracting and procurement applicable to the Medicaid Enterprise. Using a contract management framework, we then provide an overview of our processes to evaluate bids and award contracts on competitive and non-competitive basis. We provide further details on our processes, laws, and contracts in **Section 4** of this report.

After examining the contracting processes in our Medicaid Enterprise, we developed our Requirement 3: Contracting Reform Plan that identifies contracting reform improvement opportunities. To operationalize our plan, we have identified specific initiatives to address the

<sup>3</sup> Office of the Governor of Puerto Rico. (2020). Executive Order for Executive Contracting, Number: OE-2020-082 signed by Governor Wanda Vázquez Garced on November 16, 2020. Retrieved from <https://aldia.microjuris.com/2020/11/17/publican-nuevas-guias-para-contratos-gubernamentales/>.

opportunity areas and aligned them with an implementation plan that will establish early successes while carefully planning details such as governance and staffing of the initiatives during the Requirement 3: Contracting Reform Plan and optimizing with further initiatives continuing beyond the plan that will demand more time and effort. We reviewed leading practices from states and conducted interagency workshops to identify four areas of opportunity to enhance our procurement and contracting practices:

- Increase competition and establish alternative competitive contracting processes.
- Engage stakeholders and expand the strategic development and planning processes for procuring services.
- Drive increased standardization and consistency in the scoring and selection process.
- Increase transparency, make more contracting information publicly available.

To strengthen our overall approach to contracting, we identified specific initiatives to address each of the areas of opportunity. Details are documented in the report on **Requirement 3: Contracting Reform Plan**<sup>4</sup>

- **Managed Care Contracts subject to oversight by the Centers for Medicare & Medicaid Services:** We evaluated our compliance and oversight activities required by the Centers for Medicare & Medicaid Services (CMS) of the managed care contracts awarded under Puerto Rico’s State plan. The scope of the Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Final Rule in 2016 aligns to eight functional areas of oversight required by CMS. We also reviewed leading practices from states to identify opportunities to improve our business processes and tools. Below are some opportunities we are considering to enhance oversight of our managed care contracts. Each of these areas is described and analyzed in detail in **Section 5** of this report.

Opportunity	Description of Opportunity	Section Reference to Functional Area
Integrate Oversight Teams	Develop an integrated team that works together across MCOs/MAOs that would allow for more cross training and cross coverage. This approach would allow us to build stronger teams who are more knowledgeable and familiar with issues and can identify trends across MCOs/MAOs and functional areas, and to enhance our capabilities to work through complex oversight issues.	5.3 State Monitoring Standards
Improve the Governance of Contract Oversight Processes	Create governance processes to enable departments across Puerto Rico’s Medicaid Enterprise to collaborate more readily by sharing relevant, actionable information at the right time, engaging MCOs in meaningful ways, and enabling effective operations and goal setting.	5.3 State Monitoring Standards
Increase Transparency with Puerto Rican Beneficiaries	Publish information and report about the MCOs’ quality of care and update records regularly in the online portals, thereby making information easily accessible to the beneficiaries and the public. Increased transparency allows our beneficiaries to view the performance of individual MCOs prior to selecting an MCO and holds MCOs accountable to improve their performance.	5.4 Quality of Care

<sup>4</sup> PL 116-94: Further Consolidated Appropriations Act, 2020:(133 STAT 3105), Division N, Title 1 §202(a)(7)(A)(iii)  
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Opportunity	Description of Opportunity	Section Reference to Functional Area
Enhance the EQRO's Role	Use the External Quality Review Organization (EQRO) and/or Quality Improvement Organization (QIO) for additional oversight activities, such as validating encounter data, conducting consumer and provider surveys, calculating performance measures, and performing appointment availability studies on clinical or non-clinical services.	5.4 Quality of Care
Integrate Quality Oversight	Implement an integrated quality report that combines disparate sources of information and allows the Puerto Rico Medicaid Enterprise to review data inclusively and draw insights.	5.4 Quality of Care
Leverage Telehealth to Expand the Existing Provider Network	Promote telehealth opportunities to expand health care access to areas of the Island that are lacking providers, especially increasing access to specialists and serving more beneficiaries in rural areas.	5.5 Network Adequacy and Access to Care
Reduce Reliance on MCO-Reported Data	Validate MCO reports with external sources and confirm the accuracy of the information reported. This enhanced validation will improve the reliability of network information, provide opportunities to hold MCOs responsible for information provided, and in turn incentivize accurate reporting from MCOs.	5.5 Network Adequacy and Access to Care
Improve Frequency of Data Reporting by Leveraging Automation	Use automation to enable our teams to more frequently and more effectively collect and validate data, calculate and verify network adequacy, and strengthen MCO reporting efforts.	5.5 Network Adequacy and Access to Care
Standardize Processes of Grievances and Appeals and Share Data across Medicaid Enterprise	Implement an integrated system to track and trend grievances and appeals, allowing the Medicaid Enterprise to standardize the logging of grievances, appeals and hearings, and examine the data for trends, patterns, root causes, and other insights. Having a unified system would allow the information and, more importantly, the insights, to be shared across the Medicaid Enterprise.	5.7 Grievances and Appeals
Track Trends in Grievances and Appeals to Identify and Resolve Systemic Issues	Track trends and patterns in grievances, appeals, and hearings to allow us to enhance issue resolution and better identify where improvements can be made, such as service and quality improvements, revising or clarifying policies and procedures, and/or improving communication.	5.7 Grievances and Appeals
Improve Collaboration for Marketing Materials Development	Increase alignment with CMS to help improve the MAOs' marketing materials and activities by incorporating and adhering to CMS marketing and communication guidelines, with input from the advisory committee to the Medicaid director.	5.8 Marketing and Communication Activities
Introduce Additional Factors into the Default Enrollment Methodology	Strengthen the default enrollment methodology to incorporate additional factors in order to improve the experience of our beneficiaries and incent high-performing MCOs.	5.9 Enrollment and Disenrollment

Opportunity	Description of Opportunity	Section Reference to Functional Area
Increase Provider Enrollment	Encourage more providers to enroll through the new Provider Enrollment Portal (PEP), which enables us to improve the integrity of our provider data and assess our MCOs' provider networks.	5.9 Enrollment and Disenrollment
Improve Data Integrity and Automation	Increase system integration, collaboration, and automation across the Medicaid Enterprise to improve sharing financial information with MCOs and our federal partners. These improvements allow for better consistency with reporting and processing, which in turn, allows for better data reconciliation across sources and data-driven insights.	5.10 Financial Oversight, including Rate Development Standards and Payment Management
Temporarily Modify Payment Methodologies and Profit-Sharing Arrangement	Explore potential levers for further recoupment of excess profits to complement the existing mechanisms in place	5.10 Financial Oversight, including Rate Development Standards and Payment Management

Table 1. Opportunities to enhance contract oversight of managed care contracts in Puerto Rico.

## 2. DIFFERENCES IN MEDICAID PROGRAM FUNDING BETWEEN STATES AND PUERTO RICO/OTHER TERRITORIES

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The Medicaid program is arguably the most consequential federal program in Puerto Rico because it provides health care services to 1.6 million people, or 46 percent of the Island's population. However, our program differs in fundamental ways when compared to state Medicaid programs. Federal Medicaid funds for United States Territories are limited in two ways:

1. Total federal Medicaid spending in the territories is subject to an annual Medicaid Cap pursuant to section 1108 of the Social Security Act. As a result, the Federal government will match every Medicaid dollar spent by the territories up to each jurisdiction's cap, and any spending above the cap is provided solely by the territory.
2. The federal Medicaid matching rate for territories is set in statute at 55 percent, unlike states which receive unrestricted matching federal funds between 50 percent and 83 percent of their Medicaid costs according to the state's Federal Matching Assistance Percentage (FMAP).

The following table shows the disparity between Puerto Rico and comparable state Medicaid programs on administrative spending per member per year (PMPY) and per member per month (PMPM). Comparing Medicaid programs of similar size (1-2 million enrollees) and with a high proportion of enrollment in managed care (over 80 percent in comprehensive managed care), it demonstrates that Puerto Rico is getting approximately one-third (1/3) of the administration expenditures of similar programs.

State <sup>5</sup>	2018 Medicaid Enrollment <sup>6</sup>	2018 Percent Comprehensive Managed Care <sup>7</sup>	2019 Administration Expenditures <sup>8</sup>	PMPY	PMPM
(A)	(B)	(C)	(D)	(E)=(D)/(B)	(F)=(D)/(B)/12
Virginia	1,063,122	82%	\$437,968,202	\$411.96	\$34.33
Kentucky	1,385,239	91%	\$266,167,884	\$192.15	\$16.01
Maryland	1,401,781	83%	\$505,358,312	\$360.51	\$30.04
Tennessee	1,510,045	92%	\$564,787,478	\$374.02	\$31.17
Louisiana	1,640,075	84%	\$337,092,213	\$205.53	\$17.13
New Jersey	1,668,451	94%	\$898,752,077	\$538.67	\$44.89
Arizona	1,849,465	84%	\$277,807,148	\$150.21	\$12.52
<b>Average<sup>9</sup></b>	<b>1,502,597</b>	<b>88%</b>	<b>\$469,704,759</b>	<b>\$312.60</b>	<b>\$26.05</b>
Puerto Rico	1,505,610	100%	\$156,284,437	\$103.80	\$8.65

Table 1. Medicaid Enrollment and Administration Expenditures for Comparable State Medicaid Programs

Puerto Rico is committed to meeting all the Congressional requirements that have been added as part of Public Law 116-94. However, we are concerned that without parity in the Medicaid program or, at a minimum, additional administrative funding, the full and permanent implementation of these changes will be challenging. For example, Puerto Rico can sometimes have only one employee evaluating a request for proposal (RFP) since the day to day operational needs and limited administration funding doesn't support additional resources aligned to the RFP evaluation process.

Puerto Rico is requesting that Congress consider application of the FMAP as used with states. In addition, Congress is requested to consider removing the Medicaid Cap on federal Medicaid funds through 1108(g). If only the FMAP formula is applied, then Puerto Rico will, as a result, reach the Medicaid Cap sooner. Funding parity would help Puerto Rico plan for long term structural changes and allow for real transformational changes to our Medicaid Enterprise.

<sup>5</sup> Includes states where 2018 Medicaid enrollment is between 1,000,000 to 2,000,000 and over 80% enrollment in comprehensive managed care. Excluded the State of Washington which had administrative costs in excess of \$1.3 billion.

<sup>6</sup> Medicaid.Gov. *The FY 2018 Medicaid Managed Care Enrollment Report*, Latest available report retrieved from: <https://data.medicare.gov/Enrollment/2018-Managed-Care-Enrollment-Summary/gn4b-7d7q/data>

Total Medicaid Enrollees represents an unduplicated count of all beneficiaries in FFS and any type of managed care, including Medicaid-only and Medicare-Medicaid ("dual") enrollees.

<sup>7</sup> Medicaid Enrollment in Comprehensive Managed Care represents an unduplicated count of Medicaid beneficiaries enrolled in a managed care plan that provides comprehensive benefits (acute, primary care, specialty, and any other), as well as PACE programs. It excludes beneficiaries who are enrolled in a Financial Alignment Initiative Medicare-Medicaid Plan as their only form of managed care.

<sup>8</sup> Medicaid.Gov. *FY 2019 Financial Management Report, Total Computable Net Administrative Expenditures*, Latest available report retrieved from: <https://www.medicare.gov/medicaid/financial-management/state-expenditure-reporting-for-medicare-chip/expenditure-reports-mbescbes/index.html> Excludes administrative costs for the following service categories: Family Planning, Skilled Professional Medical Personnel - Single State Agency, Skilled Professional Medical Personnel - Other Agency, Peer Review Organizations, TPL - Recovery, TPL - Assignment Of Rights, Nurse Aide Training Costs, Preadmission Screening, Resident Review, Drug Use Review, School Based Administration, Interagency Costs (State Level), Planning for Health Home for Enrollees with Chronic Conditions, and Non-Emergency Medical Transportation

<sup>9</sup> The average administration expenditure is weighted based on Medicaid enrollment.

# 3. INTRODUCTION TO THE PUERTO RICO MEDICAID ENTERPRISE

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PRDOH is the SSA for administering our State Medicaid Program. For purposes of the Medicaid program administration, PRDOH is the SMA. The Medicaid program is administered by PRDOH and PRHIA, which collectively is referred to as the Medicaid Enterprise. This is a long-standing sister agency relationship, defined by an interagency memorandum of understanding (MOU). PRHIA (commonly referred to as Administración de Seguros de Salud [ASES]), was created in 1993 to oversee, monitor and evaluate services offered by the managed care organizations (MCOs) under contract with PRHIA. PRHIA is a public corporation overseen and monitored by a Board of Directors (BOD). Puerto Rico’s Medicaid Program (PRMP), a department under the PRDOH, oversees the Medicaid State Plan, determines Medicaid eligibility of residents, and is responsible for the operation of the Medicaid Management Information System (MMIS) for the program.

In addition, PRHIA, PRMP and the Government of Puerto Rico at large follow guidance issued each year by the federally appointed Financial Oversight and Management Board for Puerto Rico (FOMB). In addition to meeting federal requirements, PRHIA and PRMP must also abide by regulations established by the Government of Puerto Rico.

## Puerto Rico Department of Health

The PRDOH’s administration of its Medicaid program under Title XIX of the Social Security Act is structured as a categorical program called the “Medicaid Program.” The PRDOH Medicaid program is chartered with ensuring appropriate delivery of health care services under Medicaid, CHIP, and the Medicaid Preferred Drug Program (PDP); the latter two structured as extended Medicaid programs.

Since the inception of the Medicaid program in Puerto Rico, and up until the early 1990s, PRMP’s role was mostly limited to providing the categorically needy access to Medicaid services by operating local offices throughout all the municipalities on the Island. In these offices, residents 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 into the Medicaid program. Health care services to Medicaid-eligible individuals and families were delivered through the Puerto Rico government’s public health service facilities.

## Puerto Rico Health Insurance Administration

In 1993, the Government of Puerto Rico enacted transformation of the entire public health system. The Puerto Rico Health Reform Program (referred to initially as Reforma and now known as Plan Vital) marked the creation of a government health insurance program under a managed care delivery system. These reforms expanded Medicaid coverage for individuals and families with incomes between 50 -100 percent of the federal poverty guideline—significantly increasing the number of residents with government-subsidized health coverage.

In 1993, an interagency MOU (since then updated multiple times), was established to delegate the implementation of the Medicaid State Plan’s managed care delivery model to PRHIA, a public

corporation established by Law No. 72 on September 7, 1993, as amended. Under this agreement, the PRMP 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 delivery system. The process of selecting the insurance carriers, negotiating and managing those contracts was assigned to PRHIA pursuant to Law No. 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 enrolled in a Medicare Advantage Organization (MAO). Medicare Platino wraps around Medicare Advantage benefits, giving the dually eligible enrollees any additional benefits provided by the Medicaid program. PRHIA holds contracts with the MAOs.

### **The Puerto Rico Health Insurance Administration Board of Directors**

PRHIA is governed by a Board of Directors (BOD) made up of eleven (11) members, six (6) that are Ex-Officio Members and five (5) that are appointed by the Governor of Puerto Rico with the advice and consent of Puerto Rico’s Senate. The Ex-Officio Members include the Secretary of Health, the Treasury Department Secretary, the Administrator of the Administration of Mental Health and Addiction Services (ASSMCA), the Director of the Office of Management and Budget (OMB), the Executive Director of The Puerto Rico Fiscal Agency and Financial Advisory Authority (AAFAF) and the Insurance Commissioner, or their delegates. The Governor of Puerto Rico appoints the President of the Board of Directors from among its members. The primary purpose and functions of the BOD include:

- Implementation of medical services based on health insurance.
- Negotiation and contracting for medical insurance coverage.
- Negotiation and contracting with health service plans for health services.
- Organization of alliances and groups 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 awarding 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 documentation of the relationship of their beneficiaries, payment claims and the pertinent financial and statistical reports.
- Approval, amendment and repeal of 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

The Financial Oversight and Management Board for Puerto Rico (FOMB) was created under the Puerto Rico Oversight, Management and Economic Stability Act (PROMESA) 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 works to fulfill the mandate of the PROMESA to ensure fiscal sustainability and restore access to capital markets. In the first instance, due to a 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 the PROMESA to require the Oversight Board's approval of certain contracts to assure that they "promote market competition" and "are not inconsistent with the approved fiscal plan."

In its oversight of the Medicaid Enterprise, the FOMB must approve all government contracts and amendments with an aggregate value of \$10,000,000 or more. 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 "Plan Vital" MCOs must be submitted to the FOMB for review and approval prior to execution. Also, pursuant to PROMESA section 204(b)(4), certain proposed rules, regulations, administrative orders, and executive orders must be submitted for FOMB review prior to enactment.

# 4. CURRENT STATE FOR CONTRACTS AND BIDS FUNDED BY MEDICAID IN PUERTO RICO

## 4.1 Types of Contracts Procured by Puerto Rico Medicaid Enterprise

The following sections provide an overview of the types of contracted services procured by the Medicaid Enterprise, and an overview of the territorial laws applicable to the Medicaid Enterprise for procurement and contracting. Our contracting processes adhere to territorial laws and regulations. Then, leveraging the Contract Management Maturity (CMMM) framework, we describe the processes for bidding and awarding contracts on a competitive and non-competitive basis. These sections complement the detailed documents provided in the Fiscal Year (FY) 2020 Annual Report to the U.S. Congress, describing the Puerto Rico Health Insurance Administration (PRHIA) process for proposal evaluations, their departmental responsibilities, and a contracting consideration checklist.

Puerto Rico currently procures and administers four types of contracts that utilize Medicaid Federal and non-federal funds. In Puerto Rico's FY 2020-2021, Puerto Rico Medicaid Enterprise administered 165 contracts amounting to \$3.4 billion in four types of Medicaid-funded contract categories: Health Care Delivery Services, Professional Services, Non-Professional Services and Goods, and Office Leasing.<sup>10</sup>

### Health Care Delivery Services

In FY 2020-2021, the Puerto Rico Medicaid Enterprise administered 20 health care delivery services contracts that utilize Medicaid Federal and non-federal funds, totaling \$3.3 billion.<sup>10</sup> Health care delivery services accounted for 98 percent of contract amounts funded by Medicaid in FY 2020-2021. These included, among others:<sup>11</sup>

- Managed Care Organizations (MCOs) to administer Plan Vital, the government health insurance plan
- Medicare Advantage Organizations (MAOs) to administer Medicare Platino, the Medicare-Medicaid program for dually eligible enrollees
- Pharmacy Benefit Manager (PBM)
- Pharmacy Program Administration (PPA) for the Pharmacy Rebate Program
- Enrollment counselor
- Other services for beneficiaries, such as the purchasing of ventilators

<sup>10</sup> *Medicaid-funded contracts in FY 2020-2021*, as organized into contract categories, provided by Puerto Rico Medicaid Program and Puerto Rico Health Insurance Administration, November 2020. Contracts for FY 2020-2021 are not yet final, and contract amounts are subject to change.

<sup>11</sup> MCOs receive a per member per month (PMPM) premium payment for providing health care services to beneficiaries in the Plan Vital program. Therefore, contract amounts for MCOs in the Plan Vital program vary monthly based on the beneficiaries assigned to each MCO and the utilization of those beneficiaries. The contract amounts for FY 2020-2021 span from July 2020 to September 2021. During this contract year, rates for dental services and MCO premiums were revised. Molina terminated their Plan Vital contract effective October 31, 2020 and beneficiaries were re-assigned to the remaining four MCOs. Molina provided services for four months in FY 2020-2021 (July 2020 to October 2020).

## Professional Services

As allowed by territorial procurement laws, Professional Services contracts are defined as an exceptional measure in Puerto Rico and must be used only when the contracting agency does not have the internal resources to fulfill service requirements.<sup>12</sup> Professional Services constitute those services in which the main outcomes are the product of intellectual labor or highly technical or specialized knowledge. For Professional Services, territorial laws<sup>13</sup> establish guidelines and parameters for the contracting processes, controls for the use of public funds, and rules for specific contracted services. Certain certifications from companies are required, and agencies are restricted from contracting with former public servants within two years of that person leaving their role. Public agencies must report twice a year to the Puerto Rico Office of Management and Budget (OMB) their list of Professional Service contracts or amendments that have been awarded.

The Puerto Rico Medicaid Enterprise administered 85 contracts for Professional Services that utilize Medicaid federal and non-federal funding, amounting to \$77.2 million total funds in FY 2020-2021.<sup>14</sup> As mentioned in the Program Management risk area highlighted OIG Final Report findings, titled '**A-02-20-01011 Risk Assessment Puerto Rico Medicaid Program**'<sup>15</sup>, deep cuts in Medicaid funding for the Island, limitations in hiring and reduced training opportunities prevent development of institutional knowledge and skill necessary to effectively operate the Puerto Rico Medicaid program. Puerto Rico mitigates this moderate risk area, in part, by procuring Professional Services. Depending on the scope of services needed by the Puerto Rico Medicaid Enterprise, the Departments may procure Professional Services through either a competitive or non-competitive awarding process.

- **Competitive basis** – 54 percent of the total spending on Professional Service contracts funded by Medicaid (or \$41.7 million for 14 contracts) were awarded on a competitive basis in FY 2020-2021.<sup>14</sup> Professional Services from companies are often procured through a competitive bidding process, in the form of a Request for Proposal (RFP) or Request for Qualifications (RFQ).
- **Non-Competitive basis** – 46 percent of the total spending on Professional Service contracts funded by Medicaid (or \$35.5 million for 71 contracts) in FY 2020-2021 were awarded on a non-competitive basis. Procurement for Professional Services by individuals (e.g., attorneys) are often awarded on a non-competitive basis, with selection criteria often based on known experience and competence, as well as professional trust.

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<sup>12</sup> Office of the Governor of Puerto Rico. (July 2006). *Administration Principles that regulate the Hiring of Professional Services and Consultants in the Public Sector*; and *Executive Order for Executive Contracting*, Number: OE-2020-082 signed by Governor Wanda Vázquez Garced on November 16, 2020. Retrieved from <https://aldia.microjuris.com/2020/11/17/publican-nuevas-guias-para-contratos-gubernamentales/>.

<sup>13</sup> Office of the Governor of Puerto Rico. (July 2006). *Administration Principles that regulate the Hiring of Professional Services and Consultants in the Public Sector*.

<sup>14</sup> *Medicaid-funded contracts in FY 2020-2021*, as organized into contract categories, provided by Puerto Rico Medicaid Program and Puerto Rico Health Insurance Administration, November 2020. Contracts for FY 2020-2021 are not yet final, and contract amounts are subject to change.

<sup>15</sup> Office of Inspector General, Department of Health & Human Services. (December 11, 2020). A-02-20-01011 Risk Assessment Puerto Rico Medicaid Program. Retrieved from <https://oig.hhs.gov/oas/reports/region2/22001011.asp>.

## Non-Professional Services and Goods

In accordance with Law No. 73-of 2019 (“Centralization of the Government of Puerto Rico Purchases by the General Services Administration”), from the Government of Puerto Rico,<sup>16</sup> non-professional contracts are now competitively procured by the Puerto Rico General Services Administration (PR GSA, or Administración de Servicios Generales in Spanish). On November 30, 2020, it was communicated that the *Uniform Regulation for Purchases and Bids of Goods, Works, and Nonprofessional Services* was approved by the Financial Oversight and Management Board for Puerto Rico (FOMB) and filed with the Government’s State Department. As such, this regulation will go in effect in 30 days.<sup>17</sup> As part of the regulation, all bidders for highly technical and/or strategic Non-Professional Services and goods will have a competitive bidding and awarding process, such as sealed RFP or RFQ. Additionally, their submitted bids will be evaluated by committees and reviewed by the PR GSA Board of Directors. The PR GSA is designated as the only entity authorized to carry out and negotiate the acquisition of non-professional goods, works, and services for governmental entities in Puerto Rico. As such, the Medicaid Enterprise selects vendors for Non-Professional Services and goods from the PR GSA’s list of pre-approved vendors<sup>18</sup>, and the contract(s) are then executed and managed by the Puerto Rico Department of Health (PRDOH) or PRHIA. In FY 2020-2021, the Puerto Rico Medicaid Enterprise administered 10 contracts for Non-Professional Services that utilized Medicaid Federal and non-federal funds, amounting to \$1.6 million total funds.<sup>19</sup> Example of procured services Non-Professional Services and goods include:

- Cleaning services for Medicaid offices
- Office equipment, such as photocopiers, printing and mail, and water fountains
- Unarmed security guards

## Rent / Lease of Office Space

Leasing contracts relate to the renting and leasing of spaces and/or buildings that are utilized by the Puerto Rico Medicaid Enterprise for official use, primarily for the local eligibility offices across the Island and the offices used by administrative staff in San Juan. In FY 2020-2021, Puerto Rico’s Medicaid Enterprise administered 50 contracts for office/leasing that utilized Medicaid Federal and non-federal funds,<sup>19</sup> amounting to \$5.2 million in total funds. These apply for space that is contracted from individuals, private entities, or public entities. Furthermore, these contracts have a limited competitive nature and are selected based on a set of steps outlined in the subsection: Current Processes for Competitive Contracts Funded by Medicaid in Puerto Rico, including the evaluation of the available options and the adequacy of the facility.

<sup>16</sup> The (Sealed) Request for Proposal (RFP) and the Request for Qualifications (RFQ) are the primary solicitation methods used in the execution of strategic sourcing by PR GSA. Other solicitation methods available to the new PR GSA procurement organization by Law 73-2019 include: Informal Purchase; Informal Auction; Formal Auction; Request for Proposals; Sealed Request for Proposals; and Request for Qualifications.

<sup>17</sup> Puerto Rico Administración de Servicios Generales. (November 20, 2020). *Press Release: Letter FOMB*. Retrieved from <http://www.asg.pr.gov/ComunicadosPrensa/Documents/FOMB/Letters%20FOMB%20-%20Procurement%20Platform.pdf>

<sup>18</sup> Puerto Rico Administración de Servicios Generales. (Last revised in 2020). *Contracts*. Retrieved from <http://www.asg.pr.gov/Contratos/Pages/default.aspx#>.

<sup>19</sup> *Medicaid-funded contracts in FY 2020-2021*, as organized into contract categories, provided by Puerto Rico Medicaid Program and Puerto Rico Health Insurance Administration, November 2020. Contracts for FY 2020-2021 are not yet final, and contract amounts are subject to change.

## 4.2 Applicable Laws for Contracting in Puerto Rico

The Puerto Rico Medicaid Enterprise structures the contracting processes for both competitive and non-competitive procurements in accordance to territorial laws and regulations. The territorial laws primarily govern the source selection and contract approval phases of the contracting process with regulations outlining parameters on the uniformity of the process and the preferences that should be given to local companies in Puerto Rico. For contract approval, several laws discuss the specific guidelines to procurement, whether competitive or non-competitive; budget constraints; approvals needed to proceed with any given contract in Puerto Rico; and relevant employees' actions; and disciplinary actions for violations. The Government Accountability Office (GAO) has even also stated that the Puerto Rico Medicaid Enterprise had conflict of interest standards consistent with federal requirements.<sup>20</sup> A list of the Puerto Rico laws, regulations, and administrative orders applicable to the Medicaid Enterprise for procurements and contracting are presented below in Table 3. These were also listed in the appendix of the FY 2020 Annual Report to Congress, *Compendium of Relevant Contracting Reform Puerto Rico Regulations*.

Law/Regulation	Reference Name	Relevance
Act No. 18 of 1975, and amended by Act No. 17 of 1990 and Act No. 127 of 2004	Contract Registration Act	<ul style="list-style-type: none"> <li>Requires that all government entities keep a registry of all contracts granted, including amendments</li> <li>Requires the registration and submission of every contract to the Comptroller's Office</li> </ul>
Act No. 147 of 1980, (Article 8), as amended	Organic Law of the Office of Management and Budget	<ul style="list-style-type: none"> <li>Declares that during an election year it is unlawful to incur expenses or obligations that exceed 50 percent of the budgetary appropriation of each item and that Directors of the agencies shall be directly responsible for any violation. Some agencies, that do not constitute regular operating expenses, are excluded</li> </ul>
Act No. 14 of 2004	Law for Investment in the Puerto Rican Industry	<ul style="list-style-type: none"> <li>Indicates that during the procurement process, competitive advantage is given to companies with substantial operations in Puerto Rico</li> <li>Creates a Local Preference Program in Government Procurement</li> <li>15 percent of procurements must be made to small businesses and other preferred groups</li> </ul>
Act No. 237 of 2004	Law to Establish Uniform Parameters in the Procurement Processes of Professional and Consultative Services for the Government Agencies and Entities of the Commonwealth of Puerto Rico (Estado Libre Asociado de Puerto Rico, in Spanish)	<ul style="list-style-type: none"> <li>Establishes uniform parameters in contracting processes of professional and consulting services</li> <li>Establishes financial standards for bidders to comply</li> <li>Prohibits political conflicts of interest</li> </ul>

<sup>20</sup> In accordance with 45 CFR 75.327(c)(1)

Law/Regulation	Reference Name	Relevance
Contracting Legal Principles for Professional Services Brochure, 2006	Contracting Legal Principles for Professional Services	<ul style="list-style-type: none"> <li>The Comptroller's Office of Puerto Rico created a booklet called "Principios Legales y de Sana Administración que regulan la contratación de Servicios Profesionales y Consultivos en el Sector Publico"</li> <li>Establishes rules for procurement of professional and consulting services in the public sector in Puerto Rico</li> <li>Establishes the minimum requirements for professional and consulting services contracts in the public sector in Puerto Rico</li> </ul>
Regulation No. 33 of 2009 as amended	Registry of Contracts, Deeds and Related Documents and the Submission of Copies to the Office of the Controller of the Commonwealth of Puerto Rico	<ul style="list-style-type: none"> <li>Standardizes the procedure for the submission of contracts to the Comptroller's Office</li> <li>Establishes guidelines that the Comptroller's Office must adhere to regarding the administration of the registry, public examination of the documents, and the issuance of copies</li> </ul>
Act No. 3 of 2010	<i>(None)</i>	<ul style="list-style-type: none"> <li>Addresses the Economic, Fiscal, and Budgetary Crisis to Guarantee the Functioning of the Government of Puerto Rico</li> </ul>
Act No. 1 of 2012, (Article 4.3)	Law of the Government Ethics Office of Puerto Rico	<ul style="list-style-type: none"> <li>Prevents public servants from accepting or keeping a job in addition to any public employment which may impair their freedom of judgment in their function</li> <li>Declares that public servants cannot authorize or sign contracts that create conflicts of personal interest</li> </ul>
Act No. 48 of 2013, (Article 1), as amended	Law to Establish the Special Contribution of 1.5 percent in Professional Services Contracts	<ul style="list-style-type: none"> <li>Imposes a tax on government contracts; imposes a special contribution of 1.5 percent of the value of contracts for professional and consulting services executed by government agencies, not deductible for income tax purposes</li> </ul>
Act No. 66 of 2014, as amended	Special Fiscal and Operational Sustainability Law of the Government of the Commonwealth of Puerto Rico	<ul style="list-style-type: none"> <li>Imposes budget restraints and requirements that all government agencies must follow due to the economic crisis in Puerto Rico</li> <li>Establishes that OMB must adhere to these constraints when approving contracts</li> </ul>
Act No. 235 of 2014	Law for the creation of the Review Board for Property Lease and Rental of Puerto Rico	<ul style="list-style-type: none"> <li>Regulates real state contracts; leases for office space for all government Agencies are regulated</li> </ul>
Act No. 3 of 2017, (Article 35)	Law to Address the Economic, Fiscal, and Budgetary Crisis to Guarantee the Proper Functioning of the Government of Puerto Rico	<ul style="list-style-type: none"> <li>Imposes budget restraints and requirements that all government agencies must follow due to the economic crisis in Puerto Rico</li> <li>Establishes that OMB must adhere to these constraints when approving contracts</li> </ul>

Law/Regulation	Reference Name	Relevance
Act No. 2 of 2018	Anti-Corruption Code for the New Puerto Rico	<ul style="list-style-type: none"> <li>Establishes the responsibilities of current and former government officials, private entities, and individuals who provide services for Puerto Rico government to combat government corruption</li> <li>Requires the submission of a sworn statement during the bidding process of a Procurement Contract whereby the private entity states that it has not been found guilty of committing corruption such as bribery or laundering</li> </ul>
Act No. 73 of 2019 (Article 35), as amended	2019 General Services Administration Centralization of Government Purchases Act	<ul style="list-style-type: none"> <li>Establishes rules for procurement of non-Professional Services, to be centralized under Puerto Rico's GSA</li> <li>Creates PR GSA's platform/website for the Single Registry of Suppliers (Registro Único de Subasta in Spanish) that includes daily auction and bid information and any other information that PR GSA deems necessary for registered bidders</li> <li>2020's Executive Order OE-2020-082 established further rules and regulations</li> </ul>
Circular Letter 141-17 of the Office of the Governor of 2017	Procedure for the prior authorization of Professional Services Contracts or Contracts in excess of ten thousand dollars	<ul style="list-style-type: none"> <li>Requires previous authorization before approving and signing all government contracts that exceed \$10,000 a year</li> </ul>
Circular Letter CC1300-16-16 of 2016	Documents required for the Formalization of Professional and Consulting Services Contracts	<ul style="list-style-type: none"> <li>Established by The Puerto Rico Department of the Treasury (Hacienda) to regulate the required documentation before signing any government contract</li> </ul>
PRDOH Secretary's Circular Letter dated February 19, 2019	Procedure to Seek Approval of Contracts within the Department of Health	<ul style="list-style-type: none"> <li>Establishes the procedure to seek approval of the contracts within the Department of Health</li> </ul>
OMB Circular Letter 168-19 of 2019	Amendment to OSG-2017-001 to Establish a New Authorization Request to the Office of the Chief of Staff of the Governor of Puerto Rico to Award Contracts and to Present Certification in the Contract Processing System (PCo) of the Budget and Management Office	<ul style="list-style-type: none"> <li>Establishes additional information for the proper management and processing of authorizations granted by the Office of the Chief of Staff of the Governor of Puerto Rico</li> <li>Establishes a new certification required to award contracts titled: "Authorization request to the Office of the Chief of Staff of the Governor of Puerto Rico to award contracts</li> </ul>
Circular Letter 02-17 of the Office of the Governor of 2017	Procedure for the consolidation and update of the contract registry of private leasing contracts of the Review Board for Property Lease and Rental of Puerto Rico	<ul style="list-style-type: none"> <li>Regulates real state contracts; leases for office space for all government Agencies are regulated</li> <li>Establishes the process for authorization requests from the Review Board for Property Lease and Rental of Puerto Rico for leasing or purchasing private property</li> </ul>

Table 2. Laws/Regulations for Contracting in Puerto Rico.

### 4.3 Leveraging Contract Management Maturity Model to examine processes used to evaluate bids and award contracts in Puerto Rico

To examine the current contracting processes in place, we aligned our activities to the six Contract Management Phases of the CMMM from the National Contract Management Association.<sup>21</sup> More than 200 companies from 12 different industries have successfully applied the framework to their contract management processes. The CMMM covers six contract management phases: procurement planning, solicitation planning, solicitation, source selection, contract administration, and contract closeout. Only the first five phases will be addressed in this report because of the focus on **Contracting Oversight and Approval** and the OIG’s assessment of the Contracting risk area. The first four contract management phases align to Congressional Requirement (f)(2)(A)(i) and (f)(2)(A)(ii), regarding examining the process used by Puerto Rico to evaluate bids and award contracts under the Medicaid State Plan. The fifth contract management phase, contract administration, addresses Congressional Requirement (f)(2)(A)(iii), to examine oversight by the Centers for Medicare & Medicaid Services (CMS) of contracts awarded under the Medicaid State Plan. In addition to this report, we are in the process of procuring an independent auditing organization to audit MCO contractual compliance, recoupments and other issues currently under review at the Financial Oversight and Management Board for Puerto Rico (FOMB), as stated in the FY 2020 Annual Report in October 2020. The relevant contract management phases are shown in Figure 1 below.

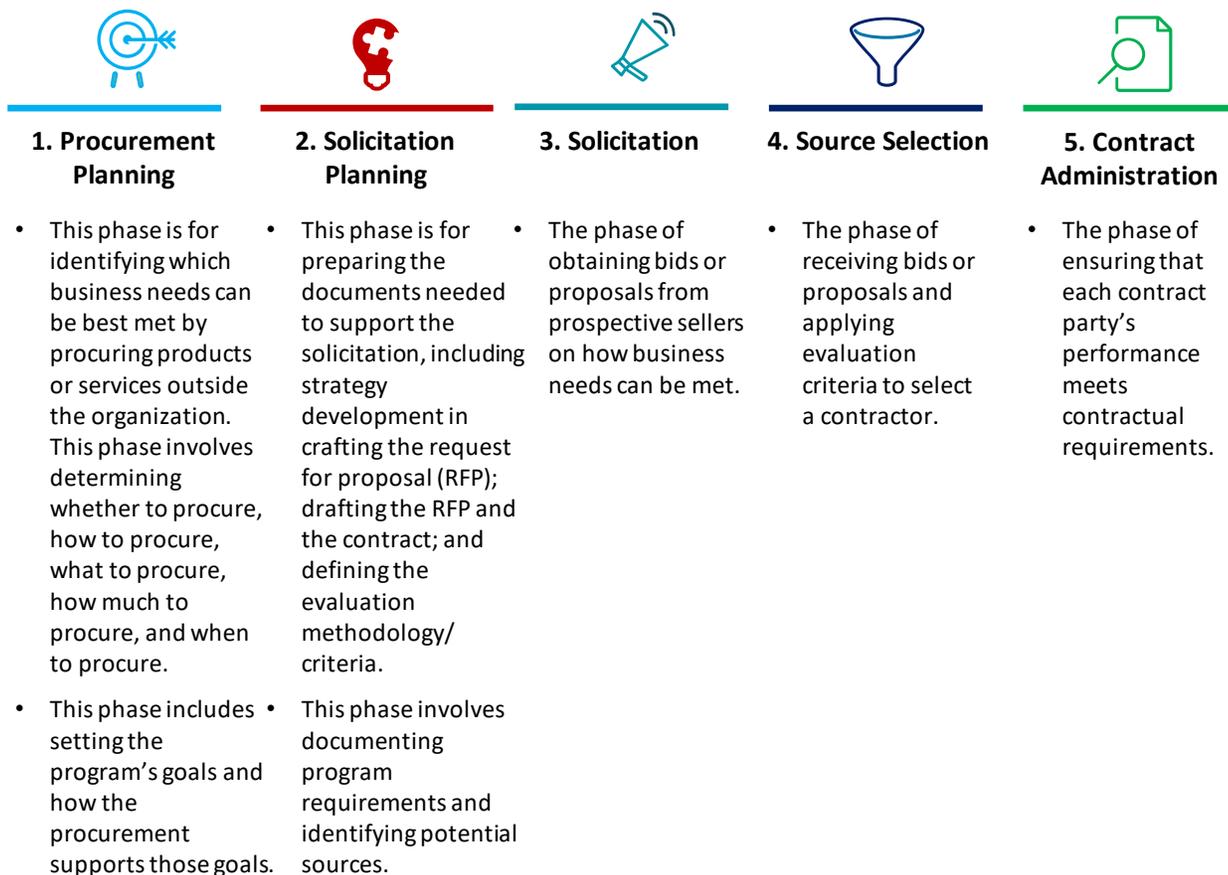


Figure 1. Contract Management Phases According to CMMM.

<sup>21</sup> Naval Postgraduate School (U.S.), Garrett, G. A., & Rendon, R. G. (2015). *Contract Management Process Maturity: The Key for Organizational Survival*. National Contract Management Association. Retrieved from <http://hdl.handle.net/10945/62015>.

This publication is a work of the U.S. Government as defined in Title 17, United States Code, Section 101.

## 4.4 Current Processes for Competitive Contracts Funded by Medicaid in Puerto Rico

This section provides an overview of the competitive process for evaluating bids and awarding contracts (with respect to the Puerto Rico Medicaid State Plan) administered by Puerto Rico that utilize Federal Medicaid funding. Reviewing this process also addresses OIG’s assessment for the Contracting risk area. As described earlier in this section, there are four different types of contracts currently procured by the Medicaid Enterprise that utilize Medicaid Federal and non-federal funding. On a competitive basis, PRDOH currently procures **Professional Services** and PRHIA procures contracts for administering **Health Care Delivery Services** (Including MCOs, MAOs, PBM, and enrollment counselor). Both Departments also procure **Non-Professional Services and Goods** (e.g., copiers, cleaning services, security guards). The activities conducted for each of the CMMM-defined contracting phases are detailed in Table 4 below.

PRDOH’s Competitive Contracts Funded by Medicaid	PRHIA’s Competitive Contracts Funded by Medicaid (including contracts for administering health care delivery services)
<b>Procurement Planning Phase</b>	
<p>The business unit identifies a business need to procure a service/item/office.</p> <p>The procurement method is defined based on the needs identified by the agency and the corresponding guidelines for that need.</p>	<p>A PRHIA unit/office/department identifies the business needs that can be met by procuring products or services outside the organization.</p> <p>The procurement method is defined based on the needs identified by the agency and the corresponding guidelines for that need (e.g., MCO contract requires competitive bidding vs. office supplies purchased from PR GSA’s pre-approved vendors).</p> <p>If a need for a contract amendment is identified, a request with the corresponding justification is presented to the Board of Directors (BOD) for approval. If the request is approved, the process continues as usual from contract clearance and approval.</p>
<b>Solicitation Planning Phase</b>	
<p><b>Non-Professional Services</b></p> <p>The business unit identifies their desired service/item from the PR GSA price bulletin and contacts the PR GSA’s pre-approved vendor to request a quote.</p> <p><b>Professional Services from Companies</b></p> <p>The bidding and award methods depend on the type of Professional Services sought and from which available bidder(s). Professional Services by companies are often handled by competitive RFPs.<sup>22</sup></p> <p>For technology related needs (e.g., Medicaid IT design, development, installation, or enhancement), the Advance Planning Document (APD) is drafted and submitted to CMS with the federal funding request.</p>	<p><b>Non-Professional Services</b></p> <p>The Administrative Office identifies two to three vendors for their desired service/item. We are moving toward using the PR GSA pre-approved vendor to request a quote.<sup>23</sup></p> <p><b>Health Care Delivery Services</b></p> <p>The PRHIA unit/office/ department meets with specific stakeholders and subject matter experts to develop the Statement of Work (SOW). The SOW is used to update the existing Model Contract and an RFP or Request for Information (RFI) document is created. The recent MCO RFP consisted of the Cost Proposal (25 percent of scoring points) and the Technical Proposal (75 percent of scoring points).<sup>22</sup></p>

<sup>22</sup> Federal guidance from 45 CFR 75.329(d)(1) and 75.329(d)(3) is not applicable to states or to Puerto Rico regarding the content of RFP or technical evaluations of the proposals. The Puerto Rico Medicaid Enterprise follows territorial laws and seek federal approval on contracts as required by CMS.

<sup>23</sup> PRHIA transitioned into the recently approved PR GSA procurement process for Non-Professional Services starting 2020.

## Solicitation Phase

**Non-Professional Services**

The business unit contacts the PR GSA pre-approved vendor to request a quote for the desired service/item based on the price list already in place with PR GSA.

**Professional Services from Companies**

The business unit works with the Administrative Office to gather documents and develop guidelines for the proposal.

The Administrative Office and business unit develops an RFQ document, including the evaluation/selection criteria.

Once the RFQ is ready to be published, the PRDOH Contracts Office issues a public notice to invite potential bidders.

Potential bidders submit a letter of intent and their response to the proposal.

For technology related contracts, the RFQ/RFP document is submitted to CMS for approval prior to publishing or public notice.

**Non-Professional Services**

The Administrative Office contacts at least two to three vendors to request a quote for the desired service/item. The Administrative Office identifies two to three vendors for their desired service/item. We are moving toward using the PR GSA pre-approved vendor to request a quote.<sup>24</sup>

**Health Care Delivery Services**

Once the RFP is ready to be published, the RFP document is submitted to CMS for approval prior to publishing or public notice.

After approval is granted by CMS, public notice is issued on the PRHIA website, the PR GSA platform for the Single Registry of Auctions (Registro Único de Subasta in Spanish), and with prior authorization of the Puerto Rico Innovation and Technology Service. It may be published in a newspaper of general circulation to welcome offers from potential bidders. Invitations are also sent to potential bidders.

In order to obtain an electronic copy of the RFP, potential bidders must submit payment of the corresponding fee and a certification signed by the high-ranking local management official of the organization indicating their interest in submitting a proposal, that the organization has the necessary legal and financial capacity, and the contact information of the person authorized to communicate with PRHIA.

One week is allowed for potential bidders to submit notice of intent to participate and/or acknowledge receipt of the RFP and get added to the procurement distribution list. Bidders must attend mandatory pre-proposal meetings (held at PRHIA's discretion) to learn about the RFP structure and process. In the case of the recent MCO RFP, mandatory actuarial preproposal meetings are also held.

Bidders can submit questions to the designated agency contact, and the agency shares written responses with all bidders in the procurement distribution list.

The proposals and proposal bond are due for submission at least one week after the agency answered bidders' questions (e.g., MCO bidders are required to have a proposal bond of \$100,000 in Certified Check or Original Proposal Bond to PRHIA and commit to entering into a contract with PRHIA, if awarded the RFP). The original copy of the bond is submitted at PRHIA's Administration and Finance Office. All procurement scheduled events

<sup>24</sup> PRHIA transitioned into the recently approved PR GSA procurement process for Non-Professional Services starting 2020.

## PRDOH's Competitive Contracts Funded by Medicaid

## PRHIA's Competitive Contracts Funded by Medicaid (including contracts for administering health care delivery services)

can be amended during the process if the need arises and are equally applicable to all participants.

Bidders submit proposals electronically to the PRHIA document repository to individual folders created for each participant.

For the MAOs interested in Platino, PRHIA issues a Request for Information (RFI) process to start the yearly contracting process with the MAOs.

### Source Selection Phase

#### Non-Professional Services

The business unit and Contracts Office reviews the quote and validates the vendor's quote against the PR GSA's price bulletin for accuracy.

If the quote is validated, the Medicaid Executive Director sends it to the Secretary of Health, who reviews the quote, and either approves or denies the contract.

#### Professional Services from Companies

The PRDOH Contracts Office evaluates the proposals using the established evaluation/selection criteria.

The scoring and awarded proposal are submitted to the Secretary of Health for review and approval by the Medicaid Executive Director. The awarded proposal is reviewed by PRDOH Legal Department, then the award is signed and stamped by the Secretary of Health.

CMS reviews and provides written authorization for PR MMIS, Eligibility and Enrollment, and Health Information Exchange related contracts.

#### Non-Professional Services

The Administrative office collects and reviews the received quotes to select the proposal that best meets the needs of PRHIA. After the selection has been made, all proposals are stored for recordkeeping purposes.

For quotes received from PR GSA pre-approved vendors, we validate the vendor's quote against the PR GSA's price bulletin for accuracy. If the quote is validated, the Executive Director reviews the quote, and either approves or denies the contract.

#### Health Care Delivery Services

Once the proposals are received, members of all the Evaluation Sub-Committees sign Conflict of Interest and Confidentiality Agreements. The results of the evaluation are presented in a blind format, where each proponent is identified only by a letter. The Executive Evaluation Committee conducts a holistic blind review and formulates the corresponding recommendations to the Board of Directors for their award.

For MAOs interested in Platino, PRHIA reviews the MAO's response to the RFI similarly.

The Evaluation Committee is typically comprised of the Documents Committee, the Mandatory Committee, the Technical Subcommittees, and the Cost Proposal Actuarial Committee. The Committee evaluates the proposals (in respective order) and develops recommendations for the Executive Committee. At least one PRHIA staff member will serve on each of the committees.

A proposal may be deemed non-responsive and be rejected from further consideration if the bidder fails to comply with the instructions of the RFP, submit a complete proposal, or adequately meet any submission requirement. However, PRHIA reserves the right to waive minor irregularities and minor instances of non-compliance.

The Executive Committee reviews the recommendations and develops an Executive Report for the BOD of the recommended proposals that should continue to the

negotiation phase. If the BOD does not agree with the Executive Committee’s recommendation, they could recommend changes.

Once approved by the BOD to proceed, the Negotiations Committee negotiates with the interested contractors and provides recommendations to the Executive Committee.

The Executive Committee reviews and presents the final award recommendations to the BOD. The BOD reviews and approves, modifies, or declines the recommendations. After the Notice of Intent to Award Contract is issued, any affected party gets 20 days to challenge the award. Proposal Bonds are returned to the unsuccessful bidders within the specified period of time established in the RFP.

Once approved, the PRDOH Secretary is notified and submits the MCO contracts to obtain approval by CMS. Throughout the process, CMS reviews, comments, submit recommendations and approves the contracts before publication. The contracts are considered live documents that continue to evolve during the procurement process, and final approval is provided prior to the contracts being executed. Currently, CMS reviews the contracts for the enrollment counselor, the MCOs serving Plan Vital, and the PBM.

**Contract Administration Phase**

**Contract Clearance**

The PRDOH Budget Office reviews and approves the scope of work in the contract.

Once the proposal is approved by the Secretary of Health, the PRDOH Legal Department evaluates the scope of work and contract for correctness and completeness.

The contractor reviews and agrees to the proposal and contract, and signs the contract. The PRDOH Legal Department reviews the contract for any changes proposed by the vendor and the contract.

The approved scope of work/proposal documents are sent to the PRDOH Budget Office to prepare the documentation required to submit to the Puerto Rico OMB and Office of the Chief of Staff of the Governor of Puerto Rico, per Memorandum OSG-2019-001 and OMB Circular Letter 168-19.

The PRDOH Contract Office sends the contract to the Legal Office for final review.

The Secretary of Health reviews the final scope of work/proposal and contract and signs the contract.

**Contract Clearance**

The Finance Office provides the latest contract amount and/or fee schedule and reviews the terms and conditions for payment, and sends the documentation to the Legal Department.

The Legal Department makes sure the legal certifications collected from the vendor’s proposal are up-to-date. The legal director certifies the contract complies with all government legal rules and recommends signature to the Executive Director, who signs the contract.

For MAOs selected for Platino, the MAO’s response is sent to the Legal Department for the contracting process to continue. The contract draft is shared with MAOs to get their feedback. Once PRHIA and MAOs agree to the content and terms of the contract and sign the contract, the MAO contract is sent to CMS for approval.

**Contract Approval**

For all competitive contracts except those related to Health Care Delivery Services, the Finance Office submits the documents to PCo/OMB. In addition, if the bid is over \$10,000, the Executive Director specifies the Medicaid funding for the authorization request. OMB

## PRDOH's Competitive Contracts Funded by Medicaid

### Contract Approval

The PRDOH Budget Office submits the completed application via the PCo/OMB and PEPE systems to obtain the required budget approval from the OMB and the contract approval from the Office of the Chief of Staff of the Governor of Puerto Rico, and/or to FOMB for contract approval if the bid exceeds \$10M.

If the bid is over \$10,000, the Executive Director specifies the Medicaid funding for the authorization request. OMB reviews the certification and authorization request in the PCo/OMB and PEPE, and the Office of the Chief of Staff of the Governor of Puerto Rico evaluates the request for cost and efficiency reasonableness and/or compliance with public policy. The Office of the Chief of Staff of the Governor of Puerto Rico and the OMB jointly approve the PCo/OMB application. If the bid is under \$10,000, an emergency, or an amendment with no budget impact, approval from the Office of the Chief of Staff of the Governor of Puerto Rico and the OMB is not needed. If no response is received in 7 days, it is implied the OMB grants approval.

The PRDOH Contract Office emails the contract and required certification documents to the FOMB for approval. The FOMB reviews within 7 days and either approves the contracts, rejects, or request more information. If additional information is requested, FOMB will review and either approve the contract within 7 days or rejects it.

Once PCo/OMB and/or FOMB approves the contract, the PRDOH Contracts Office registers the contract with the Comptroller's Office within 15 days and files the contract documents. No service is provided until the contract is filed with the Comptroller's Office.

The PRDOH Contract Office distributes the contract in order for Finance and Accounting to pay the contractor.

All technology related contracts must have the Implementation Advance Planning Document Letter of Approval and the Contract Approval from CMS prior to contract engagement.

## PRHIA's Competitive Contracts Funded by Medicaid (including contracts for administering health care delivery services)

reviews the certification and authorization request in the PCo/OMB, and the Office of the Chief of Staff of the Governor of Puerto Rico evaluates the request for cost and efficiency reasonableness and/or compliance with public policy. The Office of the Chief of Staff of the Governor of Puerto Rico and the OMB jointly approve the PCo/OMB application. If the bid is under \$10,000, an emergency, or an amendment with no budget impact, approval from the Office of the Chief of Staff of the Governor of Puerto Rico and the OMB is not needed. Once the OMB sends the approval letter, the Legal Department prepares the contract and the Business Associate Agreement (BAA) and collect additional required documents from the contractor.

For contracts related to Health Care Delivery Services(e.g., MCO, enrollment counselor, and the PBM), the Office of the Chief of Staff of the Governor of Puerto Rico and the OMB are notified.

Contracts that exceed \$10 million need to be approved by the Fiscal Board before the contracts goes into signing.

The Executive Director and the contractor sign the contract, and Legal Department registers the contract with the Comptroller's Office within 15 days. No service is provided until the contract is filed with the Comptroller's Office.

When both of the parties sign the contract, the Legal Department completes the Comptroller Office contact registration.

The Administrative Office distributes the contract in order for Finance to pay the contractor.

Readiness reviews are conducted after the contracts are signed, followed by the program going live.

### Contract Oversight (MCO contracts)

This phase also covers the Health Care Delivery Services contracts and the oversight of the MCOs performed by Puerto Rico. The processes related to this are covered in detail in **Section 5** of this report.

Table 3. Competitive Contracting Process for PRDOH and PRHIA.

## 4.5 Current Processes for Non-Competitive Contracts Funded by Medicaid in Puerto Rico

As required by Congressional Requirement (f)(2)(A)(i) to examine the process used by Puerto Rico to evaluate bids and award contracts under the Medicaid State Plan, this section provides an overview of the non-competitive process awarding contracts administered by Puerto Rico that utilize Federal Medicaid funding. On a non-competitive basis, both PRDOH and PRHIA procure **Professional Services**. Territorial law authorizes non-competitive procurements for Professional Services. Definitions of

service types and the rules that govern them are set forth in Puerto Rico’s Uniform Administration Procedures law. Both PRDOH and PRHIA also procure through a non-competitive awarding process **Office/Space Leasing** funded by Medicaid federal and non-federal funds, which are for the local eligibility offices across the Island and the offices used by administrative staff. The activities conducted for each of the CMMM contracting phases are detailed in Table 5 below.

PRDOH’s Non-Competitive Contracts Funded by Medicaid	PRHIA’s Non-Competitive Contracts Funded by Medicaid
<b>Procurement Planning</b>	
<p>The business unit identifies a business need to procure a service/item/office.</p>	<p>A PRHIA unit/office/department identifies the business need(s), using their own experience for procuring products or services outside the organization that does not constitute an PRHIA employee job position.</p>
<b>Solicitation Planning</b>	
<p><b>Professional Services</b></p> <p>The procurement method is defined based on the needs identified by the agency and the corresponding guidelines for that need. Contracts for Professional Services from an individual are conducted on a non-competitive basis and awarded based on known experience and competence – as well as professional trust of the vendor.</p> <p>For technology related needs (e.g., Medicaid IT design, development, installation, or enhancement), the APD is drafted and submitted to CMS with the federal funding request.</p> <p><b>Office/Space Leasing</b></p> <p>The need for changing office/space leasing is identified and justified. Examples may be issues with the current office/space, the current contract is cancelled or ended, natural disaster damages the property beyond repair, and/or additional square footage is needed. The justification is documented, including the number of beneficiaries that will use the space.</p>	<p><b>Professional Services</b></p> <p>The procurement method is defined based on the needs identified by the agency and the corresponding guidelines for that need. PRHIA identifies the vendor with whom they would like to contract for Professional Services based on known experience and competence of the vendor.</p> <p><b>Office/Space Leasing</b></p> <p>The need for changing office/space leasing is identified and justified.</p>
<b>Solicitation</b>	
<p><b>Professional Services</b></p> <p>The business unit contacts the desired vendor to request a scope of work and their fee, which depends on the vendors’ years of experiences and qualifications. PRDOH must comply with territorial laws and regulations with solicitations. For example, PRDOH must consider the resources, infrastructure and experience when setting fees for Professional Services within a reasonable framework. The rate guideline for legal services, for example, depends on the attorney’s years of experience; the hourly rate may be up to \$125 for attorneys with more than 10 years of experience.<sup>25</sup></p>	<p><b>Professional Services</b></p> <p>The vendor is then contacted to provide a proposed scope of work and their fee, which may depend on the vendor’s years of experiences and qualifications. PRHIA must comply with territorial laws and regulations with solicitations. For example, PRHIA must consider the resources, infrastructure and experience when setting fees for Professional Services within a reasonable framework. The rate guideline for legal services, for example, depends on the attorney’s years of experience; the hourly rate may be up to \$125 for attorneys with more than 10 years of experience.<sup>25</sup></p>

<sup>25</sup> Office of the Governor of Puerto Rico. (July 2006). *Administration Principles that regulate the Hiring of Professional Services and Consultants in the Public Sector*.

## PRDOH's Non-Competitive Contracts Funded by Medicaid

The business unit director works with the Medicaid Executive Director to draft a letter of justification explaining the scope of work, benefits, costs and share of funding, and account fund codes to the Secretary of Health for approval and signature.<sup>26</sup>

### Office/Space Leasing

The Regional Directors are leveraged for their knowledge and help to identify possible spaces, including the options presented by the Review Board for Property Lease and Rental (Junta Revisora De Propiedad Inmueble in Spanish) based on recommendations from the Public Building Authority.

The Puerto Rico Medicaid Program (PRMP) team visits the locations and evaluates each with a PRDOH engineer. The engineer approves on the adequacy of the space. The PRMP team compiles information on each location (e.g., square footage, facilities, accessibility).

After space has been confirmed to meet the needs, an appraisal of the building by an independent appraiser is conducted as mandated by law.

## PRHIA's Non-Competitive Contracts Funded by Medicaid

The selection process varies based on experience, core competencies, and familiarity with the PRHIA.

After the service proposal is received, the director of the PRHIA department presents it to the Executive Director Office.<sup>26</sup>

### Office/Space Leasing

PRHIA researches the available buildings and spaces depending on the needs identified. The options from the Public Building Authority are assessed to identify if they meet the needs for the space usage and maximum occupancy. If none of the spaces made available by the Public Building Authority fulfil the needs, at least 3 additional private spaces are evaluated.

## Source Selection

### Professional Services

The letter of justification is submitted to the Secretary of Health for review and approval by the Medicaid Executive Director. The memo is then reviewed and signed and stamped by the Secretary of Health. If the Secretary does not agree with the letter of justification, they may recommend changes or ask for a different vendor /office location.

For technology related needs, CMS reviews the APD submitted and approves the request and associated budget.

### Office/Space Leasing

PRMP evaluates the options and submits to the Review Board for Property Lease and Rental, which evaluates the options and approves the selected option based on the request sent by PRDOH via OMB.

### Professional Services

The Executive Director and staff review the proposal, according to the recommended budget of each contract and the scope of work requested.

The Executive Director prepares a report to present to the Contracting Committee designated by the Board of Directors (BOD), schedules a meeting to evaluate the proposal with them, and discusses the recommendation that will be presented to the PRHIA's BOD. The Contracting Committee evaluates the proposal, the necessity of it, the amount for each service, and the maximum amount for the contract year.

The BOD reviews the Contracting Committee's recommendation and approve or decline the contract. If the BOD does not agree with the Contracting Committee's recommendation, they could recommend changes or ask for a different vendor.

When the BOD agrees with the proposal and statement of work, then the Executive Office sends the approved proposal to PRHIA's Finance Office. The Finance Department and Legal Department prepare the documentation required to submit to the OMB and Office of the Chief of Staff of the Governor of Puerto Rico, per Memorandum OSG-2019-001 and OMB Circular Letter 168-19.

<sup>26</sup> Federal procurement guidance *does not* apply to states or Puerto Rico, which specify for other non-federal entities four circumstances under which non-competitive procurements can be awarded from 45 CFR 75.329(f)(1)-(4).

**Office/Space Leasing**

If any of the spaces made available by the Public Building Authority meets the needs, PRHIA proceeds to the Contract Administration phase. If the selection is made for a space outside of the options from the Public Building Authority, PRHIA considers and evaluates the available private spaces and provides a recommendation. PRHIA's Executive Director approves the selected space and proceeds to the Contract Administration phase.

**Contract Administration**

**Contract Clearance**

The PRDOH Budget Office reviews and approves the scope of work in the contract.

Once the proposal is approved by the Secretary of Health, the PRDOH Legal Department evaluates the scope of work and contract for correctness and completeness.

The contractor reviews and agrees to the proposal and contract and signs the contract.

The PRDOH Legal Department reviews the contract for any changes proposed by the vendor and certifies the contract.

The approved scope of work/proposal documents are sent to the PRDOH Budget Office to prepare the documentation required to submit to the Puerto Rico OMB and Office of the Chief of Staff of the Governor of Puerto Rico, per Memorandum OSG-2019-001 and OMB Circular Letter 168-19.

The PRDOH Contract Office sends the contract to the Legal Office for final review. If approved by the Legal Office, then the contract is sent to the Secretary of Health, who reviews the final scope of work/proposal and contract and signs the contract.

**Contract Approval**

The PRDOH Budget Office submits the completed application via the PCo/OMB and PEPE systems to obtain the required budget approval from the OMB and the contract approval from the Office of the Chief of Staff of the Governor of Puerto Rico, and/or to FOMB for contract approval if the bid exceeds \$10 million.

**Contract Clearance**

The Finance Office review all the services proposals to submit in the PCo. This platform is created by the OMB to obtain the required budget approval from the OMB and the contract approval from the Office of the Chief of Staff of the Governor of Puerto Rico.

The Finance Office compiles the application form and certifications required and sends the documentation to the Legal Department for legal certifications and final evaluation.

The Legal Department collects other legal certifications and conducts the final evaluation. In addition to the proposal and its approval from the Board of Directors and Executive Director, Legal reviews the following documents:

- Certification from the Finance Office director, certifying that PRHIA has the budget for the contract.
- Certification from the Human Resources director, certifying that the contract does not constitute an PRHIA employee job position.
- The OMB/PCo approval application from PRHIA's Finance Office, which also includes Contractor Certification Requirement; Certification under de Government Ethics Code; Sworn Statement under Act 2-2018; and Evidence of being active under the System for Award Management, provided by the vendor.

After all documents are evaluated by the legal department, the legal director certifies the contract will comply with all government legal rules. The legal director's recommendation goes to the Executive Office through an internal form and a summary of completion of the process.

The PCo/OMB application and documents are then sent to the Executive Director for the Executive Director's certification required by the OMB and Office of the Chief of Staff of the Governor of Puerto Rico, which is forwarded the Finance Office.

**PRDOH’s Non-Competitive Contracts Funded by Medicaid**

If the bid is over \$10,000, the Executive Director specifies the Medicaid funding for the authorization request. OMB reviews the certification and authorization request in the PCo/OMB and PEPE, and the Office of the Chief of Staff of the Governor of Puerto Rico evaluates the request for cost and efficiency reasonableness and/or compliance with public policy. The Office of the Chief of Staff of the Governor of Puerto Rico and the OMB jointly approve the PCo/OMB application. If the bid is under \$10,000, an emergency, or an amendment with no budget impact, approval from the Office of the Chief of Staff of the Governor of Puerto Rico and the OMB is not needed. If no response is received in seven days, it is implied the OMB grants approval.

The PRDOH Contract Office emails the contract and required certification documents to the FOMB for approval. The FOMB reviews within 12 days and either approves the contracts, rejects, or request more information. If additional information is requested, FOMB will review and either approve the contract within 12 days or reject it.

Once PCo/OMB and/or FOMB approves the contract, the PRDOH Contracts Office registers the contract with the Comptroller’s Office within 15 days and files the contract documents. No service is provided until the contract is filed with the Comptroller’s Office.

The PRDOH Contract Office distributes the contract in order for Finance and Accounting to pay the contractor.

**Office/Space Leasing**

In addition to the steps outlined above, the Review Board for Property Lease and Rental evaluates the options and authorizes the option based on the request sent by PRDOH.

The Review Board for Property Lease and Rental evaluates the request and signs and approves the contract for the selected office/space.

**PRHIA’s Non-Competitive Contracts Funded by Medicaid**

**Contract Approval**

The Finance Office submits the completed application to PCo/OMB.

If the bid is over \$10,000, the Executive Director specifies the Medicaid funding for the authorization request. OMB reviews the certification and authorization request in the PCo/OMB, and the Office of the Chief of Staff of the Governor of Puerto Rico evaluates the request for cost and efficiency reasonableness and/or compliance with public policy. The Office of the Chief of Staff of the Governor of Puerto Rico and the OMB jointly approve the PCo/OMB application

If the bid is under \$10,000, an emergency, or an amendment with no budget impact, approval from the Office of the Chief of Staff of the Governor of Puerto Rico and the OMB is not needed.

For contracts awarded under emergency circumstances without approval from the Office of the Chief of Staff of the Governor of Puerto Rico or OMB, an email with the justification of the emergency must be sent to the Emergency Contracts Mailbox within 24 hours of the contract award. If the Office of the Chief of Staff deems that the action was unjustified, specific actions will be taken against the contract

If no response is received in seven days, it is implied that the OMB grants approval.

The OMB provides the budget approval for the contract to the Finance Office via PCo. The Finance Office sends the PCo/OMB approval certification to the Legal Department, along with a chart of all the approved contracts, its amounts for the fiscal year and the budget item account number.

Once Legal Department receives the OMB approval, an advisor in the Legal Department is assigned to the contract. The advisor collects additional documents and governmental certifications from the contractor and prepares the contract and the BAA.

Once all the documents and government certifications are received, the Legal Department contact the contractor to sign the BAA and contract. The Executive Directors sign the contract on behalf of the agency.

Once signed, the legal administrative assistant works on the pre-registry of the Puerto Rico’s Comptroller’s Office and Executive Director’s signature.

Once the contract is signed by both parties (PRHIA and Contractor), the administrative assistant completes the contract registration with the Comptroller Office.

Table 4. Non-Competitive Contracting Process for PRDOH and PRHIA.

## Analysis of Contracts Not Subject to Competitive Bidding or Requests for Proposal

Our contracting processes adhere to territorial laws and regulations. These provide a greater level of flexibility for contract procurement and awarding than some of the CMS guidelines for other non-federal entities, particularly as it relates to competitive bidding requirements.<sup>27</sup> In Fiscal Year 2020-2021, we awarded one percent of our total contract spending on a *non-competitive basis* for 133 Medicaid-funded contracts amounting to \$40.9 million.<sup>28</sup> As required by Congressional Requirement (f)(2)(a)(II), to examine which contracts are not subject to competitive bidding or requests for proposals under Medicaid State Plan, Figure 2 shows the dollar amount and percentage of the Medicaid-funded contracts awarded on a non-competitive or competitive basis by the Puerto Rico Medicaid Enterprise in FY 2020-2021. Additionally, Table 6 shows the contract amounts awarded on a non-competitive or competitive basis (as dollar values and percentages) for our four types of Medicaid-funded contracts: Health Care Delivery Services, Professional Services, Non-Professional Services and Goods, and Office Leasing.

**FY 2020-2021 Medicaid-Funded Contract Amounts Awarded on Competitive or Non-Competitive Basis**

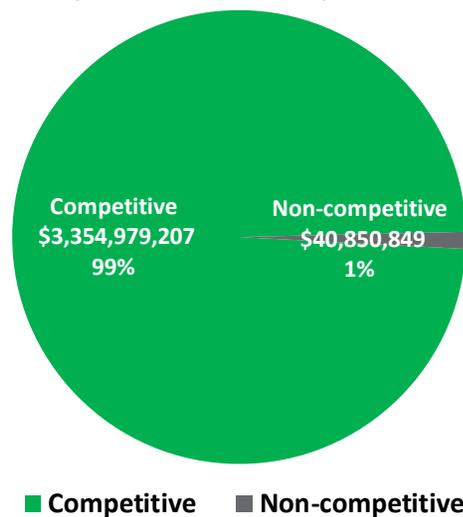


Figure 2. FY 2020-2021 Medicaid-Funded Contract Total Amounts Awarded on Competitive or Non-Competitive Basis.

Contract Type	Number of Contracts	Total Value	Awarded on Competitive Basis (Dollar Amount and as Percent of Value)		Awarded on Non-Competitive Basis (Dollar Amount and as Percent of Value)	
Health Care Delivery Services	20	\$3,331,750,214	\$3,311,677,214	>99%	\$73,000	<1%
Professional Services	85	\$77,240,783	\$41,737,266	54%	\$35,503,517	46%
Non-Professional Services	10	\$1,629,727	\$1,564,727	96%	\$65,000	4%
Office Leasing	50	\$5,209,332	\$0	0%	\$5,209,332	100%
<b>Total Amount</b>	<b>165</b>	<b>\$3,395,830,056</b>	<b>\$3,354,979,207</b>	<b>99%</b>	<b>\$40,850,849</b>	<b>1%</b>

Table 5. FY 2020-2021 Medicaid-Funded Contract Amounts Awarded on Competitive or Non-Competitive Basis, by Contract Type.

<sup>27</sup> Federal procurement guidance in from 45 CFR 75.329(f)(1)-(4) does not apply to states or Puerto Rico, which specify for other non-federal entities circumstances under which non-competitive procurements can be awarded.

<sup>28</sup> *Medicaid-funded contracts in FY 2020-2021*, as organized into contract categories, provided by Puerto Rico Medicaid Program and Puerto Rico Health Insurance Administration, November 2020. Contracts for FY 2020-2021 are not yet final, and contract amounts are subject to change.

The CMS Medicaid Manual Guide states that “all procurement transactions, regardless of whether by sealed bids or by negotiation, and without regard to dollar value, shall be conducted in a manner that provides the required open and free competition.” Moreover, it is mentioned that “The nature of a procurement for Fiscal Agent, MMIS or Automated Data Processing services/equipment suggests that the method of procurement be by competitive negotiation”.<sup>29</sup> As mentioned, for FY 2020-2021, Medicaid-funded contracts awarded on a non-competitive basis amassed to one percent of total Medicaid-funded contract spending, or \$40.9 million. With the incorporation of the recently approved PR GSA solicitation process and other recent mandates, we are working towards improving the non-competitive awarding process in order to provide contracting transparency and increase competition. Please refer to the report on **Requirement 3: Contracting Reform Plan**<sup>30</sup> for improvement initiatives for contracting and awarding on a non-competitive basis.

Contracts for health care delivery services procured non-competitively represent \$0.07 million in Medicaid-funded contract spending. The MCO contracts for Plan Vital, which were competitively bid and awarded, comprise the largest expenditure for not only health care delivery services contracts, but for all the Medicaid-funded contracts in total for Puerto Rico. The GAO stated that PRHIA’s procurement for Medicaid MCOs—which resulted in nearly \$4.4 billion for procurements lasting between two and three years—had a documented process that was consistent with federal guidance.<sup>31</sup> For health care delivery services, the non-competitive contracts are comprised predominately of the purchases of specific drugs for beneficiaries with certain conditions.<sup>32</sup>

The recently approved PR GSA solicitation process provides us the opportunity to improve our transparency and efficiency. Non-Professional Services and goods will be procured by vendors selected competitively through the PR GSA. As these services and goods are competitively bid and awarded by PR GSA, resulting in a list of pre-approved vendors available to the Puerto Rico Medicaid Enterprise, which has allowed us to move away from non-competitive bidding for Non-Professional Services and goods. About four percent of contract spending for Non-Professional Services and goods was awarded on a non-competitive basis in FY 2020-2021. For Non-Professional Services and goods in FY 2020-2021, non-competitive Medicaid-funded contracts were for cleaning and security services and amounted to \$65,000.

Office leasing contracts have a limited competitive nature as described in **Section 4**. Fifty contracts for Medicaid eligibility and administrative office locations across the Island were awarded on a non-competitive basis in FY 2020-2021 with \$5.2 million from Medicaid Federal and non-federal funds. Although there is limited competitive nature, we have a documented procedure and structure for procuring Medicaid-funded office leases. This can be seen above in Table 5 regarding the current processes for non-competitive contracts. It is important to note that, per the FOMB approved Fiscal Plan for the Government of Puerto Rico, we must continue consolidating our Medicaid eligibility offices from municipalities to regions. Currently, we have reduced the number of eligibility offices from 85 in 2017 to 64 as of December 2020. We could improve eligibility services for beneficiaries by looking at options to streamline the contracting processes for offices where we can reduce the traffic and use of contracted eligibility offices by implementing technology that allows for beneficiaries to automatically

<sup>29</sup> U.S. Centers for Medicare & Medicaid Services. *The State Medicaid Manual*. Retrieved from <https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021927>.

<sup>30</sup> PL 116-94: Further Consolidated Appropriations Act, 2020:(133 STAT 3105), Division N, Title 1 §202(a)(7)(A)(iii)

<sup>31</sup> In the inquiries received from the GAO in October 2020, the GAO also stated that federal procurement guidance from 45 CFR. 75.329(f)(1)-(4); 45 CFR. 75.329(d)(1); or 75.329(d)(3) *does not* apply to states or Puerto Rico.

<sup>32</sup> *Medicaid-funded contracts in FY 2020-2021*, as organized into contract categories, provided by Puerto Rico Medicaid Program and Puerto Rico Health Insurance Administration, November 2020. Contracts for FY 2020-2021 are not yet final, and contract amounts are subject to change.

recertify through electronic means. This action could transform the Medicaid eligibility office from one where the beneficiary goes to certify their eligibility to one where beneficiaries will go to handle eligibility exceptions or obtain service.

Of the 85 Professional Services contracts awarded by the Medicaid Enterprise in FY 2020-2021 using \$86.2 million in Medicaid funding, 71 contracts totaling \$35.5 million were awarded on a non-competitive basis for eight different types of services. Figure 3 shows the percentage of Medicaid-funded contract amounts for Professional Services that were awarded on a non-competitive and competitive basis, as well as the breakdown by service type of non-competitive Professional Service contract amounts in the Medicaid Enterprise for FY 2020-2021.

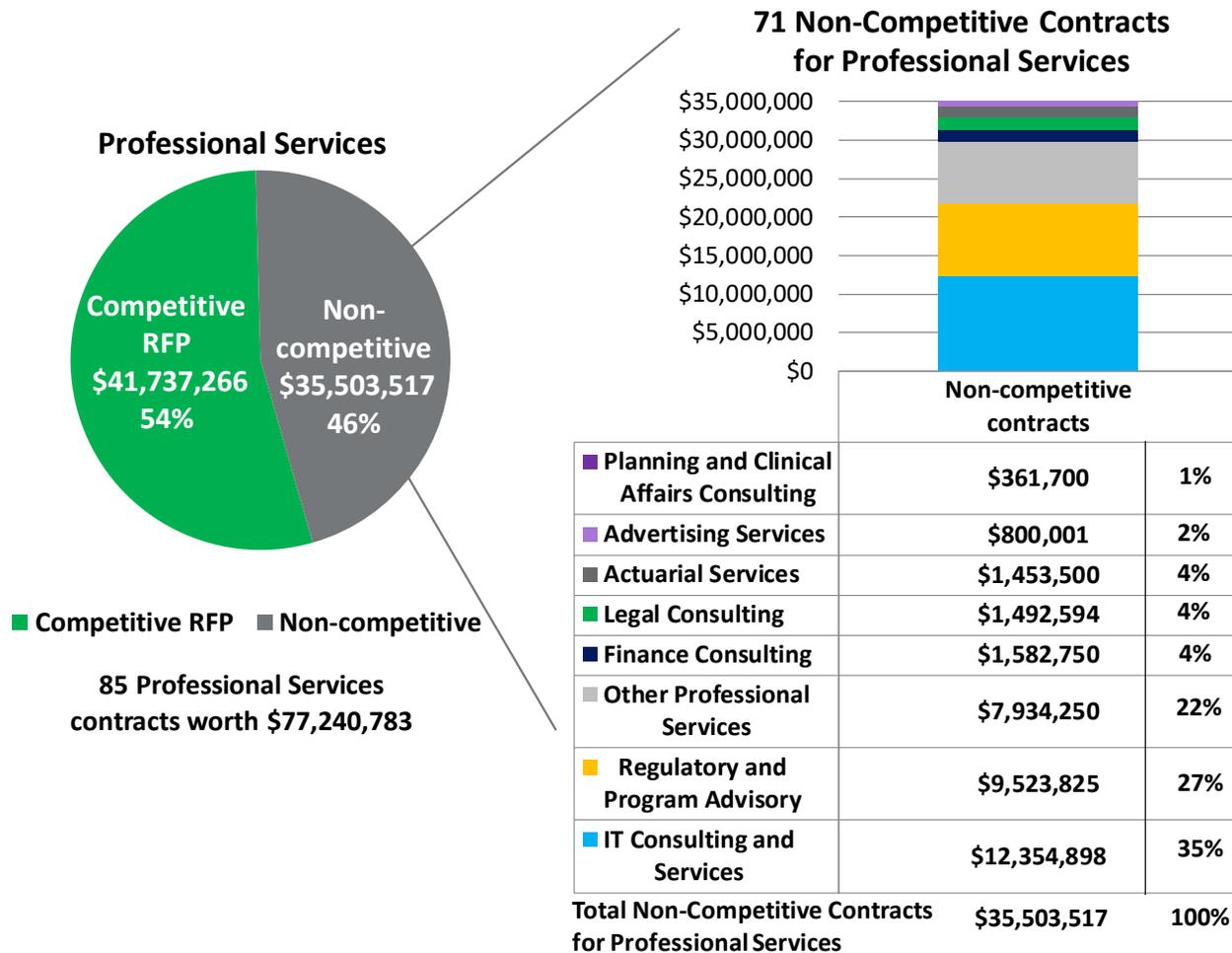


Figure 3. Professional Services Contract Amount Awarded on Competitive or Non-Competitive Basis for FY 2020-2021, and Breakdown by Service Type of Non-Competitive Professional Service Contract Amounts.

IT consulting and services accounted for \$12.4 million in FY 2020-2021, the largest percentage (35 percent) of non-competitive Professional Service contract spending that year. For example, we had a non-competitive procurement for independent verification and validation services (IV&V) of the Eligibility and Enrollment system in FY 2020-2021. There was a competitive procurement that resulted in the vendor being selected for the IV&V services in the PR MMIS project. The same vendor was selected for performing the IV&V services for the Eligibility and Enrollment system and this selection was approved by CMS. It is important to note that written authorization from CMS is received before procuring PR MMIS, Eligibility and Enrollment, and Health Information Exchange related contracts, and

territorial law authorizes non-competitive procurements for Professional Services. Other Professional Services awarded on a non-competitive basis include project management services, administrative temporary staffing services, and public relations; those accounted for \$7.9 million, or 22 percent, of non-competitive, Professional Service contract spending in FY 2020-2021.

In order to align more with leading practices and federal guidance, we could consider strategically developing procurements and exploring more ways to increase competition for contracts that receive Medicaid funding. Please refer to the report on **Requirement 3: Contracting Reform Plan**<sup>33</sup> for improvement initiatives for contracting and awarding on a non-competitive basis, which also addresses the Contracting risk area highlighted in the highlighted OIG Final Report findings, titled '**A-02-20-01011 Risk Assessment Puerto Rico Medicaid Program**'<sup>34</sup>.

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<sup>33</sup> PL 116-94: Further Consolidated Appropriations Act, 2020:(133 STAT 3105), Division N, Title 1 §202(a)(7)(A)(iii)

<sup>34</sup> Office of Inspector General, Department of Health & Human Services. (December 11, 2020). A-02-20-01011 Risk Assessment Puerto Rico Medicaid Program. Retrieved from <https://oig.hhs.gov/oas/reports/region2/22001011.asp>.

## 5. MANAGED CARE CONTRACTS SUBJECT TO OVERSIGHT BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES

### 5.1 Overview of Puerto Rico's Contract Oversight Environment

Managed care contract oversight is a shared effort across the Medicaid Enterprise in Puerto Rico, with support provided by Puerto Rican and Federal government agencies, external organizations, providers, our beneficiaries and their advocates. The Puerto Rico Department of Health (PRDOH) administers the Medicaid and the Children's Health Insurance Program (CHIP) and delegates the administration of the contracts for the managed care delivery system to the Puerto Rico Health Insurance Administration (PRHIA).

Managed care contract oversight focuses on eight functional areas:

- Monitoring activities to contract standards refers to the monitoring of systems that must be in place to address all aspects of the managed care program, including the performance of each Managed Care Organization (MCO).<sup>35</sup>
- Quality improvement and medical management refers to the oversight of the comprehensive quality strategy for assessing and improving the quality of health care and services provided by the MCOs.<sup>36</sup>
- Provider networks and access to care refers to the oversight activities that determine the suitability of an organization's network to serve its Medicaid beneficiaries.<sup>37</sup>
- Program integrity refers to implementing and maintaining arrangements or procedures to detect and prevent fraud, waste, and abuse.<sup>38</sup>
- Grievances and appeals refer to the systems in place for a grievance process, an appeals process, and access to the state's fair hearing system.<sup>39</sup>
- Marketing and communication refer to marketing conducted by the MCOs is accurate and does not mislead, confuse, or defraud the beneficiaries or the state agency.<sup>40</sup>
- Enrollment and disenrollment of beneficiaries and providers refers to the enrollment processes where the enrollee chooses an MCO or is assigned one using default enrollment processes.<sup>41</sup>
- Finance and payment refer to the reporting and transparency functions that Puerto Rico must conduct to guarantee MCO compliance, including financial audits.<sup>42</sup>

Figure 4 depicts the agencies involved in the managed care contract oversight functional areas. Each abovementioned function is represented by a color.

<sup>35</sup> 42 CFR 438.66.

<sup>36</sup> 42 CFR 438.340.

<sup>37</sup> 42 CFR 438.68.

<sup>38</sup> 42 CFR 438.608 / 42 CFR part 455 / 42 CFR 433, Subpart D.

<sup>39</sup> 42 CFR 438.402 / 42 CFR 457.1260 / 42 CFR 431.

<sup>40</sup> 42 CFR 438.104.

<sup>41</sup> 42 CFR 438.56 / 42 CFR 438.54.

<sup>42</sup> 42 CFR 447 / 45 CFR part 75.

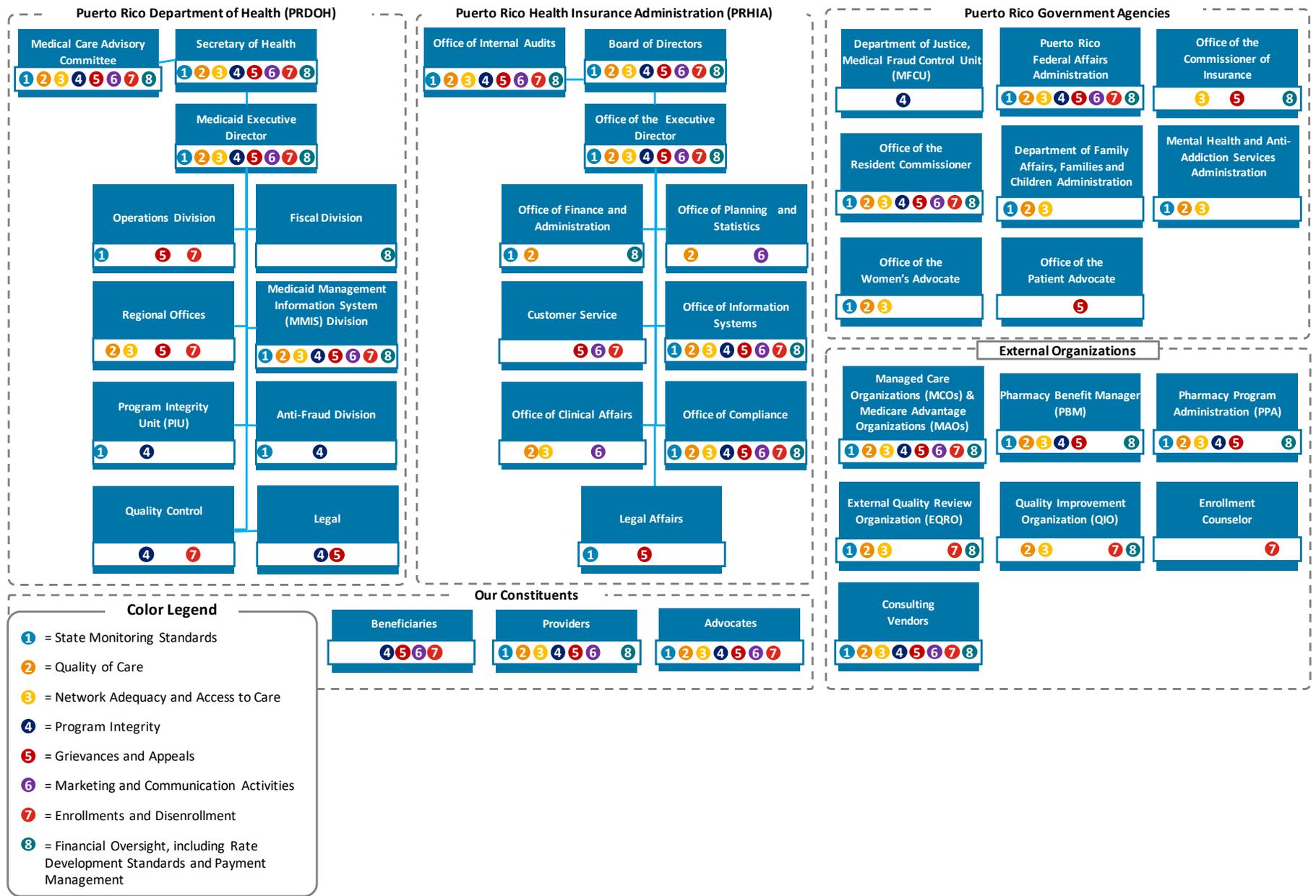


Figure 4. Puerto Rico's Contract Oversight Environment for Medicaid and CHIP Managed Care.

The Puerto Rico Medicaid Program (PRMP) is the department within PRDOH responsible for administrating Title XIX and XXI of the Medicaid and Children’s Health Insurance Program (CHIP) State Plan. Puerto Rico is advised by its Medical Care Advisory Committee about the health care services provided to the beneficiaries of Plan Vital in accordance with 42 CFR 431.12.

PRHIA maintains contracts with MCOs, Medicare Advantage Organizations (MAOs), the Pharmacy Benefit Manager (PBM), and the Pharmacy Program Administration (PPA), among others, in order to provide beneficiaries with broad health care services.

Puerto Rico administers contracts with external vendors to provide services and advise and manage certain aspects of the managed care delivery system.

- MCOs and MAOs are health insurance companies that manage the health care provided to Medicaid beneficiaries.<sup>43</sup>
- Providers contract with MCOs/MAOs and provide direct health care services to eligible beneficiaries. To receive payment for services, providers must submit an electronic or paper claim to a beneficiary’s MCO within 90 days of the beneficiary’s treatment date.
- The PBM delivers the pharmacy benefit to Medicaid beneficiaries in Puerto Rico by contracting with a network of participating pharmacies; administering the formulary, clinical programs, and the claims processing system services; and coordinating with the MCOs.
- The PPA is responsible for the rebate program management services for branded drug products; development and maintenance of the Maximum Allowable Cost list for generic drug products; development of Covered Medication Formularies for the program; and coordinating with the MCOs.
- The External Quality Review Organization (EQRO) is contracted by PRDOH to conduct the annual review of Puerto Rico’s Medicaid managed care organizations administering Plan Vital and the MAOs administering the Medicare Platino program.
- The Quality Improvement Organization (QIO) is contracted to conduct audits of Puerto Rico’s Medicaid MCOs on targeted quality-related activities (i.e., preauthorization, disease management, physician incentive program, special coverage, and hospital admission and length of inpatient stay).
- The enrollment counselor provides essential choice counseling, educational and enrollment functions to support active Medicaid beneficiaries during their annual open enrollment period and ongoing for newly eligible individuals.
- Multiple consultants are contracted to advise on regulations and policies and/or provide actuarial services, as well as provide tools to support administration, management and oversight of the Medicaid and CHIP programs.

Other Puerto Rican governmental entities involved in Puerto Rico’s Medicaid contract oversight include:

- Puerto Rico’s Department of Justice, Medicaid Fraud Control Unit (MFCU) (Departamento de Justicia de Puerto Rico, Unidad de Control de Fraude in Spanish), coordinates with PRDOH and PRHIA to refer suspected criminal cases of Medicaid fraud to the appropriate prosecuting authority.

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<sup>43</sup> Puerto Rico currently contracts with First Medical Health Plan; MMM Multi Health, LLC; Plan De Salud Menonita, Inc.; and Triple-S Salud, Inc. to administer the government health insurance program, Plan Vital.

- Puerto Rico Federal Affairs Administration (PRFAA) represents the Government of Puerto Rico before federal, state, and local governments. The office promotes the Government of Puerto Rico's economic and public policy initiatives to achieve a better quality of life for the nearly 3.5 million U.S. citizens living in Puerto Rico and advises local government agencies and municipalities on issues of interest to Puerto Rico before the federal government.
- Puerto Rico Office of the Commissioner of Insurance (also known as the Puerto Rico Insurance Commissioner's Office, or PRICO) licenses or authorizes each insurer including MCOs and MAOs and reviews their financial statements. MCOs and MAOs are subject to the Puerto Rico Insurance Code and its applicable regulations.<sup>44</sup>
- Office of the Resident Commissioner of Puerto Rico is an elected official chosen by the people of Puerto Rico in each General Election to be their authorized representative before Congress and the Federal Government.
- Puerto Rico Department of Family Affairs, Families and Children Administration (Administración de Familias y Niños in Spanish) is responsible for foster care children in the custody of the Government of Puerto Rico, for whom the MCOs provide health care services.
- Puerto Rico Administration of Mental Health and Anti-Addiction Services (Administración de Servicios de Salud Mental y Contra la Adicción in Spanish, or ASSMCA) is responsible for the planning and establishment of mental health and substance abuse policies and procedures and for the coordination, development, and monitoring of all behavioral health services rendered to enrollees in Plan Vital.
- The Office of the Women's Advocate, as established by Puerto Rico Law No. 20 of 2001 as amended, serves as an ombudsman office tasked with protecting victims of domestic violence and coordinating governmental and non-profit agencies offering prevention and intervention services.
- The Office of the Patient Advocate of Puerto Rico (Oficina del Procurador del Paciente in Spanish) is tasked with protecting the patient rights and protections contained in the Patient's Bill of Rights Act and helps with complaints, grievances, appeals and/or suspected fraud and abuse reported to their hotline, as established in Puerto Rico Law No. 11 of 2001, as amended by Law No. 77 of 2013.

## 5.2 Assessment of Puerto Rico's Managed Care Contract Oversight Processes

To comply with Congressional Requirement (f)(2)(a)(iii) examine oversight by the Centers for Medicare & Medicaid Services (CMS) of contracts awarded under the Medicaid State Plan; in this section we evaluated Puerto Rico's adherence to oversight and compliance activities for managed care contracts as established by CMS through the Medicaid and CHIP Managed Care Final Rule in 2016. CMS has since updated regulations for Medicaid and CHIP Managed Care in 2016, 2017, and 2020. The CMS Medicaid and CHIP Managed Care Final Rule (2016 Final Rule) aligns key requirements with those of other health insurance programs, modernizes how Medicaid programs purchase managed care for individuals, and strengthens the consumer experience and key consumer protections. It includes the following goals:

- To support state efforts of advancing delivery system reform and improve the quality of care
- To strengthen the individual's experience of care and key beneficiary protections
- To strengthen program integrity by improving accountability and transparency
- To align key Medicaid and CHIP managed care requirements with other health coverage programs

<sup>44</sup> Office of the Commissioner of Insurance, Commonwealth of Puerto Rico. The Puerto Rico Insurance Code and its applicable regulations as well as information for licensees can be retrieved from <http://ocs.gobierno.pr/enocspr/>.

The 2020 Final Rule strives to achieve a better balance between appropriate federal oversight and state flexibility, while also maintaining critical beneficiary protections, ensuring fiscal integrity, and promoting accountability for providing quality of care to people receiving Medicaid and CHIP.

The scope of the Final Rule aligns to eight functional areas of oversight required by CMS. Each of these areas is described and analyzed in detail in the following sections:

- Section 5.3 State Monitoring Standards
- Section 5.4 Quality of Care
- Section 5.5 Network Adequacy and Access to Care
- Section 5.6 Program Integrity
- Section 5.7 Grievances and Appeals
- Section 5.8 Marketing and Communication Activities
- Section 5.9 Enrollment and Disenrollment
- Section 5.10 Financial Oversight, including Rate Development Standards and Payment Management

For each of the areas, we included a description of the functional area, current processes and stakeholders involved, and opportunities we are considering for enhancing our contract oversight processes.

## 5.3 State Monitoring Standards

### Functional Area Description

In accordance with 42 CFR 438.66, Medicaid programs must have a monitoring system to address all aspects of the managed care program, including performance of each MCO. This functional area includes:

- Establishing contract standards
- Deliverable collection, tracking, and reporting against the standards
- Compliance against contract standards, including audits and reviews conducted by/for various groups
- Graduated remediation, penalties, and sanctions

### Current processes in Puerto Rico and stakeholders involved

#### Establishing contract standards

Puerto Rico established contract standards in the development of the managed care Request for Proposal (RFP) and Plan Vital contract, as well as the Medicare Platino program’s Request for Information (RFI) and MAOs’ contract. In addition, a new Chief Compliance Officer was hired in July 2020 to work directly with the MCOs on oversight activities. Each coordinator in the PRHIA Compliance Office focuses on a management area (e.g., Integrity; Privacy; Health Insurance Portability and Accountability Act [HIPAA]; Fraud and Abuse) and an MCO. In addition, we have two backup coordinators that are assigned to two MCOs each and are intended to cover any incidents with the main coordinator. These backup coordinators attend all meetings with the main compliance coordinators and are included in communications related to those MCOs.

As shared in the FY 2020 Annual Report in October 2020, our team developed a Comprehensive Oversight and Monitoring Plan for Medicaid managed care. Using a top-down approach to oversight, the Plan describes how Puerto Rico can measure and manage Medicaid and CHIP MCO performance by using key performance metrics, which are then compared to certain benchmarks (i.e., benchmarks over time, benchmarks against peers’ submissions, or benchmarks to expected outcomes). Figure 5 below represents the key components of the oversight program from the Plan.

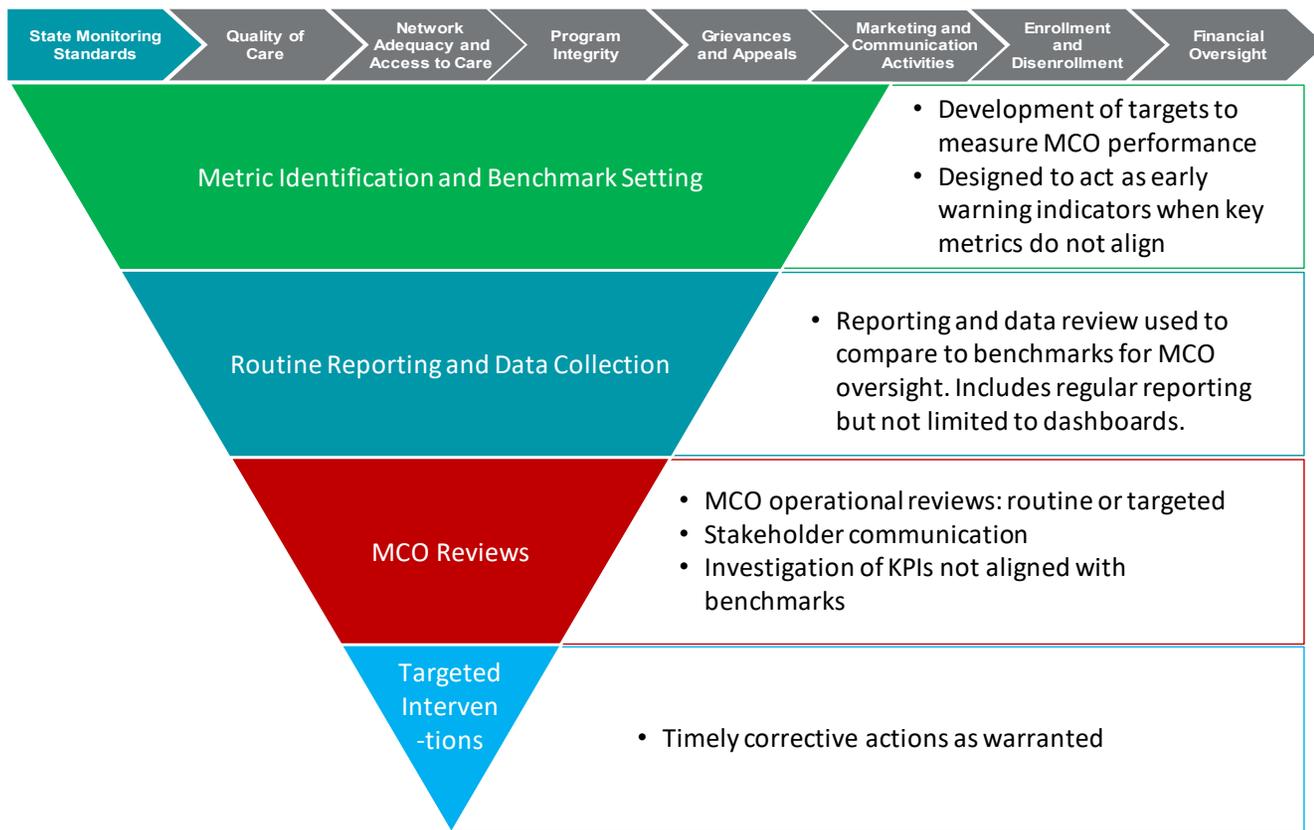


Figure 5. Oversight and Monitoring Plan Key Components.

### Deliverable collection, tracking and reporting against the standards

To follow the Comprehensive Oversight and Monitoring Plan, a series of reporting templates, along with the Plan Vital Reporting Guide, are provided to the MCOs to capture their data. The MCO contract currently defines 36 reports required from the MCOs, which are included in Table 11 in the Appendix. Those documents outline the different reporting requirements and contract standards for Medicaid MCOs. The required reports range from utilization files, network adequacy reports, and financial reports to grievance and appeals summaries and are provided by the MCOs on a weekly, monthly, quarterly, semi-annual, or annual basis.

Starting in July 2020, we have been converting reporting templates to a uniformed file format (i.e., Extensible Markup Language [XML]) to collect data from MCOs. Our team is working closely with the MCOs to assist with the ongoing transition. In addition, we also provide trainings to MCOs on how to complete the reporting templates and comply with the new file format. Once an MCO completes the report and posts the XML file to our secure file transfer site, the information is transferred into the electronic data warehouse utilized by the Medicaid Enterprise to review the file format and further process and analyze the information.

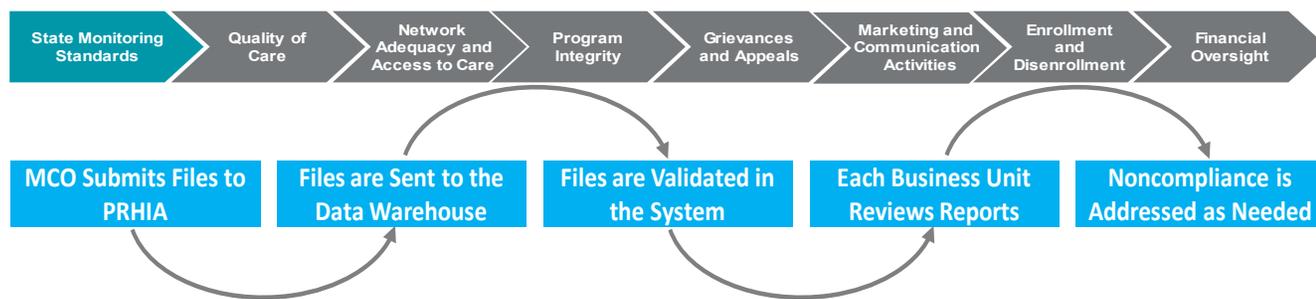


Figure 6. MCO Reporting Data Flow.

For this process, and as can be seen in Figure 6, the MCOs send proprietary reports and files to PRHIA, which are then validated for format consistency. MCOs submit their reports and deliverables electronically, using the templates and guidelines provided. Additionally, MCOs provide narrative notes in unstructured formats, such as MS Word documents, to explain abnormalities or significant changes with their reported data. We have an electronic data warehouse (EDW) to store the structured data reported from MCOs and check the reports for the appropriate data layout and required format. This information system also has a dashboard interface for each office/business unit to review the MCOs' data and reports, to which they are assigned. For example, there are multiple dashboard interfaces for PRHIA's Finance, Customer Service, and Compliance teams. Analysts then compile and extract the relevant information and pass the files into the validation system, which allows for information to be better organized for dashboards and visualizations. Each business unit then checks the corresponding information contained within the reported files and identifies issues. If the reports do not meet the contract standards, the specific business units then follow up with the individual MCO to assess the severity of the issue and take the required corrective action. If the report is not corrected or action is not taken in a timely manner, the business units refer the issue back to the PRHIA Compliance Office for an investigation to be conducted. This investigation will then carry a corresponding corrective action plan with the MCO and/or an escalation to the PRHIA Legal Department for formal sanctions to be taken.

In addition, while information received from the MCOs is stored in the EDW, this information may then be shared with the PR Medicaid Management Information System (MMIS) system through a set of system interfaces. The next development cycles for the PR MMIS plan to address financial management, including expanding the capabilities to provide more broad reporting that may be leveraged in MCO oversight and internal reporting processes, including the development of the CMS-64 and CMS-37 reports.

The Plan Vital Reporting Guide also describes the contract standards for each report. The list of reports required from MCOs are presented in Table 11 in the Appendix.<sup>45</sup> For example, the *Call Center report* (Report 1) captures information about Enrollee and Provider services and Medicaid Advice lines. This report is submitted on a monthly basis, and it is also linked to specific requirements outlined in the MCO contract. In addition, the specific reporting parameters are detailed, such as calls received, abandoned calls, and blocked calls. Another example is the quarterly *Fraud, Waste, and Abuse Report* (Report 3), which captures parameters such as fraud, waste, and abuse cases, allegations, investigations, suspensions, and terminations. Other specific reporting metrics are detailed in how

<sup>45</sup> Puerto Rico Health Insurance Administration. *Plan Vital MCO Contract Attachment 16 – List of Reports*. Retrieved from <https://www.asespr.org/wp-content/uploads/2019/01/FIRST-MEDICAL-HEALTH-PLAN-INC.-ATTACHMENT-16.pdf>.



MCOs must verify that they report any investigation of fraud, waste, or abuse within two business days of completion.

## Compliance against contract standards, including audits and reviews conducted by/for various groups

As described in the previous section, we use an electronic data warehouse that allows business units to better track their respective information. Each business unit has separate dashboards and screens to aid in the monitoring of their assigned reports/data. Furthermore, each business unit then has 15 days to review their assigned reports. If a certain contract standard is not met, the business unit must send a formal report to the PRHIA Compliance Office for further escalation.

We recently designed new oversight tools to track compliance of MCOs. There are two components in the compliance tools: the reporting tools and templates (supported by the Plan Vital Reporting Guide), and the new compliance tool. Risk assessments are conducted for each MCO in Plan Vital using 178 Key Performance Metrics (KPIs) collected from MCO reports and deliverables. Table 11 in the Appendix denotes which MCO reports inform our KPIs. The KPI metrics for each MCO are displayed in the compliance tool and organized into six targeted oversight areas:

- Network Access and Availability
- Program Integrity/Compliance
- Quality and Clinical Management
- Financial
- Claims and Encounters
- Pharmacy

These new compliance tools will be used to track KPIs from MCO self-reported data and compare that against national benchmarks and historical trends. The KPI metrics are also divided into three tiers to allow for more targeted monitoring, ranging from a high-level executive management view with tier 1, an office director-level view with tier 2, and a staff analyst-level view of day-to-day metrics with tier 3. The compliance tools are still in development and are being launched in phases.

We also recently developed a Compliance Work Plan focusing on areas that require detailed monitoring and reporting based on risk and exposure analysis, identified by changes seen in quantified and documented analyses and KPIs. The Compliance Work Plan is intended to define, among others, the evaluation, review, monitoring, and audit activities to be carried out and the owners (i.e., those responsible for carrying them out). The Work Plan also describes internal activities such as developing an electronic inventory of internal policies and procedures, staff training, and reviewing the internal code of conduct.

We conduct multiple reviews and audits of MCO performance and compliance, which are described in the table below. As a starting point to the oversight activities, reviews, and audits, we hold a kick-off meeting with the MCOs/PBMs/MAOs. As part of that meeting, PRHIA issues an RFI of all areas subject to our oversight and/or review. Once the information is received, we review it to determine if a non-compliance issue is identified and additional meetings to discuss the issues are held with the MCOs. Once the oversight activities, reviews, and audits are finalized, we hold a close-out meeting with the



MCOs. If an issue identified as non-compliant, a Corrective Action Plan can be required for tracking and resolution.

Audit/Review Conducted	Description	Frequency
Operational Reviews	Operational reviews allow for real time opportunities to address areas where MCOs may be incurring challenges. Operational reviews can include desk reviews, staff and leadership interviews, and could cover several operational topics such as Organizational Management and Claim Management.	Varies based on the operational topic / deliverable being reviewed -Once, Annually, or Quarterly
Targeted Reviews	Targeted reviews address and resolve issues in between operational reviews and could be conducted in a similar way to operational reviews. These reviews are structured in a targeted manner that offers an opportunity to communicate directly with MCO leadership around identified issues.	As needed
External quality review	The annual external quality review is delivered via a summary in a detailed technical report that aggregates, analyzes, and evaluates information on the quality, timeliness, and access to health care services that MCOs furnish to Medicaid beneficiaries. This report also contains an assessment of the strengths and weaknesses of MCOs regarding health care quality, timeliness and access, makes recommendations for improvement, and assesses the degree to which previous recommendations were addressed by the MCOs.	Annual
Performance Audits	Audits of targeted MCO processes are used to determine whether MCOs are meeting specific contractual performance requirements. For example, our Quality Improvement Organization (QIO) conducts quarterly audits of the MCO's process and compliance of prior authorizations, care management, and the Health Care Improvement Program (HCIP).	Quarterly
Compliance Audits	Compliance audits are based on risk analysis and root cause identification analysis. For example, every six months we audit the MCOs' processes for provider contracting and credentialing to validate the monthly <i>Network Provider List (NPL)</i> (Report 15).	Quarterly
Financial Audits	These audits relate to the general financial operations of the MCOs serving Plan Vital, and are conducted yearly by an independent and certified auditing organization.	Annual
MCO Readiness Reviews	A multidisciplinary team appointed by PRHIA conducts these reviews three months before the start of a new managed care program and when the contractor will provide or arrange for the provision of covered services to new eligibility groups. These reviews include desk and onsite reviews of documents, walkthrough(s) of the MCO's facilities, information system demonstrations, and interviews with staff, to assess the Contractor's ability to meet contractual requirements.	Before the start of a new managed care program or new eligibility group

Table 6. Reviews and Audits Conducted.

We conduct operational reviews to confirm MCOs' ongoing operational processes and procedures comply with requirements, and to follow up on issues uncovered through reporting issues, other



audits/reviews, and corrective action plans. Operational reviews are intended to complement the detailed annual evaluations conducted by the EQRO. We could aim to complete operational reviews every two years, along with targeted reviews to address and resolve escalated issues as needed. Given the COVID-19 pandemic, conducting onsite operational reviews has been limited; therefore, we currently conduct remote desk reviews. After an operational review is conducted, Puerto Rico generates a formal report and shares with the MCO any findings and requests for corrective actions. As noted in the Comprehensive Oversight and Monitoring Plan, effective cross-departmental communication is critical to streamlining focus areas for the operational reviews and could be improved.

Meetings related to oversight activities, reviews and audits are held with MCOs’ Compliance, Senior Management and any additional applicable stakeholders. Depending on the issues identified, all parties meet to discuss on an as-needed basis. For example, during the COVID-19 pandemic, there have been weekly meetings held with the MCOs, PBMs, and the MAOs. We conduct quarterly visits with MCO’s Compliance department for discussion of compliance issues and/or reports of suspicious fraud, abuse or integrity activities. The PRMP Medicaid Program Integrity Office, MFCU, and PRHIA Compliance Office also meet on a quarterly basis to design and implement compliance and fraud and abuse prevention strategies and trainings. We conduct compliance meetings (at least twice per year) with medical groups and representatives from all geographic areas in Plan Vital to present results from satisfaction surveys and identify and discuss issues or concerns with MCOs. In addition, we send quarterly reports to the PRHIA Board of Directors and weekly reports to CMS.

For more information on the external quality review and other quality-related reviews and audits, please refer to Section 5.4 Quality of Care. For more information on the financial audits, refer to Section 5.10 Financial Oversight, including Rate Development Standards and Payment Management.

### Graduated remediation, penalties, and sanctions

As non-compliance issues are identified by individual offices, they are referred to the PRHIA Compliance Office to further investigate and address with the MCO in a corrective action plan for remediation. The individual offices may be involved to review the MCO’s corrective actions, if needed. If remediation is not met and the MCO fails to comply, the PRHIA Legal Department may pursue a stronger course of action through intermediate sanctions and/or fines, liquidated damages, and/or contract termination, which are specified in Articles 19 and 20 of the Plan Vital Contract. Depending on the severity of non-compliance, we may conduct targeted interventions such as:

- **Corrective Action Plans (CAPs):** Puerto Rico may require a corrective action from an MCO for the non-compliance issue identified, including a summary of the finding. MCOs are then required to provide a response and a corrective action plan describing how they will resolve the issue within a timeline with defined milestones. The PRHIA Compliance Office reviews and approves such plan and tracks the progress on the CAPs.
- **Intermediate Sanctions:** Puerto Rico may impose sanctions and monetary penalties for three categories of events, per Article 19 of the Plan Vital Contract. In 2019, we sanctioned two MCOs for non-compliance.<sup>46</sup> Other intermediate sanction could include appointing temporary management

<sup>46</sup> Puerto Rico Health Insurance Administration. *Notifications of Sanctions to MCOs*. Retrieved from <https://www.asespr.org/beneficiarios/comunicados/notificaciones-de-multas/>.



for the MCO’s operations, terminating enrollment into an MCO, suspending new enrollment into an MCO, and/or suspending or delaying payment to an MCO.

- **Liquidated Damages:** Puerto Rico may assess liquidated damages for an MCO’s breach or failure to comply for four categories of events, or may withhold a portion of an MCO’s payment, per Article 20 of the Plan Vital Contract.
- **Contract Termination:** Depending on the severity of the non-compliance, Puerto Rico may terminate all or part of the MCO contract.

Per the memorandum of understanding between PRDOH and PRHIA, PRHIA is further required to report any MCO contract non-compliance penalty assessments, and policy and procedures for overseeing the performance of the MCO contracts.

## Opportunities for enhancing the contract oversight processes

### Opportunity to Integrate Oversight Teams

**Challenge:** We assign primary and backup coordinators from the PRHIA Compliance Office to each of the MCOs to serve as clear point of contact for oversight and compliance activities. These individuals act as a liaison with the MCO and a project manager responsible for tracking progress on corrective actions and remediations, and informing other departments and offices as needed. While we are working to cross train our staff, workload constraints currently leave PRHIA vulnerable in the event of employee turnover, sick leave, or other circumstances.

**Leading Practice:** A leading practice is to have a team coordinating with the MCOs, instead of a single point of contact, exposing coordinators to multiple functional areas across MCOs and creating overlap across staff to reduce reliance on a single staff member.

**Opportunity:** With additional resources, we could consider expanding the primary coordinator to a team and increasing the backup coordinators, reducing the workload, allowing for more effective staff and meaningful MCO interactions. Having an integrated team working together across MCOs/MAOs would allow us to increase cross-training and cross-coverage, enabling us to better distribute the workloads and increase capacity for our staff to respond to urgent issues timelier. In turn, we can build stronger capabilities to identify trends across MCOs/MAOs and work through complex oversight issues. This emphasis on cross-cutting teams would also address Program Management risk area highlighted in the final report findings, titled ‘**A-02-20-01011 Risk Assessment Puerto Rico Medicaid Program**’<sup>47</sup>

### Opportunity to Improve the Governance of Contract Oversight Processes

**Challenge:** In an informal manner, the PRHIA Compliance Office may share findings from ongoing investigations, corrective actions, and remediations with the departments or offices involved in the original non-compliance issue. The PRHIA Compliance Office may also involve other offices in reviewing the MCO’s progress and corrective action, as needed. Although the PRHIA directors meet

<sup>47</sup> Office of Inspector General, Department of Health & Human Services. (December 11, 2020). A-02-20-01011 Risk Assessment Puerto Rico Medicaid Program. Retrieved from <https://oig.hhs.gov/oas/reports/region2/22001011.asp>.

every two to three weeks to discuss priorities, information on oversight and compliance is not shared routinely in regular meetings with directors and leadership. The structure for sharing trends and findings, and the escalation procedures can be improved.

**Leading Practice:** A leading practice seen in other Medicaid programs is developing a standard process for identifying risks, sharing information, and making decisions, which has the desired outcomes of sharing relevant, actionable information at the right time, engaging MCOs in meaningful ways, and enabling effective operations and intentional goal-setting at the Medicaid agency. Medicaid programs have governance structures focused on MCO performance, supporting collaborative and routine sharing of trends or patterns across all MCOs with the broader department or Medicaid Enterprise. An actionable oversight governance cycle starts with oversight and compliance activities that inform program and cross-departmental analyses. These in turn result in escalation of critical issues, and greater leadership awareness and engagement with MCOs. The agency analyzes issues to identify root causes and develops intervention strategies and improvements to address gaps throughout the governance cycle. As examples, to address gaps in collaboration, decision-making, or issue escalation, the agency may identify changes or new processes related to how information is used or shared (e.g., MCOs reporting package) or with meetings and activities (e.g., meetings with MCO leadership, operational reviews).

**Opportunity:** A governance model can be created to enable all departments across the Medicaid Enterprise to discuss, routinely and prior to each formal review, potential issues and/or positive results uncovered through the various oversight activities of MCOs. In addition, practices to formalize meetings with MCOs should be further encouraged, on at least a monthly cadence. This process can better inform our leadership and staff across the Medicaid Enterprise as they monitor MCO performance and compliance, conduct reviews and audits, and engage with MCOs.



## 5.4 Quality of Care

### Functional Area Description

The Quality of Care functional area refers to the monitoring of the comprehensive quality strategy for assessing and improving the quality of health care and services provided by the MCOs via quality and performance improvement programs [42 CFR 438.340]. In addition, Medicaid programs must require MCOs, through contracts, to establish and implement an ongoing comprehensive Quality Assessment Performance Improvement (QAPI) program for services it furnishes to enrollees [42 CFR 438.330 / 42 CFR 457.1240]. It also includes the management of external quality reviews via EQROs in charge of conducting the validation of MCO performance measures for contract compliance [42 CFR 438.350 / 42 CFR 457.1250]. This functional area also includes:

- Puerto Rico Medicaid Managed Care Quality Strategy
- External quality reviews: Each MCO must be reviewed by an External Quality Review Organization (EQRO) at least annually, with enough information being collected via an EQRO in charge of conducting the validation of MCO performance measures for contract compliance
- Utilization management and prior authorization
- Quality and performance improvement programs (QAPI and PIPs)
- Monitoring Quality Measures and Outcomes in Claims and Encounter Data

### Current processes for the functional area in Puerto Rico and stakeholders involved

#### Puerto Rico Medicaid Managed Care Quality Strategy

The Medicaid Enterprise has established required quality assessment and performance improvement strategies, ensuring delivery of quality health care by all MCOs. Every three years, we update and release a quality management strategy (QMS).<sup>48</sup> The purpose of the strategy is to ensure beneficiaries are receiving the service at or of above the established standards, with a focus on performance improvement by providing quality services that are patient-centered and aimed at increasing the use of preventive care. The current strategy outlines how we comply with federal requirements and meet the program goals and objectives, by, for example, conducting regular and consistent reviews of the QMS, highlighting progress towards the goals and measures related to MCO progress. With this plan, one of the main drivers is to transform the Medicaid Enterprise into an information driven organization with access to information down to the level of point of care. Nonetheless, while the initial steps have been taken and tools are being leveraged, there is room for improvement on further integration of the information sources, validation of the MCO compliance to the plan, and a greater enforcement of penalties and corrective action plans.

We also use a rotating schedule of quality metrics to assess performance of the MCOs with a defined strategy of what the Medicaid Enterprise needs to look for. This allows for a more general review to be conducted despite not having many staff conducting oversight of quality. The quality metrics currently reported by the MCOs are stored in multiple tools and databases, and these tools are continuing to be enhanced to provide more detailed dashboards with specific utilization metrics. The quality information is reported by the MCOs. As such, there are challenges to track and validate the information for which we are building initiatives and to better integrate the existing systems and enhance the process for gathering insights.

<sup>48</sup> Puerto Rico Health Insurance Administration. (2019). *Puerto Rico Medicaid Quality Management Strategy*. Retrieved from <https://www.asespr.org/beneficiarios/sobre-ases/medicaid-quality-strategy-cms/>.



Puerto Rico conducts multiple other quality reviews of the MCOs, as seen in the table below.

Quality Audit / Review Conducted	Description	Frequency
External Quality Review	<p>The EQRO conducted an annual audit of:</p> <ul style="list-style-type: none"> <li>• Validation of Performance Measures</li> <li>• Validation of Performance Improvement Projects (PIPs)</li> <li>• Review conducted within the previous three-year period to determine the MCO’s compliance</li> <li>• Validation of Network Adequacy</li> </ul>	Annual
Performance Audits by Quality Improvement Organization (QIO)	<p>The QIO conducted targeted audits of:</p> <ul style="list-style-type: none"> <li>• Hospital Admissions and Length of Inpatient Stays for Physical and Behavioral Health Services Audit (HALOS)</li> <li>• Prior Authorization (PA)</li> <li>• Special Coverage</li> <li>• Care Management</li> <li>• Health Care Improvement Program (HCIP)</li> </ul>	<p>HALOS: Semi-Annual            PA: Quarterly            Special Coverage: Semi-Annual            Care Management: Annual            HCIP: Quarterly</p>
Health Care Improvement Program (HCIP)	<p>MCOs report on quality initiatives:</p> <ul style="list-style-type: none"> <li>• High Cost Conditions Initiative</li> <li>• Chronic Conditions Initiative</li> <li>• Healthy People Initiative</li> <li>• Emergency Room High Utilizers Initiative</li> </ul>	Quarterly
MACPro Portal	We use CMS’s procedures every year to report HEDIS® measures in the MACPro Portal	Annual
<i>Audited HEDIS® Results Report</i> (Report 24)	We refer to the National Committee for Quality Assurance (NCQA) to define annually the updated list of the HEDIS® measures value set collected from MCOs in the <i>Audited HEDIS® Results Report</i> (Report 24). Each MCO must report the metrics selected by Puerto Rico to the EQRO and in Report 24.	Annual
Reports	We use the list of MCO reports (seen in the Appendix) and Plan Vital Reporting Guide to define the specific reports assigned to the Clinical Affairs Office.	Varies

Table 7. Quality of Care Audits and Reviews Conducted.

### External quality reviews

Each MCO must be reviewed by an EQRO at least annually, to validate MCO performance measures for contract compliance. Puerto Rico had two different auditing contractors focusing on different parts of the Quality oversight activities, an EQRO and a QIO. Currently, the EQRO contract is under renewal negotiations with PRDOH for 2020 activities, and the QIO contract has expired yet we have ongoing discussions in place about renewal.



From a process perspective, the MCOs report their quality plan to Puerto Rico, and the EQRO and QIO confirm that the MCOs are, in fact, following their outlined plan and meeting our expectations. With the current process, once the auditing entity finalizes the reports, they are submitted to the MCOs and PRHIA requests a formal response. After the response is received, a formal meeting is scheduled to discuss the findings and compare them with the findings from the MCO self-reported information. If any issues of non-compliance remain, the PRHIA Clinical Affairs Office submits the findings to the PRHIA Compliance Office, which continues the investigation and determines if any formal corrective actions are required.

While not required, the MCOs could have their program accredited by an external independent organization, such as the National Committee for Quality Assurance (NCQA). The Medicaid Managed Care Final Rule’s non-duplication provision allows states to accept information obtained from Medicare or a private accrediting entity in lieu of a review by the state or its EQRO. Regardless of accreditation, the MCOs must submit their program for our review and approval. All reports received are reviewed and discussed with the MCOs, and if necessary, corrective actions are required to be presented.

### Utilization management and prior authorization

Each MCO is required to adopt clinical practice guidelines and present policies and procedures for authorization of services, with mechanisms to ensure the consistent application of review criteria for authorization decisions. On a quarterly basis, MCOs must report on the number of prior authorization requests received, processed, denied, or pending for certain types of services and for the High Cost High Needs (HCHN) Program enrollees, in the *Executive Director and Utilization Data Report* (Report 14.F). We outline preventive service standards that require MCOs to ensure preventive services and screenings, allowing for better utilization management mechanisms. In addition, on an annual basis, the MCOs submit CMS-416 reports for children that contain specific Early and Periodic Screening, Diagnostic and Treatment (EPSDT) measures on screenings and participation rates.

The QIO conducted a comprehensive audit of the prior authorization sampled cases completed by the MCOs on a quarterly basis in 2019. The objectives of the audit were to ensure the MCOs’ decisions to approve or deny prior authorization cases were made based on medical necessity, and to verify that the MCOs complied with prior authorization determinations and notification timeframe standards established by Puerto Rico. In preparation for the audits, the QIO had an onsite meeting with each MCO to discuss the objective of the audit, sampling methodology, and the requirements of the sampled cases’ clinical documentation for the audit. The audit report was shared with Puerto Rico, similar to the abovementioned EQRO’s process.

### Quality and performance improvement programs (QAPI and PIPs)

Currently, MCOs are responsible for complying with Federal and Puerto Rico standards for Quality Management and Quality Improvement. The MCOs must establish a Quality Assessment Performance Improvement (QAPI) program that meets Federal requirements 42 CFR 438.330. Some of the areas this program must include are monitoring of the quality of service provided to beneficiaries, staff with sufficient experience in quality assessment, and an annual evaluation of the success of the plan.

MCOs are also responsible for having Performance Improvement Projects (PIPs) that meet both Federal



and Puerto Rico regulations in accordance with 42 CFR 438.330. The goal of the PIPs is to achieve a sustainable, long-term improvement of clinical care for beneficiaries. Puerto Rico, through the MCO contract, established the areas that the PIPs must improve. At a minimum, the topics of the PIPs are:<sup>49</sup>

- One clinical care project in the area of increasing fistula use for Enrollees at risk for dialysis
- One clinical care project in the area of behavioral health
- One administrative project in the area of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening
- One administrative project in the area of reverse co-location and co-location of physical health and behavioral health and their integration

Puerto Rico has the authority to request more PIPs throughout the term of the contract. The MCOs must design the implementation and evaluation of the PIPs. The documentation for the PIPs must be submitted to us for review, along with the QAPI, and is also reviewed by the EQRO. If either the QAPI or PIP is not submitted to us or the EQRO, the MCOs may be sanctioned.

### Monitoring Quality Measures and Outcomes in Claims and Encounter Data

As noted in the Comprehensive Oversight and Monitoring Plan, interdepartmental coordination is a guiding principle of Medicaid managed care quality and clinical oversight. Coordination throughout the oversight areas and reviewing any areas of overlap with utilization and quality are crucial, since those impact other oversight areas such as finance, program integrity, and network adequacy and access to care. For more information on monitoring claims and encounter data for financial oversight, refer to Section 5.10 Financial Oversight, including Rate Development Standards and Payment Management. For more information on monitoring claims and encounter data for oversight of program integrity, refer to Section 5.6 Program Integrity. Refer to Section 5.5 Network Adequacy and Access to Care for more information on oversight of MCOs’ provider networks and beneficiaries’ access to care.

Puerto Rico’s QMS identifies a series of quantitative and qualitative measures to more effectively monitor quality of care and clinical outcomes. For these measures, we utilize nationally recognized quality measures, including the NCQA’s HEDIS® and the CMS Adult and Child Core Set measurements, leveraging multiple tools to implement the vision outlined in the QMS.

To comply with contract requirements, MCOs are required to report quarterly on the core set of quality measures and report annually on the HEDIS® measures. In addition, MCOs develop initiatives to improve the population health, focusing on health promotion, prevention and improving the quality of life, care, and services. The Healthy People Initiative is one such example which focuses on preventive screening for enrollees, including high cost or chronic conditions.

As of December 2020, we will begin submitting Medicaid and CHIP (MAC) Scorecard measures, a subset of the Adult and Child Core Sets, to CMS through the MACPro portal. We are prepared to report on 15 of the 17 measures through the MACPro portal, and we are on track to report all 17 in the subsequent year. Additional MAC Scorecard measures may be calculated by CMS via information gathered from other reporting, such as our submission of the 416 report. Note that CMS has not yet

<sup>49</sup> Puerto Rico Health Insurance Administration. (2019). *Puerto Rico Medicaid Quality Management Strategy*. Retrieved from: <https://www.asespr.org/beneficiarios/sobre-ases/medicaid-quality-strategy-cms/>.



publicly announced which of the measures submitted via MACPro will be published in the 2021 MAC Scorecard. Therefore, our progress for submitting measures this year is discussed in terms of what CMS included in the 2020 MAC Scorecard. For more information, please refer to the report on **Requirement 9: Reporting on Medicaid and CHIP Scorecard Measures**.<sup>50</sup>

## Opportunities for enhancing the current state

### Opportunity to Increase Transparency with Puerto Rican Beneficiaries

**Challenge:** Puerto Rico currently receives several reports regarding quality of care from the MCOs.<sup>51</sup> However, the only reports currently published online are the EQRO Technical Reports from 2014 and 2015,<sup>51</sup> and information that is currently gathered could be made more widely available to the public. For example, information from these types of reports could be used by beneficiaries during the enrollment process in order to better compare MCOs.

**Leading Practice:** Leading practices in other Medicaid programs make more information publicly available, often including a website, MCO report card, and/or Annual Managed Care Program Report that allows beneficiaries to compare MCOs on quality measures, performance metrics, and satisfaction scores. Increased transparency allows the public to view the performance of individual MCOs prior to selecting an MCO and puts accountability on MCOs to improve their scores. Other state Medicaid agencies have included annual publications of HEDIS® reports and recent EQRO technical reports, in addition to the annual publication of the quality strategy. Several jurisdictions provide health plan dashboards for beneficiaries and the public to compare health plan information. A health plan dashboard may feature health plan contact information, enrollment data, complaint and independent medical reviews data, enforcement actions, and financial data. In addition, leading practices include the publishing of quality related documents, via a form that allows stakeholders and committees to submit suggestions for clinical initiatives to improve quality and efficiency of Medicaid services.

**Opportunity:** We can take the opportunity to more frequently publish and share the quality information and reports from the MCOs, including keeping the current records updated in the online portals for beneficiaries and the public to more easily access information, including during the MCO enrollment process. This information can also be published in a more consumer friendly manner via dashboards or high-level summaries. For more information on Increasing Transparency with Puerto Rico Beneficiaries, please refer to the report on **Requirement 9: Reporting on Medicaid and CHIP Scorecard Measures**.<sup>52</sup>

### Opportunity to Enhance the EQRO's Role

**Challenge:** We use an EQRO and a QIO to conduct reviews on mandatory functions that CMS requires and reimburses 50 percent as an administrative expense. These reviews include performance measurement validation, performance improvement project (PIP) validation, a review conducted

<sup>50</sup> PL 116-94: Further Consolidated Appropriations Act, 2020:(133 STAT 3111), Division N, Title 1, Subtitle B, §202(f)(4)

<sup>51</sup> The Plan Vital contract defines reports regarding quality of care from the MCOs as a quarterly *Grievances and Appeals Report*; a quarterly *Health Care Improvement Program (HCIP) Report*; an annual *Enrollee Satisfaction Survey Report*; and an annual *Audited HEDIS® Results Report*.

<sup>52</sup> PL 116-94: Further Consolidated Appropriations Act, 2020:(133 STAT 3111), Division N, Title 1, Subtitle B, §202(f)(4)

within the previous three-year period to determine the MCO's compliance, and a network adequacy validation. We have yet to finalize the contracts with vendors for 2020 activities; currently, the EQRO contract is under renewal negotiations for 2020 activities and the QIO contract has expired with ongoing discussions in place for renewal. In addition, the audit results from the EQRO and QIO on the MCOs reveal that a significant number of findings were reported, but there is room for improvement on the process to remediate such findings. We handled each finding independently and could improve tracking to identify year-over-year trends in the findings.

**Leading Practice:** Other Medicaid programs have expanded the role of the EQROs support additional areas, which include engaging the EQROs into the six optional activities defined by CMS:<sup>53</sup> validation of encounter data reported by the MCOs; administration or validation of quality of care surveys to consumers or providers; calculation of additional performance measures; implementation of additional performance improvement projects; conducting focus studies on quality of care; and assistance with quality rating of Medicaid and CHIP MCOs. Medicaid programs are encouraged to use an EQRO and/or QIO for performing medical and utilization review activities<sup>54</sup>, and quality reviews of Medicaid MCOs by the enhanced federal match rate of 75 percent made available to states. EQRO-related activities conducted on MCOs<sup>55</sup> by an entity other than a qualified EQRO are eligible for the 50 percent match rate.<sup>56</sup>

**Opportunity:** With additional resources and similar incentives available to states, we could leverage the EQRO and/or QIO to validate encounter data, conduct consumer and provider surveys, calculate performance measures, and perform studies of appointment availability for clinical or non-clinical services.

## Opportunity to Integrate Quality Oversight

**Challenge:** We currently receive quality data through several sources such as CAHPS<sup>®</sup>,<sup>57</sup> HEDIS<sup>®</sup> measures<sup>58</sup>, and MCO reports and deliverables. These reports help us monitor MCO performance on a quarterly or annual basis. These data sources are reviewed separately and hence there is no cross referencing of information across reports, increasing the difficulty of trend identification and increasing the workload for our team.

**Leading Practice:** States are monitoring quality measures beyond the MACPro scorecard measures. States use those measures and HEDIS<sup>®</sup> measures to benchmark performance year-over-year. As a leading practice, states may benchmark measures against other Medicaid programs, may collect more frequent HEDIS-like information from MCOs on measures that need improvement, and may follow up quarterly with the MCOs about what they are doing to improve. As a leading practice seen

<sup>53</sup> Centers for Medicare & Medicaid Services. (2020). *Quality of Care External Quality Review*. Retrieved from <https://www.medicare.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html>.

<sup>54</sup> 42 CFR 433.15(b)(6).

<sup>55</sup> 42 CFR 438.358 / 42 CFR 438.320.

<sup>56</sup> 42 CFR. 433.15 / 42 CFR 438.370(b).

<sup>57</sup> The Consumer Assessment of Health care Providers and Systems (CAHPS<sup>®</sup>) is a registered trademark of the Agency for Health care Research and Quality (AHRQ).

<sup>58</sup> The Health care Effectiveness Data and Information Set (HEDIS<sup>®</sup>) is a registered trademark of NCQA.

in mature Medicaid quality programs, several states link data sets of differing quality measures and sources, and then view them in a broad manner to better determine if the MCOs are adequately meeting their stated quality plans and achieving improvement or quality incentives. This linkage can be achieved via a high-level dashboard(s) that combine the reported data to present the benchmarks and information for each of the MCOs.

**Opportunity:** The implementation of an integrated quality report that would combine the disparate sources of information currently being received would allow our team to review quality in a broader manner and extract accurate insights more effectively. This would in turn allow our team to consume the information needed to conduct quality oversight via a single source of truth and determine compliance with stated plans and required metrics. This effort could build upon our quality related KPIs and compliance tool.



## 5.5 Network Adequacy and Access to Care

### Functional Area Description

Network adequacy is the methodology by which Puerto Rico determines the suitability of an organization’s network in order to serve Medicaid recipients, such as by evaluating time and distance of doctors and specialists per zip code. Per CMS requirements, states that contract with MCOs must develop and enforce network adequacy standards. As of November 2020, at minimum, time and distance standards must be established for: primary care; obstetricians/gynecologists; behavioral health (mental health and substance use disorder); specialty care; hospital; pharmacy; pediatric dental; and additional provider types when they promote the objectives of the Medicaid program [42 CFR 438.68]. MCOs will certify the adequacy of the networks at least annually. This functional area includes:

- Developing and Enforcing Network Adequacy Standards
- Ensuring Access to Care
- Monitoring MCOs’ Provider Directories and Out-of-Network Usage

### Current processes for the functional area in Puerto Rico and stakeholders involved

#### Developing and Enforcing Network Adequacy Standards

Upon establishing the island-wide Plan Vital in 2018, Puerto Rico established five standards to ensure access to care, meet CMS requirements, and maintain quarterly compliance to 42 CFR 438.68: provider to enrollee ratios, provider access per municipality, required network providers, time and distance requirements, and appointment availability. Standards are based on historic trends and utilization, and current industry constraints. In 2018, Puerto Rico certified each of the MCO’s initial networks of providers and granted exceptions to the MCO when applicable because of contracting or coverage limitation.

Puerto Rico continues to monitor the exceptions granted, and the MCOs’ reports of contracted providers, as well as their annual *Provider Network Development and Management Plans*, that measure compliance with network standards and assist with gathering federally required data. To provide the foundation for oversight of the MCO’s network and access to care, the MCO’s annual *Provider Network Development and Management Plan* includes:

- A summary of Network Providers, by type and geographic location in Puerto Rico.
- Demonstration of monitoring activities to ensure that access standards are met, and enrollees have timely access to services.
- A summary of Network Provider capacity issues by service and municipality, the MCO’s remediation and quality management/quality improvement activities and the targeted and actual completion dates for those activities.
- Network deficiencies by service and by geographical area and interventions to address the deficiencies.
- Description of ongoing activities for provider network development and expansion taking into consideration identified participating provider capacity, network deficiencies, service delivery issues and future needs.
- If an exception has been granted, an update on recruiting initiatives.



The MCO certifies the truthfulness, accuracy, and completeness of the report data used to monitor their providers and access. The monthly *Network Provider List (NPL)* (Report 15) collects provider details from the MCO, such as name, specialty, National Provider Identifier (NPI) number, whether the provider passed credentialing (yes, no, blank), and the number of PCPs, gynecologists, cardiologists, or gastroenterologists within the primary medical group (PMG). For more information on the shared process for enrolling, screening, and credentialing providers, please refer to Section 5.9 Enrollment and Disenrollment. With the NPL, we check for and validate the layout and format of the submitted report. The MCO may also provide narrative notes, such as describing abnormalities in the reported data. The quarterly *Geographic Access Report* (Report 16) collects the MCO’s compliance with network standards. Using the ratio requirements per Section 9.4.3 of the contract, the MCO reports, by provider type, the count of providers in their network, the count of enrollees in the network, if the standard was met (yes or no), and notes any reasons for not meeting the standards. For municipality requirements, required network providers, and time and distance requirements, the MCO reports the count of contracted providers, if the standard was met (yes or no), and notes any reasons for not meeting the standard. This report also tracks network exceptions granted to the MCO. The MCO also provides geographic access maps and data tables demonstrating compliance with time and distance requirements. MCOs are aided in completion of these reports by methods such as the use of a software tool to determine time and distance to providers and conducting a self-check on their network compliance.

Once the *Network Provider List* and the *Geographic Access Report* are collected and analyzed, staff reviews the report against the contract standards within ten days. Staff documents any observations, findings or recommendations from their review. Staff may follow up with the MCO for clarification or require further action from the MCO with a due date. The information collected in these reports allows us to review the network compliance and revisit the standards for provider networks to determine where revisions may be required. Puerto Rico benchmarks the network standards for Plan Vital against private insurance plans, while also considering current constraints with the current number of health care providers on the Island. The standards take this into consideration during review.

While pharmacy does not have any network adequacy standards, we will work to establish some specific standards for pharmacy networks as there are over 900 hundred pharmacies in the network across the island. There are ongoing efforts to guarantee at least one pharmacy in each municipality of the island. As an example, we enhance the dispensing fee for the Vieques and Culebra municipalities, allowing increased availability during 2020.

If not resolved, non-compliance incidents and violations are referred to the Compliance Office for further investigation and remediation within 20 days, such as a corrective action plan. MCOs that are not meeting these standards are subject to potential consequences. Mechanisms for enforcement of standards exist but are not frequently employed.

### Ensuring Access to Care

Each MCO has an annual *Provider Network Development and Management Plan* and reports quarterly their network assurance review activities and any outreach to individual providers. The MCO is expected to monitor 25 percent of providers each quarter for accuracy of address and contact information, and for any problems, complaints, or grievances regarding access or appointment



availability. The quarterly snapshot of activities by provider type and the review schedule are reported by the MCO in the *Appointment Availability Report* (Report 17). The following appointment standards are required in section 9.5.1 of the Plan Vital contract:

Condition Type	Appointment Standard
Urgent Conditions	Emergency Services – 24 Hours
	Urgent Conditions Outpatient – 48 Hours
	Urgent Conditions Laboratory – 2 Hours
	Behavioral Health Crisis Services – Clinical Necessity
Non-Urgent Conditions	Routine Physical Exams – 30 Calendar Days
	Routine Physical Exams Less than 21 Years of Age – EPSDT
	Routine Evaluations for Primary Care – 30 Calendar Days
	Covered Services – 14 Calendar Days
	Specialist Services – 30 Calendar Days
	Dental Services – 60 Calendar Days
Diagnostic/Laboratory Services	Behavioral Health Services – 14 Calendar Days
	Diagnostic Laboratory – 14 Calendar Days
	Diagnostic Imaging – 14 Calendar Days
Prescription Drugs	Other Testing Appointments – 14 Calendar Days
	Prescription Fills – In Person (ready for pick up) – 40 Minutes
	Prescription Fills – Phoned – 90 Minutes

Table 8. Appointment Standards from MCO as required in section 9.5.1 of the Plan Vital contract.

By reviewing these standards, we can identify any limitations in timely access to care, such as the limited number of providers. This may be partly due to the limitations in the number of providers on the Island, which could be further addressed as described below on an opportunity. To address the limited number of health care providers on the Island, the Incentives Act for the Retention and Return of Medical Professionals (Law No. 14-2017), will use tax incentives to encourage medical professionals to remain in Puerto Rico. A contract amendment in September 2020 implemented measures for the MCOs to increase access to care through telehealth and remote work by adding and supporting telehealth and paying the same amount for either in-person or remote work. This helped increase access to care in response to the global COVID-19 pandemic.

Furthermore, MCOs establish relationships (if needed, through memoranda of understanding) with the Administration of Mental Health and Anti-Addiction Services, Families and Children Administration, the Office of the Women’s Advocate, and other government or non-profit entities, in order to improve the delivery of behavioral health services. As seen in the FY 2020 Annual Report from October 2020, available behavioral health network providers increased from July 2019 to July 2020.



As specified in 42 CFR 438.208I(4), enrollees with special health care needs can directly access specialists, as appropriate for their health care conditions. To make it easier for beneficiaries to seek specialist care when needed within their MCO’s network, a referral from their PCP is not needed; a referral is only required for services sought outside the MCO’s preferred provider network. The MCOs track and report the number of phone calls answered from beneficiaries regarding a request for a referral to a provider or request information referrals within the MCO’s network. We continue to explore alternatives to provide access to PCPs and specialists.

### Monitoring MCOs’ Provider Directories and Out-of-Network Usage

We provide beneficiaries with information on providers in the MCO enrollment package and on planvital.org, and then collect information regarding the visits and usage of providers. When a beneficiary cannot find a provider, they may have to see a provider outside of their MCO’s general or preferred provider network to receive care. Currently, only limited monitoring of this out-of-network usage is conducted as there is a challenge to track access to care in these settings.

### Opportunities for enhancing the current state

#### Opportunity to Leverage Telehealth to Expand the Existing Provider Network

**Challenge:** As a result of the devastation caused by Hurricanes Irma and Maria, and the crisis brought on by the COVID-19 pandemic, there has been an exodus of medical professionals to the mainland United States and a lack of primary care providers and specialists on the Island. Puerto Rico’s challenge is exacerbated in rural areas where there are even fewer health care providers, but exception waivers can be granted to MCOs that have non-compliant networks in geographical areas that have a dearth of providers.

**Leading Practice:** Medicaid programs are increasingly leaning into the development of telehealth opportunities that can help rural residents access health care providers more readily. As a result of the global COVID-19 pandemic, many states have taken action to remove policy barriers to telehealth utilization to address this crisis on a temporary basis.<sup>59</sup> Several states have made permanent Medicaid policies on reimbursement for telemedicine services and encounters, and Medicaid telehealth guidance and/or payment for Federally Qualified Health Centers (FQHCs), dentistry, mental health assessments/services for children and youth, physical therapy, occupational therapy, speech therapy, and EPSDT providers.

**Opportunity:** Increased promotion of telehealth opportunities will be instrumental in increasing access in parts of the Island that are lacking providers, especially with specialists and with beneficiaries in rural areas.

#### Opportunity to Reduce Self Reliance on MCO-Reported Data

**Challenge:** We currently rely on MCO self-reported data for monitoring compliance of their network adequacy. Once received, this data is checked for format and layout but there is no validation of the information contained in the report itself. For this, we could consider additional

<sup>59</sup> COVID-19 related actions taken by each State’s Office of the Governor, Medicaid Program, Medical Board and/or Department of Insurance are available, as of November 2020, at <https://www.cchpca.org/covid-19-related-state-actions>. The National Telehealth Policy Resource Center project at the Center for Connected Health Policy is made possible by Grant #G22RH30365 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, U.S. Department of Health and Human Services.

independent validations to ensure MCOs' reports are accurate in terms of provider networks and access for beneficiaries. The *Network Provider List (NPL)* provides a good example of a select report that is currently delivered by the MCO but that is not being cross-checked with external sources to verify the information contained within. For more information on the challenges and next steps with provider data, please refer to Section 5.6 Program Integrity and Section 5.9 Enrollment and Disenrollment.

**Leading Practice:** A few noteworthy practices include:

- Improving data integrity of provider networks by comparing MCO-provided data against other data sets such as MMIS Medicaid enrolled providers, the National Plan and Provider Enumeration System (NPPES), and geocoding to validate providers' location and addresses.
- Comparing directories of providers (i.e., contact information and location) with publicly available internet business listings.
- Reviewing provider directories as published by MCOs and posted to each MCO's website.
- Conducting "secret shopper" calls to verify the accuracy of providers' information and appointment availability, enabling states to collect data on the actual network available to their Medicaid recipients. States may contract with an EQRO or have their own staff conduct this type of provider network validation activities.

**Opportunity:** With additional resources, we could further validate MCO reports with external sources and confirm the information reported. This would improve the reliability of network information, provide opportunities to hold MCOs responsible for information provided, and in turn incentivize accurate reporting from MCOs. In addition, our team could implement some of the leading practices mentioned above such as the secret shopper calls, to validate that the specific metrics being reported are consistent with the results received from these calls.

## Opportunity to Improve Frequency of Data Reporting by Leveraging Automation

**Challenge:** We have an electronic data warehouse that stores MCO-reported information and presents it in dashboards for each business unit/office. Network adequacy reports are collected monthly, quarterly, or annually. However, given that provider networks are highly dynamic and frequently changing, the current reporting frequency can leave our beneficiaries exposed to inaccurate data about availability of providers. In addition, while some metrics pertaining to out-of-network usage are currently collected from MCOs, this information can often be limited and challenging to validate. There is room for greater formalization of the review and action plan process.

**Leading Practice:** States leading in this functional area have automated collection and calculation of the MCOs' network adequacy by using their daily beneficiary information as well as weekly provider lists from the MCOs, allowing for greater analysis and quicker identification of issues. This allows the state to engage with MCOs and address network adequacy concerns on a more frequent basis. In addition, states can quantify the impact to beneficiaries' access from provider terminations and an MCO's non-compliant or excepted provider networks.



**Opportunity:** Leveraging automation, our teams could engage in more efficient data validation, and more frequent and effective data collection and reporting efforts with MCOs, potentially achieving weekly or bi-weekly reporting cadences. By collecting data in an automated manner, using new or existing systems, metrics and trends can be better understood and utilized more effectively to identify gaps and develop strategies to enhance network adequacy. This level of automation and calculation would allow us to more fully understand the impact to beneficiaries’ access and work with our MCOs to address any network deficiencies.

## 5.6 Program Integrity

### Functional Area Description

Program Integrity references how Medicaid programs, through its contract with MCOs, must require that the MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. [42 CFR 438.608]. This functional area includes:

- Fraud, waste, and abuse
- Monitoring the Quality and Integrity of Claims and Encounter Data
- Cost Avoidance, Third Party Liability (TPL), and Recovery Activities

### Current processes for the functional area in Puerto Rico and stakeholders involved

#### Fraud, waste, and abuse

On November 2018, Puerto Rico established a memorandum of understanding (MOU) among PRHIA, PRDOH, and the Department of Justice Medicaid Fraud Control Unit (MFCU) that states the responsibilities and roles of each agency in addressing and combatting fraud, waste, and abuse. PRMP operates the PRMP Program Integrity Unit (PIU), whereas PRHIA establishes the contract provisions with MCOs, MAOs, and PBMs to comply with PRMP-PIU’s guidelines. PRMP-PIU oversees quality, access and timeliness of care for managed care enrollees; PRMP has the responsibility to notify and get the approval from CMS.<sup>60</sup>

It is the responsibility of both PRDOH and PRHIA to submit any suspected case of fraud, waste, or abuse to MFCU in a timely manner. If either PRDOH or PRHIA can recategorize a case from suspected to credible then an official referral is made to MFCU; once this happens, the accused entity may have their payments suspended if appropriate. If MFCU accepts the referral, then it is the responsibility of either PRDOH or PRHIA to provide the required information for MFCU to take on the investigation. If MFCU rejects the referral, then the accused entity must have its payment resumed unless MFCU refers the case to a different government agency with the proper jurisdiction. If MFCU rejected the referral because no fraud was found, then it is the responsibility of the Medicaid Enterprise to release payments that were withheld to the accused entity. If MFCU rejected the referral because it determined that either PRDOH or PRHIA should handle the case, then it is the responsibility of either of those agencies to take lawful action and notify MFCU within 60 days of when the case is closed. To enforce the MOU and combat fraud, waste, and abuse in the Medicaid Program, representing members of PRDOH, PRHIA, and MFCU must meet once a month to expedite current referrals or cases, develop further regulations to combat fraud and overpayments, or create fraud trainings for members of the three participating agencies.

An additional MOU exists solely between PRDOH, PRMP, and PRHIA, which describes the overall Medicaid responsibilities between the two agencies, and also provides an in-depth description of the individual roles each agency has with program integrity.<sup>61</sup> PRDOH is responsible for operating and reporting activities for the PRMP-PIU while PRHIA establishes the contract provisions with MCOs, MAOs and PBMs to comply with PRMP-PIU’s guidelines. Additionally, PRMP-PIU oversees quality, access and timeliness of care for managed care enrollees. It is the responsibility of PRHIA to submit several

<sup>60</sup> Office of the Puerto Rico Attorney General, Medicaid Fraud Control Unit, Puerto Rico Department of Health, Puerto Rico Health Insurance Administration. (November 13, 2018). *Memorandum of Understanding (MOU)*.

<sup>61</sup> Puerto Rico Department of Health, Puerto Rico Medicaid Program, Puerto Rico Health Insurance Administration. (June 2, 1976). *Restated Memorandum of Understanding (MOU) as defined in Act No. 113 of June 2, 1976, as amended*.



program integrity-related documents to PRMP-PIU such as letters of suspension/termination of provider, letters of sanction imposed on providers or MCOs, and letters on how PRHIA handled fraud complaints from MCOs, providers, or members. Quarterly meetings are held to enforce the MOU and maintain accurate and up-to-date information between the agencies. This shared approach aligns with the Comprehensive Oversight and Monitoring Plan, released as an appendix to the FY 2020 Annual Report in October 2020, describing the process to monitor and provide oversight of the MCOs.

Since its inception in October 2018, PRMP-PIU has been responsible for MCO oversight for program integrity. To lead and further support PRMP-PIU’s responsibilities, a Program Integrity Lead Officer was appointed in August 2020. Previously, PRHIA’s program integrity department was responsible for MCO oversight; MCO contracts have now been updated to require the MCOs to have direct communication with PRMP-PIU. PRMP-PIU also now has access to PRHIA’s Special Investigative Unit (SIU) portal, which receives quarterly data from MCOs on suspected provider fraud information. The recent MCO contract amendment also clarified the MCO’s roles and responsibilities for provider oversight. As the PRMP-PIU is in its formative years, it is still transitioning MCO oversight ownership. For example, PRMP-PIU does not have access to PRHIA’s financial information (e.g., capitation payments to MCOs, MCO payments to providers).

We recently launched a new process and portal<sup>62</sup> for provider enrollment in the PR MMIS. The enrollment and screening processes have become fully automated with PR MMIS notifications to providers and PRHIA. During screening, providers’ information is validated against national and Puerto Rico databases to identify any questionable providers (e.g., provider terminations due to death, CMS, or Medicare exclusion). Providers will be required to complete the initial Medicaid enrollment in the PEP system by the end of the year, which was also discussed in the OIG’s assessment for the Program Integrity and Provider Enrollment risk areas. This is the first step to improve the provider data quality. In January 2021, PRDOH aims to complete an assessment of the impact on the MCOs, MAOs, and PBM provider networks and compare the enrollments with their affiliations. Based on this assessment, the provider community may or not need an extension. For more information on provider enrollment, please refer to Section 5.9 Enrollment and Disenrollment.

### Monitoring the Quality and Integrity of Claims and Encounter Data

PRMP-PIU reviews provider outliers on a quarterly basis using PR MMIS and a separate file review process, discusses findings with MCOs, and escalates to MFCU and OIG as needed. Currently, both PRDOH and PRHIA monitor program integrity activities in two separate datasets reported by the MCOs, without validating across the datasets. PRDOH uses PR MMIS’s encounter data from MCOs while PRHIA uses a separate, simplified utilization dataset from MCOs. Furthermore, as previously mentioned, PRMP-PIU does not have access to PRHIA’s financial information or provider-level payments, nor funding source indicators on encounter/claim records. This will change in the next PR MMIS development cycle, when financial management tools will be added along with other program integrity initiatives. In the meantime, the Comprehensive Oversight and Monitoring Plan establishes a coordinating plan for program integrity efforts between PRHIA and PRMP-PIU to enhance oversight and monitoring activities of MCO payments.

The Puerto Rico Medicaid Enterprise will procure a new contractor for the Fraud and Abuse Detection Unit (FADU) to conduct data mining and refer cases to the PRMP-PIU for further investigation, since

<sup>62</sup>Puerto Rico Medicaid Program. (2020). *Provider Enrollment Portal (PEP) for the Puerto Rico Medicaid Program (PRMP)*. Retrieved from <https://pr.hppcloud.com/ProviderEnrollment/EnrollmentCreate>.



the recent contract ended in September 2020. In the meantime, PRDOH is conducting analytics and creating reports to support data mining efforts.

## Cost Avoidance, Third Party Liability (TPL), and Recovery Activities

As outlined by the MCO contract, Puerto Rico must, on a monthly basis, update MCOs with the current health insurance information of all their respective beneficiaries. The MCO contract requires MCOs to be fully responsible for determining the legal liability of third parties to pay for services given to beneficiaries and take the appropriate measures to make the third parties pay for the service (e.g., commercial payers, Medicare, Administration for the Automobile Liability Insurance [Administración de Compensación de Accidentes Automovilísticos], Workers’ Compensation State Corporation [Corporación del Fondo del Seguro del Estado], and Department of Veterans Affairs). Additionally, the MCOs, along with the coordination of PRHIA, must follow and comply with 42 CFR 433 Subpart D – Third Party Liability.

Per the Plan Vital MCO contract, the individual MCOs are responsible for implementing cost avoidance policies and recovering any potential liabilities. If an MCOs is aware of an external insurance or coverage, then the MCOs must reject any provider claim and instruct the provider to submit that claim to the third-party entity. However, there are exceptions to the rule, such as claims for prenatal care, labor and delivery, and post-partum care. In these cases, the MCOs pay the providers and then deal with the third-party entity. MCOs are required to report all cost avoidance values to PRHIA. Additionally, contractors must use any recovered funds from third parties to offset claim payments.

The MOU between PRDOH and PRHIA states the procedure in the case of an overpayment to a provider. First, PRHIA must recover the improper payments with the coordination of the corresponding MCO by validating that the MCO electronically transfers the overpayment to PRHIA. Then, PRHIA is responsible for determining that the recovery payment is electronically transferred back to PRDOH. Both processes must be documented by PRHIA and reported to PRDOH. In the case of federal funds, PRDOH must return the overpayment to CMS as per 42 CFR 455.16. In the case of Island funds, PRDOH has the flexibility to use the funds in an appropriate and lawful manner.

## Opportunities for enhancing the current state

Our opportunities for enhancing the current state of Program Integrity can be found in four additional reports to Congress. Please refer to these reports on:

- **Requirement 8: Audits of Managed Care Payments<sup>63</sup>** due on December 20, 2020, addressing any risk of fraud, waste, and abuse in the current payment processes
- **Review Program Integrity Office Policies, Procedures and Staffing** due in April 2021, addressing the recommended changes within the Program Integrity Office
- **Develop Payment Error Rate Measurement (PERM) Plan** due on June 20, 2021, addressing on how Puerto Rico will meet the requirements for implementing PERM and developing quarterly progress reports to Congress
- **Review Medicaid Eligibility Quality Control (MEQC) Policy Procedures, and Staffing** due on June 20, 2021, addressing recommended changes within the MEQC Office

<sup>63</sup> PL 116-94: Further Consolidated Appropriations Act, 2020:(133 STAT 3110), Division N, Title 1, Subtitle B, §202(f)(3)  
 Requirement 7: Contracting Oversight and Approval Report  
 Government of Puerto Rico, Office of the Governor



## 5.7 Grievances and Appeals

### Functional Area Description

The Grievances and Appeals functional area refers to how each MCO must have a system in place for enrollees that includes a grievance process, an appeal process, and access to a fair hearing system. [42 CFR 438.402 / 42 CFR 457.1260]. This functional area includes:

- Beneficiaries’ complaints, grievances, appeals, and Administrative Law Hearing
- Provider grievances and appeals

### Current processes for the functional area in Puerto Rico and stakeholders involved

#### Beneficiaries’ complaints, grievances, appeals, and Administrative Law Hearing

MCOs operate a toll-free telephone number to respond to questions, concerns, inquiries, and complaints from enrollees and to advise enrollees about how to resolve non-emergency medical or behavioral health concerns. MCOs are also expected to review and trend enrollees’ complaints about providers.

We review the MCO’s Grievance and Appeal System policies and procedures at least once during the readiness review, as well as the MCO’s related forms, notices, and enrollee handbook describing how to file a complaint, grievance, appeal, or Administrative Law Hearing.

A complaint can be filed by the enrollee or their representative within 15 calendar days after the date of occurrence that initiated the complaint. MCOs have 72 hours to resolve each complaint. A complaint is deemed a grievance if it is filed beyond the 15 calendar days after the date of occurrence, or if the complaint is not resolved in 72 hours. Enrollees can report a grievance to their MCO, to the Office of the Patient’s Advocate of Puerto Rico, or directly to PRHIA, either verbally or in writing. Once reported to an MCO, the MCO is then expected to resolve the grievance expeditiously and within 90 calendar days. If a beneficiary has a complaint regarding a provider, they can raise the complaint with the MCO; the MCO can then move the beneficiary to another provider. The MCO’s administrative processes with providers can be varied.

If a beneficiary is appealing an Adverse Benefit Determination, such as a denial of service/medication within 60 days, beneficiaries can file an appeal with the MCO. MCOs are expected to resolve appeals in 30 days if it is a standard appeal or resolve an expediated appeal in 72 hours if the beneficiary’s life, health or abilities are at risk. The MCO notifies the beneficiary and PRHIA within two days of their resolution.

If the beneficiary seeks to further appeal the MCO’s decision within 120 days, then they may request via telephone, postal mail, or fax, an Administrative Law Hearing with an Examining Officer through PRHIA. The PRHIA Customer Service Office sends all the documents received from the beneficiary to the Office of Adjudicatory Procedures and an Examining Officer. If necessary, an external medical review is requested from one of our contracted medical advisors. The Administrative Law Hearing resolution is expected within 90 days for standard resolution, or three days for an expedited resolution, depending on the nature and circumstances of the case. After the Examining Officer conducts the appeal process, a report is sent with a recommended solution to the PRHIA Executive Director, who



may confirm, modify, or reject and issue the final resolution of the case. Both the Examining Officer and the Executive Director are required to remain transparent and free of conflicts throughout the process. In addition, territorial laws allow for beneficiaries to seek an administrative/judicial review of the hearing resolution before the Court of Appeals.

MCOs track complaints, grievances, Notices of Adverse Benefit Determinations, appeals, and Administrative Law Hearing requests. Trends and findings are expected to be incorporated into the MCO’s Quality Strategy. MCOs submit on a quarterly basis a *Grievances and Appeals Report* (Report 21) that captures the volume of provider and enrollee grievances (informal complaints and formal grievances), appeals, notices of adverse benefit determinations, administrative law hearings, and the top five enrollee web comments. The PRHIA Compliance Office plans to monitor the MCO-reported data in Report 21 as KPIs on the new compliance tool. The intention of this new tool and effort is to develop volume trends and baselines, monitor overturn rates and specific reasons for grievances and appeals, and then inform the PRHIA offices to address those trends and any systemic issues (i.e., Finance, Compliance, Clinical Quality, Network Management, Care Management). As of December 2020, there are six active cases for beneficiaries being tracked for resolution.

PRHIA’s Customer Service Office operates a call center to receive and resolve complaints and grievances directly from beneficiaries and providers. Calls are logged and may be shared with other PRHIA offices as needs arise. For the purpose of keeping track of the workload, logs are kept with the cases that have been presented to the Office of Adjudicatory Procedures, along with the case status and the amount claimed if it is from a provider. Staff and Examining Officers handling the workload may notice trends and could refer it to the PRHIA Compliance Office for further investigation. For example, the pharmacy exception process was noted as trending due to the high costs incurred by an MCO without prior approval from PRHIA.

In addition to the process for health coverage related grievances and appeals described above, PRDOH, being in charge of eligibility determination for beneficiaries, has separate processes available for beneficiaries seeking to file eligibility-related grievances and appeal eligibility determinations.

### Provider grievances and appeals

MCOs resolve billing, payment, and other administrative disputes with providers, such as lost or incomplete claims forms or electronic submissions; requests for additional information on services rendered by the provider; and inappropriate or unapproved referrals issued by providers. Providers can submit a timely written complaint to the MCO, which then has 15 days to respond and resolve. Providers can dispute payment amounts or payment denials within 120 days, and the MCO can resolve those disputes within 120 days. The MCO must explain their decision and notify the provider of their option to appeal and request an Administrative Law Hearing within PRHIA.

Using the abovementioned quarterly *Grievances and Appeals Report* (Report 21), MCOs report the number of provider complaints, grievances, and or disputes, providing the number related to physical health providers and behavioral health providers, the number of open pending grievances, and the number processed using nine reasons/categories. Currently, there are 45 active cases for providers being tracked for resolution.



If a provider seeks to appeal the MCO’s decision on their complaint within 30 days, then the provider presents documentation and explains the dispute to the PRHIA Customer Service Office and requests an administrative hearing. The PRHIA Customer Service Office first looks to mediate the complaint between the provider and the MCO. This new mediation process was established two years ago to reduce the number of legal disputes for less complicated cases between providers and MCOs. To date, ten cases have been mediated and resolved through this new process. If mediation is not achieved on a case-by-case basis, or if the case is a major dispute, then the case is forwarded to the PRHIA Legal Department. The Legal Department analyzes the documentation and determines if the supporting documentation for the case is sufficient per the MCO contract and law. Then, the PRHIA Legal Department forwards the information to the Office of Adjudicatory Procedures, who assigns an Examining Officer to conduct the appeal process. After the Examining Officer conducts the appeal process, a report is sent with a recommended solution to the PRHIA Executive Director, who may confirm, modify, or reject and issue the final resolution of the case. In addition, territorial laws allow for providers to seek an administrative/judicial review of the hearing resolution before the Court of Appeals. Both the Examining Officer and the Executive Director are required to remain transparent and free of conflicts throughout the process.

Similar to grievance and appeals process for beneficiaries, the PRHIA Compliance Office plans to monitor the volume, overturn rate, and the main reasons for providers’ complaints, grievances, appeals using the MCO-reported data from Report 21 as KPIs on the new compliance tool. The tool continues to be enhanced and will eventually include grievances and appeals.

## Opportunities for enhancing the current state

### Opportunity to Formalize and Standardize Processes of Grievances and Appeals and Share Data across Medicaid Enterprise

**Challenge:** We track managed care-related grievances directly reported to PRHIA in a log and track the volume of grievances and appeals reported to MCOs in Report 21. Separately, grievances and appeals may also be reported to the Office of the Patient Advocate, which serves as an ombudsman. The sharing of grievances and appeals findings and trends is informal across PRHIA offices, and the trending of records is limited.

**Leading Practice:** A leading practice is to streamline the intake and tracking of managed care member complaints. The process of tracking grievances, appeals and hearings data is frequently formalized by implementing a system to track, categorize and trend inquiries, grievances and appeals, including enrollee name, reason for the appeal or grievance, date received, escalation needs, current status, timeliness, and resolution/decision. States review the information as part of their ongoing monitoring procedures and the performance of their appeal and grievance system in the managed care program assessment report, as well as for updates to their comprehensive quality strategies. Using aggregate data, they can examine root causes for common grievances, appeals and fair hearings to determine corrective action, policy changes and/or process improvements. Grievances and appeals information is also made available to the Medicaid Program Integrity Office to review and analyze, and to help inform and structure their audits of MCOs. The appeal and grievance information is aggregated and made publicly available on a health plan dashboard, MCO report card, and/or Annual Managed Care Program Report as mentioned in Section 5.4 Quality of Care. Other actions taken in other Medicaid programs include the use of a Managed Care Ombudsman Office to collect and resolve grievances and appeals timely, support data tracking and trending, and incorporate increased transparency and tracking, such as public sharing of grievances and appeals trends, volume by plan, and time to resolutions.

**Opportunity:** With additional resources, we could implement a universal system to track and trend grievances and appeals, enabling the Medicaid Enterprise to standardize the logging of grievances, appeals and hearings, and examine the data for trends, patterns, root causes, and other insights. Having a unified system would allow the information and, more importantly, the insights, to be better shared across the Medicaid Enterprise. This would, in turn, allow for MCO-reported data to be cross referenced for accuracy and allow, for example, the Program Integrity Unit to apply data analytics to identify trends and target MCOs for further review during the auditing processes.

### Opportunity to Track Trends in Grievances and Appeals to Identify and Resolve Systemic Issues

**Challenge:** Currently, we request MCOs to submit quarterly reports on volume of grievances, appeals, and hearings. The current quarterly report, Report 21 outlined in the Plan Vital Reporting Guideline, focuses on volume data such as the number of complaints received, the number of complaints processed, and the complaints related to physical health, behavioral health, etc. While this information allows us to compile high-level views, there is no member-level validation of the data possible.

**Leading Practice:** States are more effectively leveraging complaints data to identify risks and ultimately improve quality of services. Leading practices point towards the tracking and trending of grievances and appeals in a way that can raise awareness of issues promptly and enable analysis on past complaints. Information, trends, and insights gleaned from grievances and appeals allow the agency to have a quick pulse on the performance of the Medicaid program and the MCOs. In addition, states are leaning toward collecting minimum datasets across the agencies collecting grievances and appeals, such as enrollee name, reason for the grievance/appeal, date received, date of resolution, etc.

**Opportunity:** With the implementation of a formalized system, we could begin to track trends in grievances and appeals in a cadenced fashion by measuring the most common types of grievances and appeals over various timeframes, which will allow for enhanced issue resolution and better identify where improvements have been made. The oversight tool being implemented by the Medicaid Enterprise could also play an important role for this process, leveraging the new KPIs, centralized reporting capabilities and the targeted informational dashboards. This opportunity relates to the other above-mentioned opportunity in that, together, they provide the full cycle of improvements for the grievances and appeals process, from more accessible reporting to better resolution and tracking, allowing for trending and root cause analyses, and ultimately better program policies and performance, and improved quality of care for beneficiaries.



## 5.8 Marketing and Communication Activities

### Functional Area Description

The Marketing and Communications functional area specifies the methods by which the entity ensures the Medicaid program that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the beneficiaries or the Medicaid program [42 CFR 438.104]. This functional area includes:

- Marketing materials development
- Prohibited marketing activities

### Current processes for the functional area in Puerto Rico and stakeholders involved

#### Marketing materials development

Currently, we use both the MCO contract and additional normative letters as guidelines for marketing procedures. All written materials have established requirements that must be followed, such as having an English translation of the material readily available. MCOs must submit materials, some of which have their own specific requirements and standards, such as enrollee handbooks, provider directories, ID cards, and other health or educational information for enrollees. In addition, the MCOs must ensure that all their provider and subcontractor marketing materials are collected and submitted to Puerto Rico, as well. We then address these submissions through intra-departmental revisions. For example, PRHIA’s Office of Clinical Affairs handles information that requires in-depth and specialized revision. We could consider involving the Medical Care Advisory Committee (MCAC) in the development or review process. We then create a log of active submissions that are reviewed internally, which have a five-business day turnaround. If the materials are rejected, then the MCOs can revise, incorporate our comments, and resubmit.

In order to achieve a broad review of marketing materials, we could implement a similar review and monitoring process for both online materials, such as MCO websites, and beneficiaries’ incentives, such as flu vaccines and wellness visits. It is important to note that there are certain requirements for MCO websites provided in the Plan Vital MCO contract. However, given the limited resources in the Puerto Rico Medicaid Enterprise, there is limited verification of MCO’s adherence to these requirements.

Medicaid enrollees/beneficiaries receive the same information when selecting and enrolling in an MCO; Beneficiaries receive a notification of their subscription to the new MCO with their ID card in a single shipment and also receive information on how to access the beneficiary manual and the provider directory. If the beneficiary calls the MCO to request a printed copy of the manual and/or directory, they are to be sent by post mail. MCOs may also provide additional information to beneficiaries, such as privacy notices and Early and Periodic Screening, Diagnostic and Treatment (EPSDT). At this time, these materials received by the beneficiaries, do not include any of the MCOs/MAOs’ quality or network metrics for reference or comparison.

#### Prohibited marketing activities

We have a process for reviewing and providing written authorization for the detailed *Marketing Plans* and materials submitted by the MCOs, prior to these materials being used and distributed with beneficiaries and/or providers. The scope of this review is meant to cover the broad spectrum of communication channels available, including posters, brochures, and other materials that contain statements around the benefit packages and the provider directories.



Under the current contracting guidelines, MCOs have a defined list of prohibited activities in relation to marketing activities and materials. These include activities such as:

- Engaging in door-to-door, telephone, email, texting or cold-call marketing activities
- Offering of any inducements, gifts, or promotions
- Distributing materials with inaccurate, false, or misleading statements, as reviewed and determined by Puerto Rico.
- Distributing materials that mislead or falsely describe the provider network

Furthermore, when performing any allowable activities, these need to be conducted Island-wide, without targeting specific regions.

### Opportunities for enhancing the current state

#### Opportunity to Improve Collaboration for Marketing Materials Development

**Challenge:** We have established guidelines for marketing materials that are outlined in the Plan Vital MCO contracts (Section 6.15.6.1) and its attachment, Normative Letter 18-0807. After PRHIA reviews and revises the material, marketing materials for the Platino beneficiaries served by the MAOs are reviewed and revised by CMS in accordance with CMS’s standards. We share CMS’s revisions with the MAOs and for any findings that require reconsideration, we submit the materials back to CMS for review. Marketing materials that are not for Platino program are not revised by CMS.

**Leading Practice:** Per the Managed Care Final Rule, Medicaid programs are required to consult with the Medical Care Advisory Committee (MCAC) in reviewing the marketing materials submitted by the MCOs. In addition, other Medicaid programs have expanded their monitoring of additional marketing activities by the MCOs such as monitoring website information, health fair attendance, and incentives for their members (e.g., gift cards to beneficiaries for obtaining flu vaccines or wellness visits).

**Opportunity:** Increased alignment with CMS and relevant stakeholders could be helpful around the review and expectations of MAOs’ marketing materials and activities. This, in turn, can improve onboarding materials validations by incorporating and adhering to CMS marketing and communication guidelines with input from the advisory committee to the Medicaid agency director. In order to maintain efficiency, it would be beneficial to establish a policy and procedure on what marketing materials and activities would receive additional feedback from the MCAC and determine an appropriate review cadence.

## 5.9 Enrollment and Disenrollment

### Functional Area Description

The Enrollment and Disenrollment functional area refers to the active enrollment process where the enrollee chooses an MCO/MAO or, if not, is assigned to an MCO using the Medicaid’s program default enrollment process; or they may use a passive enrollment process where the person either maintains enrollment in the assigned MCO/MAO or selects a different MCO/MAO. In the passive enrollment process, if the enrollee does not select during the time allowed by the Medicaid program, the plan selected by the passive enrollment remains in effect [42 CFR 438.54]. It also refers to the Member Disenrollment and specifically to how MCO contracts must specify the reasons MCOs may request disenrollment of an enrollee and prohibit the MCO from requesting disenrollment of an enrollee due to an adverse change in the enrollee’s health status, or because of the enrollee’s utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs [42 CFR 438.56]. Additionally, the Provider Enrollment refers to the Medicaid’s program responsibility to enroll and screen all providers who are providing services under the State plan. [42 CFR 455.410]. The Medicaid program may terminate any provider that it determines has falsified any information or does not allow onsite visits, among other situations. [42 CFR 455.416] This functional area includes:

- Member enrollment and disenrollment
- Provider enrollment and termination

### Current processes for the functional area in Puerto Rico and stakeholders involved

#### Member Enrollment and Disenrollment

PRDOH is responsible for first determining the eligibility of a potential beneficiary for the Puerto Rico Medicaid or CHIP Program. As of November 2020, Puerto Rico has 1.2 million Medicaid eligible cases and about 87,000 CHIP eligible cases.<sup>64</sup> As the sister agency, PRHIA is then responsible for the enrollment of eligible beneficiaries into an MCO/MAO and a Primary Care Physician (PCP) and Primary Medical Group (PMG). In addition, as part of the changes implemented for Plan Vital in 2018, the geographical regions ceased, and we moved to an Island-wide coverage in which enrollees select their MCO of preference with support from an enrollment counselor.

Thus, for a potential beneficiary to enroll into an MCO, they first need to obtain a Medicaid or CHIP eligibility determination directly from PRDOH, and may do so through web portal, telephone, or in-person at local offices across the Island. We are exploring new technology and ways that allow for beneficiaries to automatically recertify through electronic means and transform the role of the Medicaid local offices.

Once a beneficiary is determined eligible for Medicaid or CHIP program, then they may select and enroll in an MCO and select their PCP/PMG. PRDOH sends daily eligibility files to PRHIA, so PRHIA can handle the daily enrollment process. To guide potential beneficiaries in the MCO selection process, PRHIA has contracted with a vendor to provide enrollment counseling. The responsibility of the enrollment counselor is to inform new enrollees of their choices either through phone, in-person, or online;

<sup>64</sup> Puerto Rico Medicaid Program. (2020). *Eligibility cases by program and region, by month*. Retrieved from <https://www.medicaid.pr.gov/Info/Statistics/>.



furthermore, the enrollment counselor must ensure the potential enrollee has unbiased and extensive information on each MCO, so that they can make an informed decision in selecting an MCO. Nevertheless, the potential enrollee does not have to use the enrollment counseling services. If the beneficiary does not select an MCO, then PRHIA will default enroll that beneficiary into an MCO. Currently, PRHIA uses a round-robin sequential approach for default auto-enrollment, meaning that each MCO receives an individual potential enrollee until every MCO has received one, then the process repeats itself. We also consider the MCO’s capability to receive the number of beneficiaries and provide services based on an approved risk-based capital analysis. The MCO section information is loaded into PRHIA’s information system and the new member notification is sent to the MCOs, which in turn, along with the help of the enrollment counselor, assign the member to their PCP and PMG. Again, the enrollee may choose to forego the enrollment counseling services and have both their PCP and PMG automatically assigned. PRHIA conducts a final validation on the subscriptions and reports back to the MCOs and PRDOH to finalize the process. It is important to note that the retroactive enrollments are handled directly by PRDOH, and PRHIA updates the beneficiary information based on the daily enrollment files provided.

Whether an enrollee selects an MCO or is automatically enrolled into an MCO, they have an opportunity to change their selection. Newly eligible beneficiaries have 60 days after their initial enrollment to change their MCO and/or PCP/PMG, if they would like. On an ongoing basis, beneficiaries have the opportunity to change MCOs, without just cause, during the annual open enrollment period for all enrollees. The enrollment counseling services are available to both new and existing enrollees during these open enrollments. Existing enrollees who wish to change MCOs outside of the enrollment period must have just cause and the change is handled on a case-by-case basis.

MCOs are allowed to request the disenrollment of enrollees. There are acceptable reasons for this request which include: the enrollee has demonstrated a pattern of abusive behavior, the enrollee has used the services in a fraudulent or wasteful manner, or the enrollee’s Medicaid eligibility has changed. The MCOs may not request disenrollment for the following reasons: missed appointments, diminished mental capacity, or pre-existing conditions. The MCO must submit the acceptable request to PRHIA. Once reviewed, PRHIA has the authority to make the enrollee first go through the MCO’s grievances and appeals system, which is described in more detail in Section 5.7 Grievances and Appeals. If not, PRHIA decides on whether to accept or deny the request for disenrollment. If PRHIA, decides to disenroll, then the enrollee has the right to a reconsideration. In the case of a second disenrollment decision, then the enrollee has the right to an Administrative Hearing, which is also described in more detail in Section 5.7 Grievances and Appeals. The MCO must continue to provide services while the enrollee transitions to another plan; additionally, the MCO, along with the enrollment counselor, must provide support throughout the transition. Finally, daily disenrollment information must be submitted to PRHIA.

For enrollees that have become ineligible for Medicaid benefits, a cancelation file is sent directly to PRHIA from PRDOH on a daily basis or by the end of the month. Once received, PRHIA processes the information and sends the notice to the MCOs, which are required to confirm the processing and receipt of the information. In addition, PRHIA, PRDOH, and the MCOs conduct monthly reconciliations of the beneficiary data to ensure accuracy.

In the case of a beneficiary voluntarily disenrolling from an MCO, the process is completed with the support of the enrollment counselor. First, the beneficiary contacts the enrollment counselor to make changes to their MCO without just cause. The enrollment counselor then sends the updated information to PRHIA on a daily basis with any changes reported, and then PRHIA compiles and processes the information on a weekly basis. Finally, PRHIA sends the updated enrollment and disenrollment information to the relevant MCOs and to PRDOH.

MCOs are required to distribute enrollment materials as part of the enrollment process for enrollees. The *Enrollee Enrollment Materials Report* (Report 2) captures on a quarterly basis mailing of initial and replacement Enrollee Enrollment materials including Enrollee ID cards, Enrollee handbooks, and Provider directories.

### Provider Enrollment and Termination

Provider enrollment, screening and credentialing is a shared effort across the Puerto Rico Medicaid Enterprise and MCOs/MAOs. Figure 7 below depicts the individual responsibilities for each step of the enrollment process.

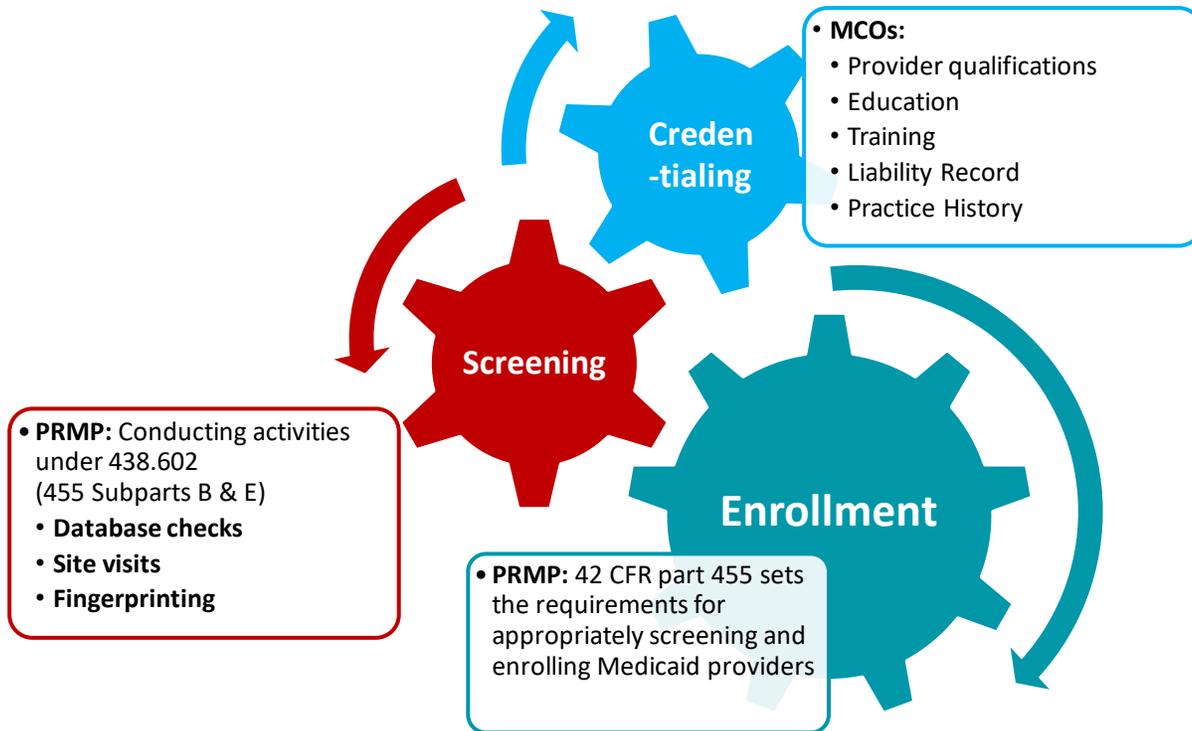


Figure 7. Provider Enrollment, Screening and Credentialing Roles across the Medicaid Enterprise.

It is the responsibility of the MCO to ensure that all its providers are enrolled within the Medicaid program and pass their credentialing. The MCO contract allows the MCOs to grant temporary contracts to providers for up to 120 calendar days. The MCO must terminate any temporary provider contract if PRHIA informs them that the provider cannot be successfully enrolled in the Medicaid program or if the aforementioned grace period has run out. When this occurs, the respective MCO must inform all affected enrollees. It is the responsibility of the MCOs to guide the providers through the enrollment process and ensure they receive any documents or provider agreements from PRHIA.



PRMP launched a new Provider Enrollment Portal (PEP) in May 2019.<sup>65</sup> This system has made much of the provider enrollment and screening process electronic. Additionally, the system allows for additional insights such as a risk level identification. Currently, we are working on increasing the PEP awareness and improving the user friendliness of the system in order to enroll all its providers. The deployment of the PEP was completed in three phases from 2019 to 2020, with the first phase focused on health professional organizations; The second phase focused on MCOs, Hospitals, Primary Care Facilities, FQHCs, Medical Groups, Laboratories, Imaging Centers, and Pharmacies; The third phase focused on individual providers. The providers enter their information into the PEP, which is screened and validated with the PR MMIS, and the provider’s application may then be approved. The enrolled provider information is then shared with PRHIA and with the MCOs/MAO. Through the PEP system, PRMP runs monthly screening tests on the risk of providers to determine which are a priority for screening and enrolling. The system generates an automated notification letter regarding the results of the screening, which is then sent to PRHIA and the MCOs.

The process for enrolling providers is ongoing. As of November 23, 2020, over 12,100 providers had been approved, enrolled, and screened using the new PEP. The Puerto Rico Medicaid Enterprise continues to improve the providers’ processes, PEP, and PR MMIS, which was also discussed in the OIG’s assessment for the Program Integrity and Provider Enrollment risk areas. The deadline for the provider community to complete the initial enrollment in PEP is December 31, 2020. In January 2021, we aim to assess the provider networks of the MCOs, MAOs, and PBM, and compare enrollments with their affiliations. Based on this assessment, the provider community may or not need an extension to enroll. An additional opportunity is described in the following section to increase provider enrollment.

MCOs/MAOs contract with providers to provide health care services to their enrolled beneficiaries. Monthly, the MCOs/MAOs notify the Puerto Rico Medicaid Enterprise of their contracted providers and PCP/PMG affiliations using the *Network Provider List (NPL)* (Report 15), which is described in more detail in Section 5.5 Network Adequacy and Access to Care. The provider information from the MCO/MAOs’ monthly NPL is updated in the PR MMIS. Please see Section 5.5 Network Adequacy and Access to Care for more information.

An MCO/MAO may request to terminate a provider’s contract only if there is “proper cause.” As examples, there could be a pattern of non-compliance with contract requirements, or the provider fails to correct their obligations. The MCO may not terminate a contract, if provider exercises its appeal rights or advocates on behalf of itself or an enrollee. PRHIA, though, has the authority to terminate a provider contract if it fails to comply with the provider contract obligations or if it does not address, within 15 calendar days, the notice to correct any contract negligence, and other reasons listed in the MCO contract. The provider only has one opportunity, as laid out in the provider contract, to appeal the termination. Finally, the MCO must inform PRHIA at 45 calendar days before the effective termination of a provider contract. This time allows PRHIA to determine the impact of that provider termination on access to care for Medicaid beneficiaries. The MCO must provide an explanation as to how network adequacy will be maintained and how they will help the affected enrollees find a replacement (primary care) provider.

<sup>65</sup> Puerto Rico Medicaid Program. (2020). *Provider Enrollment Portal (PEP) for the Puerto Rico Medicaid Program (PRMP)*. Retrieved from <https://pr.hppcloud.com/ProviderEnrollment/EnrollmentCreate>.



## Opportunities for enhancing the current state

### Opportunity to Introduce Additional Factors into the Default Enrollment Methodology

**Challenge:** We currently utilize a round robin approach to assign beneficiaries to MCOs if the beneficiary does not self-select an MCO. In addition, for this assignment methodology, we also consider the MCO’s capability to receive beneficiaries based on an approved risk-based capital analysis conducted by our external contractor. We acknowledge that this methodology does not provide the ability to reward high-performing MCOs and could be improved for a more effective distribution.

**Leading Practice:** According to the Medicaid and CHIP Managed Care Final Rule, states may consider additional criteria to conduct the default/passive enrollment process when an individual does not self-select an MCO, including: the previous plan assignment of the member, quality assurance and improvement performance, procurement evaluation elements, accessibility of provider offices for people with disabilities (when appropriate), and other reasonable criteria that support the objectives of the managed care program. Leading practices in other Medicaid programs have incorporated quality driven criteria into their default/passive enrollment process to incentivize and reward quality, assigning more beneficiaries into the high-performing MCOs that demonstrate consistent quality delivery.

**Opportunity:** We envision a potential opportunity for the Medicaid Enterprise to strengthen the default enrollment methodologies based on the examples seen in other Medicaid programs, incorporating additional factors that would end up enhancing the experience of the beneficiary and rewarding high-performing MCOs. To effectively integrate this methodology, our team would need to improve collaboration across teams to gather the necessary information and insights required for an enhanced default/passive enrollment process.

### Opportunity to Increase Provider Enrollment

**Challenge:** We have implemented a new Provider Enrollment Portal (PEP) within the PR MMIS<sup>66</sup>, which improves several processes for the MCOs and the providers. Among other benefits, it enables an electronic enrollment and screening process, additional insight gathering tools such as risk level identification, and a streamlined credentialing process for providers. As of November 23, 2020, over 12,100 providers were approved and enrolled via the new PEP; however, approximately 8,500 are expired/cancelled and have not yet enrolled. We have a communication plan that includes trainings, webinars, guides, etc., however, there have been difficulties to raise awareness for the new portal and encouraging providers to enroll by the deadline of December 31, 2020.

**Leading Practice:** Create structured plans regarding provider enrollment. These plans include prioritizing certain provider types and increased communications to providers not yet enrolled, such as targeted emails and notices. In addition, other Medicaid programs validate encounter records in their MMIS against the provider networks reported by the MCOs. Those providers that are not enrolled but are present in the MCO network are sanctioned or refused payment.

<sup>66</sup> Puerto Rico Medicaid Program. (2020). *Provider Enrollment Portal (PEP) for the Puerto Rico Medicaid Program (PRMP)*. Retrieved from <https://pr.hppcloud.com/ProviderEnrollment/EnrollmentCreate>.



**Opportunity:** These practices could help us not only prioritize the providers, but also expedite the overall provider enrollment process. The next step would be to complete an assessment of the provider networks of the MCOs, MAOs and PBM. Based on this assessment, the provider community may or not need an extension to enroll. Having all Medicaid providers enrolled and screened in PR MMIS’s PEP would increase the program’s integrity.



## 5.10 Financial Oversight, including Rate Development Standards and Payment Management

### Functional Area Description

The Financial Oversight functional area refers to the reporting and transparency functions that Puerto Rico must conduct to guarantee MCO compliance, including Financial Audits. In addition, for Rate Development Standards, states must provide all validated encounter data, fee-for-service data, and audited financial reports for the populations served by MCOs to the actuary developing capitation rates for three prior years [42 CFR 438.5]. This functional area includes:

- Financial Reporting and Transparency
- Payment Management
- Financial Audits
- Oversight in the Capitation Rate Setting Process and Rate Development Standards
- Value Based Purchasing

### Current processes for the functional area in Puerto Rico and stakeholders involved

#### Financial Reporting and Transparency

On a quarterly basis, the MCOs provide unaudited financial statements, 30 days after each quarter. The MCOs must also submit audited annual financial statements following Generally Accepted Accounting Principles (GAAP), as well as an Annual Report filed with the Puerto Rico Insurance Commissioner’s Office (PRICO), reconciling the PRICO’s Annual Report with its annual audited financial statements. Additionally, MCOs provide their annual corporate report of its parent company. Currently we compare the financial statements with the MCO-reported utilization and evaluate information for such things as:

- Member Months
- Earned Premiums
- Other Income
- Line 10 - Inpatient Hospital Services through Line 15 – Other Medical Services
- Capitation Payments
- Incentive Pool, Withhold Adjustments and Bonus Amounts
- Incurred Claims by Service Category
- Amounts estimated for incurred but not reported (IBNR) claims for services rendered
- Accrued Capitation Amount
- Accrued Incentive Pool, Withhold Adjustments and Bonus
- Other Accrued General Medical Expenses

For administrative details, MCOs report amounts spent on Health Care Quality Improvement (HCQI) activities in the Medicaid program as defined in 45 CFR 150.158, as well as Other Administrative Costs and Unallowable Services Expenses.



Our team has a process to analyze the abovementioned information, and there is also a reconciliation process conducted to calculate the recoups and any additional adjustments from prior months. One challenge that our team has experienced is that there are multiple systems across the Medicaid Enterprise that contain different sets of information that are not consistently in sync. This includes the CMS-64 file transfer process, which is currently conducted on a manual basis, and is also addressed by the OIG’s assessment for Other High-Risk Factors.

Furthermore, the Medical Loss Ratio (MLR) is calculated from MCO reported data, as well as with the Premium Tax Component of Reported Revenue, health insurance provider fee, Incurred Claims Adjustments, Adjustments or Exclusions to HCQI/ Health Information Technology (HIT) Meaningful Use Expenses, and Fraud Reduction Expenses or Fraud Recoveries. MCOs submit a *Medical Loss Ratio Report* (Report 36) in the format specified by PRHIA, by July 31 following the end of the contract year.

## Payment Management

Payments to the MCOs are on a monthly basis. To prepare and process payments, we start processing files received from the MCOs between the 1st and 15th of the month and analyze the enrollment files with the number of active enrollees for the MCO and the rate for each. As part of this process, eligibility records are validated, the ineligible beneficiaries are calculated, and the payment premiums are computed. The eligibility is determined using daily eligibility files that are received from Medicaid, including any disenrolled beneficiaries. In addition, the eligibility from the previous month is inspected, so the corresponding payments can be recouped as part of the current month’s remittance. Once the eligibility has been completed, the premium payments are calculated, ascertained, and sent to the MCOs.

For more information, please refer to the report on **Oversight of Managed Care Payment**.

## Financial Audits

MCOs are required to submit quarterly unaudited Financial Statement reports and yearly audited Financial Statements. These audits have to be conducted by an independent and certified auditing organization. In addition to the results, the MCOs need to submit the findings and recommendations from the audit along with responses to any such findings. Once the audited statements are reviewed and compared with the existing self-reported records and findings are reported, the MCOs present a corrective action plan to PRHIA for review and approval. After this, the MCOs must implement the plan within 15 calendar days, unless there is an explicit extension granted. Furthermore, these audited statements are later used for the rate setting processes that are described in the following section.

As we continue to review and audit the MCOs, there are planned improvements to better collect data with a greater level of detail and more frequently for the sub-capitation arrangements that MCOs hold with certain providers, which may appear in the encounter records as approved claims with no payments. This creates inconsistencies and gaps in the auditing process. In addition, current systems used for encounter data tracking and financial reporting are not connected across the Medicaid Enterprise. The data sharing processes are disconnected (creating potential multiple sources of truth), manual, and possibly error prone, limiting a clear tracking of adjustments and limiting comparison of MCO-reported data. As such, increasing the integration between data sources and the level of analysis would allow us to develop trends based on data gathered and improve the corrective plans presented by the MCOs, which would also address the OIG’s assessment for Overpayment Reporting and Other High-Risk Factors risk areas.

## Oversight in the Capitation Rate Setting Process and Rate Development Standards

We adhere to actuarial professional standards for the rate development process to validate base data and information and develop sound capitation rates using subject matter experts to aid the process. The rate setting process is completed six months in advance of the implementation of the new rates, allowing for timely CMS approvals to be requested as needed during the process, gathering approvals in advance whenever possible.

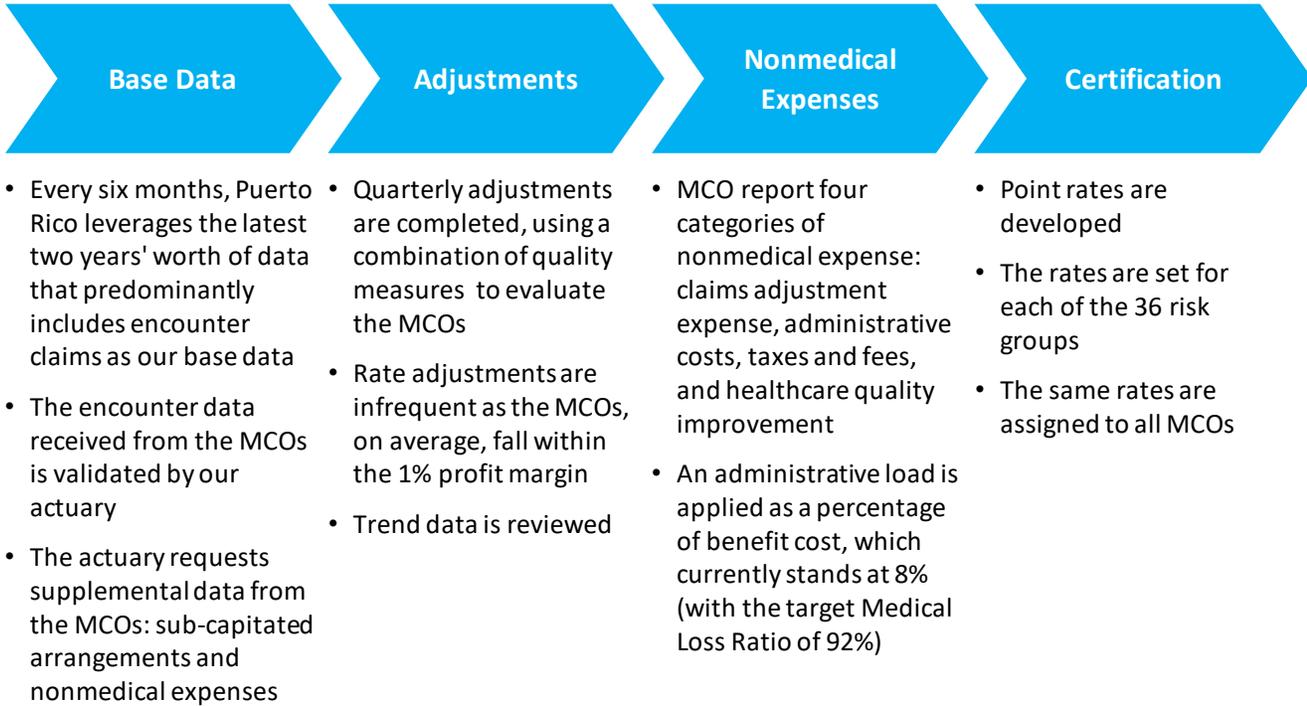


Figure 8. Rate Setting Process.

The actuarial calculations are conducted following a thorough process of metric validation, and detailed internal and external peer reviews. The basis for rate development is three years of audited financial statements and encounter information validated by our actuaries. An important additional data source collected from MCOs is supplemental information on sub-capitated arrangements. Other metrics that are validated in the process include administrative costs, qualitative data, and self-reported financial information. Once the validation process has been completed, the sub-capitated arrangements are defined based on the risk profile of the different MCOs. We use a “ground up” approach developing our rates independently by building upon projected health care costs and estimated administrative costs. We target 92 percent medical loss ratio and one percent target profit margin for Plan Vital, which is more aggressive than those seen in other Medicaid programs. Rates are defined as a point for each rate cell, adhering to CMS regulations.

In 2005 when the Medicare Advantage program was implemented stateside, Puerto Rico and the territories were not included in the Low-Income Subsidy program. As such, Puerto Rico did not have the opportunity to automatically transfer Dual Eligibles into MAOs as has been done in most states. Given this situation, Puerto Rico negotiated with CMS and HHS the creation of a special dual eligible program called “Medicare Platino” which, through the use of an Enhanced Allotment Plan (EAP)



provided by federal statute, Puerto Rico was able to provide dual eligibles the option to voluntarily opt out of Medicaid managed care and enroll in MAOs through the Platino program. Because of this, the vast majority of dual eligible beneficiaries are covered by Platino, which consists of available Medicare Advantage Dual Eligible Special Needs Plans (D-SNP) (also known as MAOs) targeted for these beneficiaries. This plan is funded similarly to other Medicare Advantage plans whereby the MAOs submit bids to CMS, and in turn, receive monthly Medicare Advantage capitation payments. In addition to these payments from CMS, MAOs contract with PRHIA and receive a \$10 per member per month (PMPM) wrap payment from Medicaid, which is funded by the abovementioned EAP. This payment funds wrap around benefits to elevate the Medicare Advantage benefits to Medicaid levels (e.g., \$0 cost sharing, elimination of the donut hole, access to drugs on Medicaid’s state formulary).

### Value Based Purchasing

Puerto Rico currently withholds two percent of the monthly capitation amount paid to the MCOs as part of the Health Care Improvement Program (HCIP). MCOs have an opportunity to earn this retention fund back each quarter through four quality improvement initiatives targeting high cost conditions, chronic conditions, healthy people, and high utilization of the emergency room. The payout to the MCOs is defined in a schedule based on the number of points earned in each category, with MCOs being able to earn zero percent up to 100 percent of the two percent retention in increments of 25 percent. The program evaluates MCO performance against defined benchmarks using dozens of metrics across conditions, indicators of healthy behavior, and service categories.

In addition, Diagnosis Related Groups (DRGs) have also been considered for improvement opportunities to reimburse hospitals the fixed amounts based on certain medical diagnoses, as these inpatient services are currently paid under a Per Diem model in Puerto Rico. These initiatives are currently not included in the rates and would be launched in 2021, as stated in the FY 2020 Annual Report in October 2020.



## Opportunities for enhancing the current state

### Opportunity to Improve Data Integrity and Automation

**Challenge:** Currently, we have separate accounting and financial systems within the Medicaid Enterprise. In addition, we have manual processes for tracking and reporting on the expenditures across all the grants and Federal funds received by the Puerto Rico Medicaid program. It is a challenge for us to track and manage the allocation and oversight of said funds as the data is reported via a legacy tracking tool that does not provide sufficient details to accurately track spending and allocation.

**Leading Practice:** Leading practices point towards the integration of collaborative systems to create a single reporting source across teams, enabling data automation, and providing access to appropriate staff.

**Opportunity:** We are in the process of expanding the capabilities of PR MMIS to provide more broad reporting that may be leveraged in MCO oversight and internal reporting processes including the development of the CMS-64 and CMS-37 reports, which also addresses OIG’s assessment for the Overpayment Reporting risk area. Increasing system integration, collaboration, and automation across the Medicaid Enterprise could improve information sharing with MCOs and our federal partners and allow for better reporting consistency and process automation, which in turn, allows for better data reconciliation across sources and data-driven insights. In addition, these enhancements would allow for a breakdown of the administrative costs for the program, including the tracking of funds that are being spent in Puerto Rico or taken to the mainland. This will be explored in greater detail as part of the reports on **Requirement 8: Audits of Managed Care Payments**<sup>67</sup> being submitted on December 20, 2020.

### Opportunity to Temporarily Modify Payment Methodologies and Profit-Sharing Arrangement

**Challenge:** The global COVID-19 pandemic has created an unprecedented situation for Medicaid. Capitation payments have continued to be paid throughout the duration of the pandemic without adjustment for the sudden drop in utilization for non-COVID-19 related services such as elective surgeries. This highlights across Medicaid programs the need to incorporate profit-sharing arrangements that protect from significant overpayment while also allowing and encouraging MCOs’ ability to effectively manage their members in an increasingly efficient manner that improves overall health and health care. This will also be evaluated further starting on November 30, 2020 with our actuaries.

**Leading Practice:** CMS released a guidance in May 2020 on several options that states can consider for their Medicaid managed care contracts.<sup>68</sup> Some of those options are explored below.

<sup>67</sup> PL 116-94: Further Consolidated Appropriations Act, 2020:(133 STAT 3110), Division N, Title 1, Subtitle B, §202(f)(3)

<sup>68</sup> Center for Medicare & Medicaid Services, Department of Health & Human Services. (May 14, 2020). *CMCS Informational Bulletin: Medicaid Managed Care Options in Responding to COVID-19*. Retrieved from: <https://www.medicare.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051420.pdf>.

- Medical Loss Ratio and Experience Rebates:** Puerto Rico currently imposes a 92 percent medical loss ratio (MLR) on all MCOs providing services to Puerto Rico's Medicaid population. Should the MLR for any MCO fall below 92 percent, the difference between the actual MLR and 92 percent must be remitted in its entirety to Puerto Rico (which is then shared back with the federal government at the corresponding Federal Medical Assistance Percentage rate). Based on our evaluation of other state Medicaid programs, our MLR of 92 percent appears to be more aggressive. Should a state impose an MLR in its MCO contracts, it must be no less than 85 percent. Only 30 states impose some form of MLR remittance requirement, and only 24 of those states require remittance. The remaining six states require remittance only some of the time. For example, one state waives the remittance requirement if an MCO achieves a high National Committee for Quality Assurance (NCQA) health insurance plan rating. Some states only impose remittance requirements on Medicaid expansion benefits relating to adult beneficiaries. Some states who do not require MLR remittance use other tactics such as profit sharing. Another state, for example, defines brackets of the amount of the MCO's profit to be shared back with the state. Should profits (net income before taxes) exceed three percent but not exceed five percent of capitation payments made, MCOs must remit 20 percent of the profit in that bracket. The remittance required continues to scale until profit exceeds 12 percent; at that point, MCOs must remit all profit back to the state over the threshold.
- Retroactive Risk Mitigation Strategies:** While not widely approved, CMS has considered state and territory requests to implement risk mitigation strategies retroactively into MCO contracts, as they relate to the Public Health Emergency. CMS's standard position is that all risk mitigation tactics should be prospective but understands COVID-19 has brought about unique situations. As exemplified in an informal bulletin released in May 2020, such retroactive risk mitigation strategies could include two-sided risk corridors using MLR as the risk measure. This would allow states to recoup additional funds should an MCO's MLR fall below the minimum allowed, but it also allows for MCOs to receive supplemental payments should they have higher than average risk (e.g., treating a disproportionate share of COVID-19 patients).
- Invest in Network Providers:** Health care workers and facilities are not immune to the economic effects of COVID-19. The loss in revenue from deferred services has driven layoffs or facilities to close their doors. As part of the COVID-19 response, the May 14, 2020 bulletin also outlines several investments that states and MCOs can make to maintain adequate network access. Such investments may include requiring MCOs to make retainer payments to habilitation and personal care providers or making state directed payments to temporarily increase provider payments for certain types of providers. Both actions can direct excess profit away from MCOs and towards providers in need of funding to stay afloat.
- Rate adjustments:** In accordance with CMS guidelines, states and territories may make de minimis adjustments to rates throughout the fiscal year. However, rate adjustments larger than 1.5 percent must be accompanied by a revised actuarial rate certification with sufficient justification for the adjustment. While COVID-19 has resulted in significant disruption in the health care industry and impacted utilization, the exact impact due to COVID-19 is still developing and not easily measured to provide sufficient justification to revise assumptions or adjust in the revised rate filing. Therefore, revising capitation rates prospectively or retroactively will be a very difficult undertaking. There are states exploring this option, and some have already cut their capitation rates retrospectively solely due to COVID-19.

**Opportunity:** While we have mechanisms in place to recoup the potential excess profit, we will continue to explore the abovementioned levers to use for further recoupment of these profits, which also addresses the Overpayment Reporting risk area highlighted in the OIG Final Report findings, titled ‘**A-02-20-01011 Risk Assessment Puerto Rico Medicaid Program**’<sup>69</sup>.

<sup>69</sup> Office of Inspector General, Department of Health & Human Services. (December 11, 2020). A-02-20-01011 Risk Assessment Puerto Rico Medicaid Program. Retrieved from <https://oig.hhs.gov/oas/reports/region2/22001011.asp>.

## 6. ASSUMPTIONS

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Opportunities to improve contract oversight will depend on our resources and capacity. We describe in our contracting reform plan the activities to prioritize the contract oversight opportunities and implement in phases. Please refer to the report on **Requirement 3: Contracting Reform Plan**<sup>70</sup>.

To comply with the mandate from the U.S. Congress and other Federal Government entities, Puerto Rico Medicaid Enterprise submitted two responses on November 13, 2020 to inquiries received on October 29, 2020 from the U.S. Comptroller General’s Government Accountability Office (GAO). As it relates to responding to *“any changes that the Comptroller General determines necessary to improve the program integrity of such plan (or waiver)”*, as of December 20, 2020, the deadline of the submission of this report to Congress, the U.S. Government Accountability Office (GAO) led by the Comptroller General has not finalized their report about Puerto Rico. We will add an addendum to this report with our response and include any opportunities for Congress, the Secretary of Health and Human Services, or Puerto Rico.

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<sup>70</sup> PL 116-94: Further Consolidated Appropriations Act, 2020:(133 STAT 3105), Division N, Title 1 §202(a)(7)(A)(iii)  
Requirement 7: Contracting Oversight and Approval Report  
Government of Puerto Rico, Office of the Governor

# 7. APPENDIX

## Acronyms

This section includes acronyms in the report addressing **Contracting Oversight and Approval**.

Acronym	Definition
AAFAF	Puerto Rico Fiscal Agency and Financial Advisory Authority
APD	Advance Planning Document
ASSMCA	Puerto Rico Administration of Mental Health and Anti-Addiction Services
BAA	Business Associate Agreement
BOD	Board of Directors
CAHPS®	Consumer Assessment of Health care Providers and Systems
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CHIP	Children’s Health Insurance Program
CMMM	Contract Management Maturity Model
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus disease 2019
DRGs	Diagnosis Related Groups
D-SNP	Dual Eligible Special Needs Plan
EAP	Enhanced Allotment Plan
EDW	Electronic Data Warehouse
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FADU	Fraud and Abuse Detection Unit
FMAP	Federal Medical Assistance Percentage
FOMB	Financial Oversight and Management Board for Puerto Rico
FQHC	Federally Qualified Health Center
GAAP	Generally Accepted Accounting Principles
GAO	U.S. Government Accountability Office
HALOS	Hospital Admissions and Length of Inpatient Stays for Physical and Behavioral Health Services Audit
HCHN	High Cost High Needs
HCIP	Health Care Improvement Program

Acronym	Definition
HCQI	Health Care Quality Improvement
HEDIS®	Health care Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
IBNR	Incurred but Not Reported
KPI	Key Performance Metric
MAC	Medicaid and CHIP
MAO	Medicare Advantage Organization
MCAC	Medical Care Advisory Committee
MCO	Managed care organization
MEQC	Medicaid Eligibility Quality Control
MFCU	Medicaid Fraud Control Unit
MLR	Medical Loss Ratio
MMIS	Medicaid Management Information System
MOU	memorandum of understanding
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
NPL	Network Provider List
NPPES	National Plan and Provider Enumeration System
OIG	U.S. Office of Inspector General of the Department of Health and Human Services
OMB	Puerto Rico Office of Management and Budget
OSG	Office of the Chief of Staff of the Governor of Puerto Rico (Oficina de la Secretaría de la Gobernación, in Spanish)
PBM	Pharmacy Benefit Manager
PCo	Contract Processing System
PCP	Primary Care Physician
PDP	Preferred Drug Program
PEP	Provider Enrollment Portal
PERM	Payment Error Rate Measurement
PIP	Performance improvement program
PIU	Program Integrity Unit
P.L.	Public Law

Acronym	Definition
PMG	Primary Medical Group
PMPM	per member per month
PMPY	per member per year
PPA	Pharmacy Program Administration
PRDOH	Puerto Rico Department of Health
PRFAA	Puerto Rico Federal Affairs Administration
PR GSA	Puerto Rico’s General Services Administration
PRHIA	Puerto Rico Health Insurance Administration
PRICO	Puerto Rico Insurance Commissioner’s Office
PR MMIS	Puerto Rico’s Medicaid Management Information System
PRMP	Puerto Rico’s Medicaid Program
PROMESA	Puerto Rico Oversight, Management, and Economic Stability Act
QAPI	Quality Assessment Performance Improvement program
QIO	Quality Improvement Organization
QMS	Quality management strategy
RFI	Request for Information
RFP	Request for Proposal
RFQ	Request for Qualifications
SIU	Special Investigative Unit
SMA	State Medicaid Agency
SOW	Statement of Work
SSA	Single State Agency
TPL	Third Party Liability
XML	Extensible Markup Language

Table 9. Acronyms in Report for Requirement 7 – Contracting Oversight and Approval.

## Reports Required from MCOs

The 36 reports shown below are outlined in the Plan Vital Reporting Guide with the requirements and data fields for each. This list of reports and the frequency for each is included as part of Attachment 16 of the MCO contract. These reports are sent on a weekly, bi-weekly, monthly, or quarterly basis by the MCOs. The column labeled “Informs KPI in the Compliance Tool” identifies if PRHIA has plans to incorporate the report into a Key Performance Indicator (KPI) metric in the new compliance tool, which is described in more detail in Section 5.3 State Monitoring Standards.

Report Number	Report Title	Program Area / Topic	PRHIA Office to Review	Contract Section	Frequency	Informs KPI in the Compliance Tool
1	Call Center Report	Administrative	Customer Service	18.2.2.1	Monthly	No
2	Enrollee Enrollment Materials Report	Administrative	Customer Service	18.2.2.2	Quarterly	No
3	Fraud Waste Abuse Report	Administrative	Compliance	18.2.2.3	Quarterly	Yes
4	Privacy and Confidentiality Report	Administrative	Compliance	18.2.2.4	Monthly	No
5	Systems Incident Report	Administrative	Information Systems	18.2.2.5	Annually or 10 Business Days following incident	No
6	Federal Qualified Health Center (FQHC) Report	Administrative	Compliance	18.2.2.6	Quarterly	No
7	Special Coverage Registry Report	Administrative	Clinical Affairs	18.2.2.7	Monthly	No
8	High Cost High Needs Registry Report	Administrative	Planning & Quality	18.2.2.8	Monthly	No
9	Disclosure of Information on Annual Business Transactions	Administrative	Compliance	18.2.2.9	Annually	No
10	Statistical Reports	Administrative	Planning	18.2.2.10	45 days of end of year	No
11	Claims Activity Report	Claims	Clinical Affairs	18.2.3.1	Monthly	Yes
12	Encounter Data	Claims	Information Systems	18.2.3.2	Monthly	No

Report Number	Report Title	Program Area / Topic	PRHIA Office to Review	Contract Section	Frequency	Informs KPI in the Compliance Tool
13	CMS 416 Report	Covered Services	Planning & Quality	18.2.4.1	Annually	No
14	Executive Director and Utilization Data Report	Covered Services	Planning & Quality	18.2.4.2	Quarterly	Yes
15	Network Provider List	Provider Reports	Planning & Quality	18.2.5.1	Monthly	No
16	Geographic Access Report	Provider Reports	Planning & Quality	18.2.5.2	Quarterly	Yes
17	Appointment Availability Report	Provider Reports	Planning & Quality	18.2.5.3	Quarterly	Yes
18	Provider Satisfaction Survey Report	Provider Reports	Planning & Quality	18.2.5.4	Annually	No
19	Provider Training and Outreach Evaluation Report	Provider Reports	Planning & Quality	18.2.5.5	Quarterly	No
20	Physician Incentive Program Report	Provider Reports	Planning & Quality	18.2.5.6	Annually	No
21	Grievances and Appeals Report	Quality	Customer Service	18.2.6.1	Quarterly	Yes
22	Health Care Improvement Program (HCIP) Plan Report	Quality	Planning & Quality	18.2.6.2	Quarterly	Yes
23	Enrollee Satisfaction Survey Report	Quality	Planning & Quality	18.2.6.3	Annually	No
24	Audited HEDIS® Results Report	Quality	Planning & Quality	18.2.6.4	Annually	Yes
25	Integration Model Report	Utilization Management	Clinical Affairs	18.2.7.1	Quarterly	Yes
26	Systems Availability and Performance Report	Systems	Information Systems	18.2.8.1	Monthly	No

Report Number	Report Title	Program Area / Topic	PRHIA Office to Review	Contract Section	Frequency	Informs KPI in the Compliance Tool
27	Business Continuity and Disaster Recovery (BC-DR) Test Report	Systems	Information Systems	18.2.8.2	Annually	No
28	Unaudited Financial Statement	Financial Management	Finance	18.2.9.1	Quarterly	Yes
29	Report on Controls Placed in Operation and Tests of Operating Effectiveness	Financial Management	Finance	18.2.9.2	Annually	No
30	Audited Financial Statements	Financial Management	Finance	18.2.9.3	Annually	No
31	Cost Avoidance Report	Financial Management	Finance	18.2.9.4	Quarterly	No
32	Report to Puerto Rico Insurance Commissioner's Office	Financial Management	Compliance	18.2.9.5	Annually	No
33	Annual Corporate Report	Financial Management	Compliance	18.2.9.6	Annually	No
34	Pharmacy Certification	Financial Management	Finance	18.2.9.7	Every two weeks	No
35	Incurred but Not Paid (IBNR) Report	Financial Management	Finance	18.2.9.8	Quarterly	No
36	Medical Loss Ratio Report	Financial Management	Finance	18.2.9.9	Annually	No

Table 10. Reports Required from MCOs.