corruption, fraud, embezzlement, or unlawful appropriation of public funds, pursuant to Act 458, as amended, and Act 84 of 2002 or has been excluded from the Medicare, Medicaid, or Title XX Services Programs;

7.2.1.44 Include a penalty clause to require the return of public funds paid to a Provider that falls within the prohibitions stated in Section 7.2.1.43 above;

7.2.1.45 Require that all reports submitted by the Provider to the Contractor be labeled with the Provider's NPI, if applicable;

7.2.1.46 Include Provider dispute process as described in Section 13.11.6

7.2.1.47 Require the Provider to disclose information on ownership and control as specified in Section 48.2; and

7.2.1.48 Require the Provider to disclose information as listed in Section 15.2.1.9.

7.3 Termination of Provider Contracts

7.3.1 The Contractor shall comply with all Puerto Rico and Federal laws regarding Provider termination. The Provider Contracts shall:

7.3.1.1 Contain provisions allowing immediate termination of the Provider Contract by the Contractor "for cause." Cause for termination includes, but is not limited to, gross negligence in complying with contractual requirements or obligations; a pattern of noncompliance with contractual requirements or obligations that the Provider fails to correct after being notified of such noncompliance by the Contractor; insufficiency of funds of ASES or the Contractor, which prevents them from continuing to pay for their obligations; changes in Federal or State law, among others. The Contractor shall not terminate a Provider Contract in retaliation for the Provider exercising his or her Appeal rights, advocating on behalf of the Provider, or for advocating on behalf of an Enrollee.

7.3.1.2 Specify that in addition to any other right to terminate the Provider Contract, and notwithstanding any other provision of this Contract, ASES may demand Provider termination Immediately, or the Contractor may Immediately terminate on its own, a Provider's participation under the Provider Contract if:

7.3.1.2.1 The Provider fails to abide by the terms and conditions of the Provider Contract, as determined by ASES, or, in the sole discretion of ASES, if the Provider fails to come into compliance within fifteen (15) Calendar Days after a receipt of notice from the Contractor specifying such failure and

requesting such Provider to abide by the terms and conditions hereof; or

7.3.1.2.2 The Contractor or ASES learns that the Provider:

7.3.1.2.2.1 Falls within the prohibition stated in Section 7.2.1.43;

7.3.1.2.2.2 Has been or could be excluded from participation in the Medicare, Medicaid, or CHIP Programs;

7.3.1.2.2.3 Could be excluded from the Medicaid Program under 42 CFR 1001.1001 (ownership or control in sanctioned entities) and 1001.1051 (entities owned or controlled by a sanctioned person); and/or

7.3.1.2.2.4 Fails to comply with the Provider Credentialing process and requirements.

7.3.1.3 Specify that any Provider whose participation is terminated under the Provider Contract for any reason shall utilize the applicable Appeals procedures outlined in the Provider Contract. No additional or separate right of Appeal to ASES or the Contractor is created as a result of the Contractor's act of terminating, or decision to terminate any Provider under this Contract. Notwithstanding the termination of the Provider Contract with respect to any particular Provider, this Contract shall remain in full force and effect with respect to all other Providers.

7.3.2 The Contractor shall notify ASES prior to the effective date of the termination of a Provider from participation in the Contractor's network for any reason set forth in Sections 7.3.1.1 and 7.3.2.2 above, and provide the reasons for the termination.

7.3.3 Unless otherwise specified by ASES, the Contractor shall, within fifteen (15) Calendar Days after receipt or issuance of a notice of termination to a Provider, provide written notice of the termination to Enrollees who received his or her Primary Care from, or was seen on a regular basis by, the terminated Provider, and shall assist the Enrollee as needed in finding a new Provider.

7.4 Provider Payment

7.4.1 General Provisions

7.4.1.1 The Contractor guarantees payment for all Medically Necessary Services rendered by Providers on a person's Effective Date of Enrollment.

7.4.1.2 The Contractor shall require, as a condition of payment, that the Provider accept the amount paid by the Contractor or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the Enrollee's Third-Party payer) plus any applicable amount of Co-Payment responsibilities due from the Enrollee as payment in full for the service.

7.4.1.3 The Contractor shall ensure that Enrollees are held unaccountable by the Provider for the costs of Medically Necessary Services except for applicable Co-Payment amounts (described in Section 4.4.1.1.6 and Appendix C-6 of this Contract).

7.4.1.4 The insolvency, liquidation, bankruptcy, or breach of contract of any Provider will not release the Contractor from its obligation to pay for all services rendered as authorized under this Contract.

7.4.1.5 Payment arrangements with Providers may take any form allowed under Federal law and the laws of Puerto Rico, including Capitation payments, Fee-for-Service payment, and salary, if any.

7.4.1.6 All Provider payments by the Contractor shall be reasonable, and the amount paid shall not jeopardize or infringe upon the quality of the services provided.

7.4.1.7 Even if the Contractor does not enter into a capitated payment arrangement with a Provider, the Provider shall nonetheless be required to submit to the Contractor detailed Encounter Data (see Section 13.8 of this Contract).

7.4.1.8 The Contractor shall be responsible for issuing to the forms required by the Department of the Treasury, in accordance with all Puerto Rico laws, regulations, and guidelines.

7.4.1.9 The Contractor shall make timely payments to Providers in accordance with Federal requirements, including as set forth under 42 CFR 422.520.

7.4.2 Payments to FQHCs and RHCs. When the Contractor negotiates a contract with an FQHC and/or an RHC, as defined in Section 1905(a)(2)(B) and 1905(a)(2)(C) of the Social Security Act, the Contractor shall pay to the FQHC or RHC rates that are not less than the rates paid to other similar Providers providing similar services. The Contractor shall cooperate with ASES and the Department of Health in ensuring that payments to FQHCs and RHCs are consistent with Sections 1902(a)(15) and 1902(bb)(5) of the Social Security Act.

7.4.3 Requirement to Verify Eligibility. The Contractor warrants that all of its Network Providers shall verify the eligibility of Enrollees before the Provider

provides Covered Services. This verification of eligibility is a condition of receiving payment from the Contractor for Covered Services.

ARTICLE 8 UTILIZATION MANAGEMENT

8.1 General

8.1.1 The Contractor shall comply with Puerto Rico and Federal requirements for Utilization Management ("UM") including but not limited to 42 CFR Part 456.

8.1.2 The Contractor shall ensure the involvement of appropriate, knowledgeable, currently practicing Providers in the development of UM procedures.

8.1.3 The Contractor shall manage the use of a limited set of resources and maximize the effectiveness of care by evaluating clinical appropriateness, and authorizing the type and volume of services through fair, consistent, and Culturally Competent decision-making processes while ensuring equitable Access to care and a successful link between care and outcomes.

8.1.4 The Contractor shall submit to ASES on an annual basis existing UM edits in the Contractor's Claims processing system that control Utilization and prevent payment for Claims that are duplicates, unbundled when they should be bundled, already covered under another charge, etc.

8.1.5 ASES reserves the right require the Contractor to submit any Utilization Management report.

8.2 Utilization Management Policies and Procedures

8.2.1 The Contractor shall provide assistance to Enrollees and Providers to ensure the appropriate Utilization of resources. The Contractor shall have written Utilization Management policies and procedures included in the Provider Guidelines (see Section 7.1) that:

8.2.1.1 Include protocols and criteria for evaluating Medical Necessity, authorizing services, and detecting and addressing over, under, and inappropriate Utilization. Such protocols and criteria shall comply with Federal and Puerto Rico laws and regulations.

8.2.1.2 Address which services require PCP Referral, which services require Prior Authorization, and how requests for initial and continuing services are processed, and which services will be subject to concurrent, retrospective, or prospective review.

8.2.1.3 Describe mechanisms in place that ensure consistent application of review criteria for Prior Authorization decisions and consult with the requesting Provider when appropriate.

8.2.1.4 Require that all Medical Necessity determinations be made in accordance with ASES's Medical Necessity definition. Divergence from standards set forth in clinical protocols and guidelines cannot be the sole reason for denying a Covered Service if the divergence is documented by the treating physician and supported by clinical evidence and generally accepted medical norms; appropriate in type, frequency, grade, setting and duration; and not solely for the convenience of the Enrollee, treating or other Provider, or the Contractor.

8.2.1.5 Facilitate the delivery of high quality, low cost, efficient, and effective care.

8.2.1.6 Ensure that services are based on the history of the problem or illness, its context, and desired outcomes.

8.2.1.7 Emphasize relapse and crisis prevention, not just crisis intervention.

8.2.1.8 Detect over, under, and inappropriate Utilization of services to assess quality and appropriateness of services and to assess quality and appropriateness of care furnished to Enrollees with special health care needs.

8.2.1.9 Ensure that any decision to deny a Service Authorization Request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a Provider who has appropriate clinical expertise to understand the treatment of the Enrollee's condition or disease, such as the Contractor's medical director.

8.2.2 The Contractor shall submit its Utilization Management policies and procedures to ASES for review and prior written approval according to the timeframe set forth in Appendix L to this Contract. Utilization Guidelines to be used for clinical audit must be approved by ASES and must be prepared by nationally recognized companies. The Contractor submitted as part of the information requested, the licenses for use and certification of personnel training that will be using. These Guidelines should be sent to the Executive Office within thirty (30) days of signed contract.

8.2.3 The Contractor's Utilization Management policies and procedures shall define when a conflict of interest for a Provider involved in Utilization Management activities may exist and shall describe the remedy for such conflict.

8.2.4 The Contractor, and any delegated Utilization Management agent, shall not permit or provide compensation or anything of value to its employees, Agents, or contractors based on:

8.2.4.1 Either a percentage of the amount by which a Claim is reduced for payment or the number of Claims or the cost of services for which the person has denied authorization or payment; or

8.2.4.2 Any other method that encourages a decision to deny, limit, or discontinue a Medically Necessary Covered Service to any Enrollee, as set forth by 42 CFR 438.210(e).

8.2.5 Prior Authorization shall not be required for any Emergency Service, notwithstanding whether there is ultimately a determination that the condition for which the Enrollee sought treatment from an Emergency Services Provider was not an Emergency Medical Condition or Psychiatric Emergency.

8.3 Utilization Management Guidance to Enrollees.

8.3.1 As provided in Section 4.3.1.14, the Contractor shall provide clear guidance to Enrollees on its Utilization Management policies. Upon request, the Contractor shall provide Utilization Management decision criteria to Providers, Enrollees, their families, and the public.

ARTICLE 9 QUALITY IMPROVEMENT AND PERFORMANCE PROGRAM

9.1 General Provisions

9.1.1 The Contractor shall provide for the delivery of quality care to all Enrollees with the primary goal of improving health status or, in instances where the Enrollee's health is not amenable to improvement, maintaining the Enrollee's current health status by implementing measures to prevent any further deterioration of his or her health status.

9.1.2 The Contractor shall seek input from, and work with, Enrollees, Providers, community resources, and agencies to actively improve the quality of care provided to Enrollees.

9.1.3 The Contractor shall ensure that its Quality Assessment and Performance Improvement Program effectively monitors the program elements listed in 42 CFR 438.66.

9.1.4 ASES, in strict compliance with 42 CFR 438.340 and other Federal and Puerto Rico regulations, shall evaluate the delivery of health care by the Contractor. Such quality monitoring shall include monitoring of the following measures, and reporting results to CMS and ASES as required:

9.1.4.1 Health Plan and Employer Data Information Set (HEDIS)

9.1.4.2 Consumer Assessment of Health Plan Satisfaction (CAHPS)

9.1.4.3 Health Outcomes Survey (HOS)

9.1.5 The Contractor shall cooperate with any Puerto Rico or Federal monitoring of its performance under this Contract, which may include but is not limited to external quality reviews, operational reviews, performance audits and evaluations.

9.1.6 The Contractor shall identify, collect and provide any Data, Medical Records or other Information requested by ASES or its authorized representative or the Federal agency or its authorized representative in the format specified by ASES/Federal agency or its authorized representative. The Contractor shall ensure that the requested Data, Medical Records, and other Information is provided at no charge to ASES, all Federal agencies, or their authorized representative.

9.1.7 If requested, the Contractor shall provide workspace at the Contractor's local offices for ASES, any Federal agencies, or their authorized representative to review requested Data, Medical Records, or other Information.

9.2 Quality Assessment Performance Improvement ("QAPI") Program

9.2.1 The Contractor shall comply with Puerto Rico and Federal standards for Quality Management/Quality Improvement ("QM/QI").

9.2.1.1 The Contractor shall establish QAPI that specifies the Contractor's quality measurement and performance improvement activities using clinically sound, nationally developed and accepted criteria.

9.2.1.2 The Contractor's QAPI program shall be submitted to ASES for review and approval according to the timeframe specified in Appendix L of this Contract.

9.2.2 The QAPI program shall be in compliance with Federal requirements specified at 42 CFR 438, Subpart E.

9.2.3 The Contractor agrees to conduct Chronic Care Improvement Program (CCIP) relevant to its Enrollees in accordance with Section 1852 of the Act and 42 CFR 422.152, and to submit the annual report on the CCIP to CMS and ASES as required.

9.2.4 The Contractor's annual QAPI program shall be submitted to ASES for review and prior written approval according to the timeframe set forth in Appendix L to this Contract and subject to the annual reporting requirements outlined in Section 15.2.1.5.

9.2.5 The Contractor shall submit any changes to its QAPI program to ASES for review and prior written approval sixty (60) Calendar Days prior to implementation of the change.

9.2.6 Upon the request of ASES, the Contractor shall provide any Information and documents related to the implementation of the QAPI program.

ARTICLE 10 FRAUD, WASTE, AND ABUSE

10.1 General Provisions

10.1.1 The Contractor shall have and implement a comprehensive internal administrative and management controls, policies, and procedures in place designed to prevent, detect, report, investigate, correct, and resolve potential or confirmed cases of Fraud, Waste, and Abuse in the administration and delivery of services detailed in this Contract.

10.1.2 The Contractor's internal controls, policies, and procedures shall comply with all Federal requirements regarding Fraud, Waste, and Abuse and program integrity, including but not limited to Sections 1128, 1128A, 1156, 1842(j)(2), 1902(a)(68), and 1903(i)(2)(C) of the Social Security Act,42 CFR 438.608, the CMS Medicaid Integrity program, and the Deficit Reduction Act of 2005. The Contractor shall exercise diligent efforts to ensure that no payments are made to any person or entity that has been excluded from participation in Federal health care programs. (See State Medicaid Director Letter #09-001, January 16, 2009.)

10.1.3 The Contractor shall have surveillance and Utilization control programs and procedures (see 42 CFR 456.3, 42 CFR 456.4, 42 CFR 456.23) to safeguard against under-utilization, unnecessary or inappropriate use of Covered Services and against excess payments for Covered Services.

10.1.4 The Contractor shall have adequate staffing and resources to identify and investigate unusual incidents and develop and implement Corrective Action plans to assist the Contractor in preventing and detecting potential Fraud, Waste, and Abuse.

10.1.5 The Contractor shall establish effective lines of communication between the Contractor's compliance officer and the Contractor's employees to facilitate the oversight of systems that monitor service Utilization and Encounters for Fraud, Waste, and Abuse.

10.1.6 The Contractor shall submit its Fraud, Waste, and Abuse policies and procedures, its proposed compliance plan, and its program integrity plan to ASES for prior written approval according to the timeframe set forth in Appendix L to this Contract.

10.1.7 Any changes to the Contractor's Fraud, Waste, and Abuse policies and procedures must be submitted to ASES for approval within fifteen (15) Calendar Days of the date the Contractor plans to implement the changes and the changes shall not go into effect until ASES provides prior written approval.

10.1.8 The Contractor shall comply with all program integrity provisions of the PPACA including:

10.1.8.1 Enhanced Provider screening and enrollment, Section 6401;

10.1.8.2 Termination of Provider participation, Section 6501;

10.1.8.3 Provider discloser of current or previous affiliation with excluded Provider(s), Section 6401; and

10.1.8.4 Provider screening and enrollment, 42 CFR Part 455, Subpart E.

10.1.9 The Contractor shall inform ASES in writing Immediately upon becoming aware of a compliance breach related to the Contractor and/or Network Provider.

10.1.10 The Contractor shall inform the Medicaid Fraud Control Unit and ASES of any meetings it holds with any other Medicare Platino or GHP MCOs related to compliance and program integrity issues at least forty-eight (48) hours prior to the meeting. The Contractor shall provide a copy of the meeting minutes as well as the results of any follow-up investigations to ASES in writing Immediately.

10.1.11 The Contractor shall have policies and procedures prior approved in writing by ASES to address (i) Immediately notifying ASES of pending Network Provider investigations, suspensions and debarment and (ii) transitioning Enrollees from suspended and debarred Network Providers.

10.2 Compliance Plan

10.2.1 The Contractor shall have a written Fraud, Waste, and Abuse compliance plan with stated program goals and objectives, program scope, and methodology to evaluate program performance. A paper and electronic copy of the compliance plan shall be provided to ASES annually for prior written approval according to the timeframe set forth in Appendix L to this Contract. ASES shall provide notice of approval, denial, or modification to the Contractor within thirty (30) Calendar Days of receipt. The Contractor shall make any necessary changes required by ASES within an additional thirty (30) Calendar Days of the request.

10.2.2 At a minimum, the Contractor's Fraud, Waste, and Abuse compliance plan shall, in accordance with 42 CFR 438.608:

10.2.2.1 Ensure that all of its officers, directors, managers and employees know and understand the provisions of the Contractor's Fraud, Waste, and Abuse compliance plan;

10.2.2.2 Require the designation of a compliance officer and a compliance committee that are accountable to the Contractor's senior

management. The compliance officer shall have express authority to provide unfiltered reports directly to the Contractor's most senior leader and governing body;

10.2.2.3 Ensure and describe effective training and education for the compliance officer and the Contractor's employees;

10.2.2.4 Ensure that Providers and Enrollees are educated about Fraud, Waste, and Abuse identification and reporting in the materials provided to them;

10.2.2.5 Ensure effective lines of communication between the Contractor's compliance officer and the Contractor's employees to ensure that employees understand and comply with the Contractor's Fraud, Waste, and Abuse program;

10.2.2.6 Ensure enforcement of standards of conduct through well-publicized disciplinary guidelines;

10.2.2.7 Ensure internal monitoring and auditing with provisions for prompt response to potential offenses, along with the prompt referral of any such offenses to MFCU, and for the development of corrective action initiatives relating to the Contractor's Fraud, Waste, and Abuse efforts;

10.2.2.8 Describe standards of conduct that articulate the Contractor's commitment to comply with all applicable Puerto Rico and Federal requirements and standards;

10.2.2.9 Ensure that no individual who reports Provider violations or suspected cases of Fraud, Waste, and Abuse is retaliated against; and

10.2.2.10 Include a monitoring program that is designed to prevent and detect potential or suspected Fraud, Waste, and Abuse. This monitoring program shall include but not be limited to:

10.2.2.10.1 Monitoring the billings of its Providers to ensure Enrollees receive services for which the Contractor is billed;

10.2.2.10.2 Requiring the investigation of all reports of suspected cases of Fraud and over-billings;

10.2.2.10.3 Reviewing Providers for over, under and inappropriate Utilization;

10.2.2.10.4 Verifying with Enrollees the delivery of services as claimed; and

10.2.2.10.5Reviewing and trending Enrollee Complaints regarding Providers.

10.2.3 The Contractor and any Subcontractors delegated the responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall include in all employee handbooks a specific discussion of its Fraud, Waste, and Abuse policies and procedures, the rights of whistleblowers, and the Contractor's and Subcontractor's procedures for detecting and preventing Fraud, Waste, and Abuse.

10.2.4 The Contractor shall include in the Enrollee Handbook instructions on how to report Fraud, Waste, and Abuse and the protections for whistleblowers.

10.3 Program Integrity Plan

10.3.1 The Contractor shall develop a program integrity plan that at a minimum:

10.3.1.1 Defines Fraud, Waste, and Abuse;

10.3.1.2 Specifies methods to detect Fraud, Waste, and Abuse;

10.3.1.3 Describes a process to perform investigations on each suspected case of Fraud, Waste, and Abuse;

10.3.1.4 Describes the Contractor's staff responsible for conducting the investigations and reporting of potential Fraud, Waste, or Abuse, including an organizational chart documenting roles and responsibilities;

10.3.1.5 Includes a variety of methods for identifying, investigating, and referring suspected cases to appropriate entities;

10.3.1.6 Includes a systematic approach to Data analysis;

10.3.1.7 Defines mechanisms to monitor frequency of Encounters and services rendered to Enrollees billed by Providers;

10.3.1.8 Identifies requirements to complete the preliminary investigation of Providers and Enrollees;

10.3.1.9 Include provisions regarding prompt terminations of inactive Providers due to inactivity in the past twelve (12) months;

10.3.1.10 Include a risk assessment of the Contractor's various Fraud, Waste, and Abuse processes. The risk assessment shall include a listing of the Contractor's top three (3) vulnerable areas and outline action plans to mitigate risks;

10.3.1.11 Include procedures for the confidential reporting of potential Fraud, Waste, and Abuse, including potential Contractor violations, to the appropriate agency, including the prompt referral of potential Fraud, Waste, and Abuse to MFCU; and

10.3.1.12 Include procedures to ensure that there is no retaliation against an individual who reports Contractor violations or other potential Fraud, Waste, or Abuse to the Contractor or an external entity.

10.3.2 The Contractor's program integrity plan shall comply in all respects with ASES's guidelines for the development of a program integrity plan. Upon review of the Contractor's Program Integrity Plan, ASES will promptly (within twenty (20) Business Days) notify the Contractor of any needed revisions in order for the program integrity plan to comply with the guidelines and with Federal law. The Contractor, in turn, shall promptly (within twenty (20) Business Days of receipt of the ASES comments) re-submit its Plan for ASES review and prior written approval.

10.4 Prohibited Affiliations with Individuals Debarred by Federal Agencies

10.4.1 The Contractor shall not knowingly have a relationship with the following:

10.4.1.1 Any person or entity that has been, or whose affiliated subsidiary companies, or any of its shareholders, partners, officers, principals, managing employees, subsidiaries, parent companies, officers, directors, board members, or ruling bodies have been, under investigation for, accused of, convicted of, or sentenced to imprisonment, in Puerto Rico, the other USA jurisdictions, or any other jurisdiction, for any crime involving corruption, fraud, embezzlement, or unlawful appropriation of public funds, pursuant to Act 458, as amended, and Act 84 of 2002

10.4.1.2 An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under Executive Order No. 12549 or under any guidelines implementing the Executive Order.

10.4.1.3 An individual who is an Affiliate, as defined in the Federal Acquisition Regulation, of a person described in Section 10.4.1.2. The relationship is defined as follows:

10.4.1.3.1 A director, officer, or partner of the Contractor;

10.4.1.3.2 A person with beneficial ownership of five percent (5%) or more of the Contractor's equity; or

10.4.1.3.3 Any Subcontractor, or other person with an employment, consulting, or other arrangement with the Contractor for the provision of items or services that are significant and material the Contractor's obligations under this Contract.

10.4.1.3.4 A Network Provider or person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under the Contract.

10.4.2 The Contractor shall not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under Section 1129 or 1128A of the Social Security Act.

10.4.3 If ASES learns that a Contractor has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the Contractor has relationship with an individual who is an Affiliate of such an individual, this Contract may continue unless the Secretary directs otherwise. However, this Contract may not be renewed or otherwise extended in duration unless the Secretary provides to ASES and to Congress a written statement describing compelling reasons that exist for renewing or extending this Contract despite the prohibited affiliations.

10.5 Reporting and Investigations

10.5.1 The Contractor shall cooperate with all duly authorized Federal and Puerto Rico agencies and representatives in reporting, investigating and prosecuting Fraud, Waste, and Abuse.

10.5.1.1 The Contractor shall have methods for identifying, investigating, and referring suspected Fraud, Waste, and Abuse pursuant to 42 CFR 455.1, 42 CFR 455.13, 42 CFR 455.14 and 42 CFR 455.21 and providing notice to ASES as set forth under this section. All suspected or confirmed instances of Provider Fraud and Enrollee abuse and neglect shall be referred Immediately by the Contractor to ASES, the Puerto Rico Medicaid Program, and the Medicaid Fraud Control Unit.

10.5.1.2 The Contractor shall Immediately report to ASES the identity of any Provider or other person who is debarred, suspended, or otherwise prohibited from participating in procurement activities. ASES shall promptly notify the Secretary of Health and Human Services of the noncompliance, as required by 42 CFR 438.610(d).

10.5.2 The Contractor shall notify ASES within two (2) Business Days of any initiated investigation of a suspected case of Fraud, Waste, or Abuse. The Contractor shall conclude its preliminary investigation within ten (10) Business Days of identifying the potential Fraud, Waste, or Abuse and shall provide the findings of its preliminary investigation in writing to ASES within two (2) Business Days of completing the preliminary investigation.

10.5.3 The Contractor shall subsequently report preliminary results of such investigation activities to ASES and other appropriate State and Federal entities. ASES will provide the Contractor with guidance during the pendency of the investigation and will refer the matter to the US Department of Justice and the Medicaid Fraud Control Unit as appropriate. If directed by ASES and/or the Medicaid Fraud Control Unit, the Contractor shall conduct a full investigation.

10.5.4 The Contractor shall provide the results of its full investigations in writing to ASES within two (2) Business Days of completing the investigation. The Contractor shall consult with ASES, whom shall notify the Medicaid Fraud Control Unit, prior to taking any proposed action regarding an instance of suspected or confirmed fraud or Enrollee abuse.

10.5.5 The Contractor and all Subcontractors shall cooperate fully with Federal and State agencies, including the Medicaid Fraud Control Unit, in Fraud, Waste, and Abuse investigations and subsequent legal actions, whether administrative, civil, or criminal. Such cooperation shall include actively participating in meetings, providing requested Information, access to records, and access to interviews with employees and consultants, including but not limited to those with expertise in the administration of the program and/or medical or pharmaceutical matters or in any matter related to an investigation or prosecution. Such cooperation shall also include providing personnel to testify at any hearings, trials, or other legal proceedings on an as-needed basis.

10.5.6 In accordance with Section 1903(i)(2)(C) of the Social Security Act and 42 CFR 455.23, the Contractor shall have a mechanism in place to suspend payments to any Provider or other Subcontractor when there is a pending investigation of a Credible Allegation of Fraud under the Medicaid program. In addition, for any cases related to Provider Fraud, which ASES must refer to the Medicaid Fraud Control Unit, the Contractor shall refrain from, or suspend any attempt to, recoup amounts related to the reported instance of Provider Fraud from the referred Provider for a period of thirty (30) Calendar Days while the Medicaid Fraud Control Unit conducts its preliminary evaluation. The Contractor may resume recoupment efforts subsequent to the thirty (30) Calendar Days unless otherwise instructed by the Medicaid Fraud Control Unit or ASES. A determination by the Medicaid Fraud Control Unit not to pursue further action on a referred case of Provider Fraud shall in no way be interpreted to restrict attempts by the Contractor to continue to recoup outstanding amount from the

Provider, or to pursue further correction action or penalty otherwise permitted by law or under the Provider Contract.

10.5.7 If a Provider is suspended or terminated from participation in the Puerto Rico Medicaid Program by ASES, the Contractor shall also suspend or terminate the Provider.

10.5.8 If a Provider is terminated from Medicare or another state's Medicaid or State Children's Health Insurance Program, the Contractor shall terminate its Provider participation agreement with that Provider (see Section 1902(a)(39) of the Social Security Act and 42 CFR 455.416) and notify ASES Immediately.

10.5.9 The Contractor shall notify ASES at least two (2) Business Days prior to taking any action against a Provider for program integrity reasons, including, but not limited to, denial of a Provider Credentialing/Re-Credentialing application, corrective action or limiting the ability of a Provider to participate in the program (e.g., suspending or terminating a Provider). The notification shall include but not be limited to identification of the Provider and a description of the action, the reason for the action, and documentation to support the reason. The Contractor shall provide additional Information upon ASES's request.

10.5.10 The Contractor shall submit a risk assessment on an "as needed" basis and Immediately after a program integrity-related action against a Provider. The Contractor shall inform ASES of such action and provide details of such financial action.

10.5.10.1 The Contractor shall Immediately disclose to ASES any and all criminal convictions of its managing employees.

10.5.11 Regarding Provider disclosures, the Contractor shall:

10.5.11.1 Not make payment to a Provider unless the Provider has submitted completed disclosures required by Federal law either to ASES or the Contractor. This includes but is not limited to disclosure regarding ownership and control, business transactions, and criminal convictions (see 42 CFR Part 455, Subpart B).

10.5.11.2 Track information received from ASES identifying Providers from whom ASES has received completed disclosures.

10.5.11.3 For Network Providers for whom ASES has not received completed disclosures, as reported to the Contractor, collect and retain completed Provider disclosures as part of initial Credentialing and then annually, using a disclosure form prior approved by ASES in writing.

10.5.11.4 In accordance with 42 CFR 455.106, Immediately report any criminal conviction disclosures to ASES and explain what action it will take (e.g., terminate the Provider).

10.6 Service Verification with Enrollees

10.6.1 In accordance with 42 CFR 438.608(a)(5), the Contractor shall implement a process for verifying with Enrollees whether services billed by Providers were received.

10.6.2 The Contractor must employ a methodology and sampling process prior approved by ASES to verify with its Enrollees on a monthly whether services billed to the Contractor by Providers were actually received. The methodology and sampling process must include criteria for identifying "high-risk" services and Provider types.

10.7 Stark Law Compliance. The Contractor shall have mechanisms in place to ensure that payments are not made in violation of Section 1903(s) of the Social Security Act with respect to certain physician Referrals as defined in Section 1877 of the Social Security Act. The Contractor shall ensure that disclosing Parties provide a financial analysis that includes the total amount actually or potentially due and owed as a result of the disclosed violation, a description of the methodology used to determine the amount due and owing, the total amount of remuneration involved physicians (or an immediate family member of such physicians) received as a result of an actual or potential violation, and a summary of audit activity and documents used in the audit. In accordance with Section 6409 of the PPACA, the Contractor will encourage provider use of the self-referral disclosure protocols, under which providers of services and suppliers may self-disclose actual or potential violations of the physicians' self-referral statute (Section 1877 of the Social Security Act).

ARTICLE 11 GRIEVANCE AND APPEAL SYSTEM

11.1 General Requirements

11.1.1 In accordance with 42 CFR Part 438, Subpart F, the Contractor shall establish an internal Grievance and Appeal System under which Enrollees, or Providers acting on their behalf, may express dissatisfaction with the Contractor or challenge the denial of coverage of, or payment for, Covered Services.

11.1.2 The Contractor's Grievance and Appeal System shall include (i) a Complaint process, (ii) Grievance process, (iii) Appeal process, and (iv) access to the Administrative Law Hearing process. The Contractor agrees to comply with all procedures and requirements in 42 CFR Section 422.560 et. seq., and in Chapter 13 of CMS's Medicare Managed Care Manual and Law 72 of September 7 1993, as amended, and requirements under 42 CFR 431.213 and 231; 42 CFR 438.402, 404, 406, 408, 410, 414, 416, 420 and 424; and 42 CFR 483.10 and 12 governing coverage determinations, grievances and appeals for services that the Contractor determines are a Medicare Platino only benefit. In addition, the Contractor's complaint and appeal procedures governing services determined by this Contractor to be a Medicaid wraparound services under the Medicare Platino benefit shall be consistent with 42 CFR Sections 438.228, 438.402 (a)

(b) (1) (2) (3) (iii), 438.400, 438.404,406, 408, 410, 414, 416, 420, and 424, and 483.15.

11.1.3 The Contractor shall designate, in writing, an officer who shall have primary responsibility for ensuring that Complaints, Grievances, and Appeals are resolved pursuant to this Contract and for signing all Notices of Adverse Benefit Determination. For such purposes, an officer shall mean a president, vice president, secretary, treasurer, chairperson of the board of directors of the Contractor's organization, the sole proprietor, the managing general partner of a partnership, or a person having similar executive authority in the organization.

11.1.4 The Contractor shall develop a written Grievance and Appeal System and the policies and procedures that detail the operation of the Grievance and Appeal System. The Grievance and Appeal System policies and procedures shall be submitted to ASES for review and prior written approval according to the timeframe specified in Appendix L to this Contract.

11.1.5 At a minimum, the Contractor's Grievance and Appeal System policies and procedures shall include the following:

11.1.5.1 Process for filing a Complaint, Grievance, or Appeal, or seeking an Administrative Law Hearing;

11.1.5.2 Process for receiving, recording, tracking, reviewing, reporting, and resolving Grievances filed verbally, in writing, or in-person;

11.1.5.3 Process for receiving, recording, tracking, reviewing, reporting, and resolving Appeals filed verbally or in writing;

11.1.5.4 Process for requesting an expedited review of an Appeal;

11.1.5.5 Process and timeframe for a Provider to file a Complaint, Grievance or Appeal on behalf of an Enrollee;

11.1.5.6 Process for notifying Enrollees of their right to file a Complaint, Grievance, or Appeal with the Patient Advocate Office and how to contact the Patient Advocate Office;

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

11.1.5.8 Process and timeframes for notifying Enrollees in writing regarding receipt of Complaints, Grievances, Appeals, resolution, action, delay of review, and denial of request for expedited review.

11.1.6 The Contractor's Grievance and Appeal System shall fully comply with the Puerto Rico's Patient's Bill of Rights Act, to the extent that such provisions do not conflict with, or pose an obstacle to Federal regulations.

11.1.7 The Contractor shall process each Complaint, Grievance, or Appeal in accordance with applicable Puerto Rico and Federal statutory and regulatory requirements, this Contract, and the Contractor's written policies and procedures. Pertinent facts from all Parties shall be collected during the process.

11.1.8 The Contractor shall include educational information in the Enrollee Handbook regarding the Contractor's Grievance and Appeal System which at a minimum includes:

11.1.8.1 A description of the Contractor's Grievance and Appeal System;

11.1.8.2 Instructions on how to file Complaints, Grievances and Appeals including the timeframes for filing;

11.1.8.3 The Contractor's toll-free telephone number and office hours;

11.1.8.4 Information regarding an Enrollee's right to file a Complaint, Grievance, or Appeal with the Patient Advocate Office and how to file a Complaint, Grievance, or Appeal with the Patient Advocate Office;

11.1.8.5 Information describing the Administrative Law Hearing process and governing rules, including that the Enrollee must first exhaust the Contractor's Grievance and Appeal System before accessing the Administrative Law Hearing process; and

11.1.8.6 Timelines and limitations associated with filing Grievances or Appeals.

11.1.9 The Contractor shall give Enrollees reasonable assistance in completing forms and taking other procedural steps for Complaints, Grievances and Appeals. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TDD and interpreter capability.

11.1.10 The Contractor shall include information regarding the Grievance and Appeal System in the Provider Guidelines and upon joining the Contractor's Network, all Providers and Subcontractors, as applicable, shall receive training and education regarding the Contractor's Grievance and Appeal System, which includes but is not limited to:

11.1.10.1 The Enrollee's right to file Complaints, Grievances and, Appeals and the requirements and timeframes for filing;

11.1.10.2 The Enrollee's right to file a Complaint, Grievance, or Appeal with the Patient Advocate Office;

11.1.10.3 The Enrollee's right to an Administrative Law Hearing, how to obtain an Administrative Law Hearing, and representation rules at an Administrative Law Hearing;

11.1.10.4 The availability of assistance in filing a Complaint, Grievance, or Appeal;

11.1.10.5 The toll-free numbers to file oral Complaints, Grievances, and Appeals;

11.1.10.6 The Enrollee's right to request continuation of Benefits during an Appeal, or an Administrative Law Hearing filing, and that if the Contractor's Adverse Benefit Determination is upheld in an Administrative Law Hearing, the Enrollee may be liable for the cost of any continued Benefits; and

11.1.10.7 Any Puerto Rico-determined Provider Appeal rights to challenge the failure of the Contractor to cover a service.

11.1.11 The Contractor shall have procedures in place to notify all Enrollees in their primary language of Complaint, Grievance, and Appeal dispositions.

11.1.12 The Contractor shall develop Grievance and Appeal System forms to be submitted for prior written approval by ASES according to the timeframe specified in Appendix L to this Contract. The approved forms shall be made available to all Enrollees, shall meet all requirements listed in Sections 4.2 and 4.3 for written materials, and shall, at a minimum:

11.1.12.1 Instruct the Enrollee or Enrollee's Authorized Representative that documentary evidence should be included, if available; and

11.1.12.2 Include instructions for completion and submission.

11.1.13 All ASES prior approved Complaints, Grievances, and Appeals files and forms shall be made available to ASES for auditing. All Complaint, Grievance, and Appeal documents and related information shall be considered as containing protected health information and shall be treated in accordance with HIPAA regulations and other applicable laws of Puerto Rico.

11.1.14 The Contractor shall ensure that the individuals who make decisions on Grievances and Appeals are individuals:

11.1.14.1 Who were not involved in any previous level of review or decision-making or who were subordinates of any individual involved in a previous review or decision-making; and

11.1.14.2 Who, if deciding any of the following, are Providers who have the appropriate clinical expertise, as determined by ASES, in treating the Enrollee's condition or disease if deciding any of the following:

11.1.14.2.1 An Appeal of a denial that is based on lack of Medical Necessity;

11.1.14.2.2 A Grievance regarding denial of expedited resolutions of Appeal; and

11.1.14.2.3 Any Grievance or Appeal that involves clinical issues; and

11.1.14.3 Who take into account all comments, documents, records and other information submitted by Enrollee without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

11.1.15 The Contractor shall ensure that punitive action is not taken against a Provider who requests a Grievance, Appeal or an Administrative Law Hearing requests an expedited resolution, or supports an Enrollee's Grievance, Appeal or Administrative Law Hearing.

11.1.16 The Contractor and Subcontractors, as applicable, shall have a system in place to collect, analyze, and integrate Data regarding Complaints, Grievances, and Appeals. At a minimum, the record shall be accessible to ASES and available upon request to CMS and include the following information:

11.1.16.1 Date Complaint, Grievance, or Appeal was received;

11.1.16.2 Enrollee's name;

11.1.16.3 Enrollee's Medicaid ID number, if applicable;

11.1.16.4 Name of the individual filing the Complaint, Grievance or Appeal on behalf of the Enrollee;

11.1.16.5 Date of acknowledgement that receipt of Grievance or Appeal was mailed to the Enrollee;

11.1.16.6 Summary of Complaint, Grievance, or Appeal;

11.1.16.7 Date of each review or review meeting and resolution at each level, if applicable;

11.1.16.8 Date Notice of Disposition or Notice of Adverse Benefit Determination was mailed to the Enrollee;

11.1.16.9 Corrective Action required; and

11.1.16.10 Date of resolution.

11.1.17 Contractor shall have sufficient staffing to timely address Grievances, Complaints, Appeals, Provider disputes and to provide attorney representation or the attendance of other required personnel at administrative hearings, when applicable.

11.2 Complaint

11.2.1 The Complaint process is the procedure for addressing Enrollee Complaints, defined as expressions of dissatisfaction about any matter other than an Adverse Benefit Determination that are resolved at the point of contact rather than through filing a formal Grievance.

11.2.2 An Enrollee or Enrollee's Authorized Representative may file a Complaint either orally or in writing. The Enrollee or Enrollee's Authorized Representative may follow-up an oral request with a written request. However, the timeframe for resolution begins with the date the Contractor receives the oral request.

11.2.3 An Enrollee or Enrollee's Authorized Representative shall file a Complaint within fifteen (15) Calendar Days after the date of occurrence that initiated the Complaint. If the Enrollee or Enrollee's Authorized Representative attempts to file a Complaint beyond the fifteen (15) Calendar Days, the Contractor shall instruct the Enrollee or Enrollee's Authorized Representative to file a Grievance.

11.2.4 The Contractor shall have procedures in place to provide Notice of Dispositions of Complaints to all Enrollees in their primary language.

11.2.5 The Contractor shall resolve each Complaint within seventy-two (72) hours of the time the Contractor received the initial Complaint, whether orally or in writing. If the Complaint is not resolved within this timeframe, the Complaint shall be treated as a Grievance. The Contractor cannot require the Enrollee to file a separate Grievance before proceeding to Appeal.

11.2.6 The Notice of Disposition shall include the results and date of the resolution of the Complaint and shall include notice of the right to file a Grievance or Appeal and information necessary to allow the Enrollee to request an Administrative Law Hearing, if appropriate, including contact information necessary to pursue an Administrative Law Hearing.

11.3 Grievance Process

11.3.1 An Enrollee or Enrollee's Authorized Representative may file a Grievance with the Contractor or with the Office of the Patient's Advocate of Puerto Rico either orally or in writing. A Provider cannot file a Grievance on behalf of an Enrollee unless written consent is granted by the Enrollee.

11.3.2 An Enrollee may file a Grievance at any time.

11.3.3 The Contractor shall acknowledge receipt of each Grievance in writing to the Enrollee (and the Provider, if the Provider filed the Grievance on the Enrollee's behalf) within ten (10) Business Days of receipt.

11.3.4 The Contractor shall provide written notice of the disposition of the Grievance as expeditiously as the Enrollee's health condition requires, but in any event, within ninety (90) Calendar Days from the day the Contractor receives the Grievance. If the Grievance originated from a Complaint that was not resolved within the seventy-two (72) hour timeframe set forth in Section 11.2.5, the time already spent by the Contractor to resolve the original Complaint must be deducted from this ninety (90) Calendar Day timeframe.

11.3.5 The Notice of Disposition shall include the following:

11.3.5.1 The resolution of the Grievance,

11.3.5.2 The basis for the resolution, and

11.3.5.3 The date of the resolution.

11.3.6 The Contractor may extend the timeframe to provide a written notice of disposition of a Grievance for up to fourteen (14) Calendar Days if the Enrollee requests the extension or the Contractor demonstrates (to the satisfaction of ASES, upon its request) that there is a need for additional Information and how the delay is in the Enrollee's interest. If the Contractor extends the timeframe, it shall, for any extension not requested by the Enrollee:

11.3.6.1 Make reasonable efforts to provide Enrollee prompt oral notice of the delay;

11.3.6.2 Give the Enrollee written notice of the reason for the delay within two (2) Calendar Days; and

11.3.6.3 Inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with the decision to extend the timeframe.

11.4 Notice of Adverse Benefit Determination

11.4.1 Pursuant to 42 CFR 438.210(c), the Contractor shall provide written notice to the requesting Provider and the Enrollee of any decision by the Contractor to deny a Service Authorization Request, or to authorize a service in an amount, duration, or scope that is less than requested. The Contractor's notices shall meet the requirements of 42 CFR 438.404.

11.4.2 The Contractor's written Notice of Adverse Benefit Determination to Enrollees must meet the language and format requirements in Section 4.2 and 4.3 and be set in accordance with the timeframes described in Section 11.4.4.

11.4.3 The Notice of Adverse Benefit Determination shall contain the following:

11.4.3.1 The Adverse Benefit Determination the Contractor has taken or intends to take;

11.4.3.2 The reasons for the Adverse Benefit Determination,

11.4.3.3 The right of Enrollee to be provided, upon request and at no expense to Enrollee, reasonable access to and copies of all documents, records and other information relevant to the Adverse Benefit Determination;

11.4.3.4 The Enrollee's right to file an Appeal through the Contractor's internal Grievance and Appeal System and the procedure for filing an Appeal;

11.4.3.5 The Enrollee's right to request an Administrative Law Hearing after exhaustion of the Contractor's Grievance and Appeal System;

11.4.3.6 The Enrollee's right to allow a Provider to file an Appeal or an Administrative Law Hearing on behalf of the Enrollee, upon written consent;

11.4.3.7 The circumstances under which expedited review is available and how to request it; and

11.4.3.8 The Enrollee's right to have Benefits continue pending resolution of the Appeal with the Contractor or during the Administrative Law Hearing, in accordance with 42 CFR 438.420, how to request that Benefits be continued, and the circumstances under which the Enrollee may be required to pay for the costs of these services.

11.4.4 The Contractor shall mail the Notice of Adverse Benefit Determination within the following timeframes:

11.4.4.1 For termination, suspension, or reduction of previously authorized Covered Services, at least ten (10) Calendar Days before the date of Adverse Benefit Determination. However, notice must be mailed no later than the date of Adverse Benefit Determination, unless otherwise specified, if one of the following exceptions applies:

11.4.4.1.1 The Contractor has factual Information confirming the death of an Enrollee.

11.4.4.1.2 The Contractor receives a clear written statement signed by the Enrollee that he or she no longer wishes to receive services or gives Information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that Information.

11.4.4.1.3 The Enrollee is accepted for Medicaid services by another local jurisdiction, state, territory or commonwealth.

11.4.4.1.4 The Enrollee has been admitted to an institution where he or she is ineligible for further services.

11.4.4.1.5 The Enrollee's whereabouts are unknown, and the post office returns the Contractor's mail directed to the Enrollee indicating no forwarding address (refer to 42 CFR 431.231(d) for procedures if the Enrollee's whereabouts become known).

11.4.4.1.6 The Enrollee's Provider prescribes a change in the level of medical care.

11.4.4.1.7 The notice involves an Adverse Benefit Determination with regard to the preadmission screening requirements set forth in Section 1919(e)(7) of the Social Security Act.

11.4.4.1.8 The transfer or discharge from a facility will occur in an expedited fashion. The Contractor may shorten the period of advance notice to five (5) Calendar Days before the date of Adverse Benefit Determination if the Contractor has facts indicating that Adverse Benefit Determination should be taken because of probable Enrollee Fraud and the facts have been verified, if possible, through secondary sources.

11.4.4.2 For denial of payment, at the time of any Adverse Benefit Determination affecting the Claim.

11.4.4.3 For standard authorization decisions that deny or limit Covered Services within the timeframes required in Section 8.4.

11.4.4.4 If the Contractor extends the timeframe for the authorization decision and issuance of Notice of Adverse Benefit Determination according to Section 11.4.4, the Contractor shall give the Enrollee written notice of the reasons for the decision to extend if he or she did not request the extension and the Enrollee's right to file a Grievance if he or she disagrees with that decision. The Contractor shall issue and carry out its determination as expeditiously as the Enrollee's health requires and no later than the date the extension expires.

11.4.4.5 For authorization decisions not reached within the timeframes required in Section 8.4 for either standard or expedited authorizations, the Notice of Adverse Benefit Determination shall be mailed on the date the timeframe expires, as this constitutes a denial and is thus an Adverse Benefit Determination.

11.5 Appeal Process

11.5.1 The Enrollee, the Enrollee's Authorized Representative acting on behalf of the Enrollee, or the Provider may file an Appeal either orally or in writing.

11.5.2 Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal). Enrollees must confirm oral requests for Appeals in writing, unless the Enrollee requests expedited resolution.

11.5.3 The requirements of the Appeal process shall be binding for all types of Appeals, including expedited Appeals, unless otherwise established for expedited Appeals. Only one (1) level of Appeal is permitted before proceeding to an Administrative Law Hearing.

11.5.4 The Enrollee, the Enrollee's Authorized Representative, or the Provider acting on behalf of the Enrollee with the Enrollee's written consent, may file an Appeal to the Contractor within sixty (60) Calendar Days from the date on the Contractor's Notice of Adverse Benefit Determination.

11.5.5 Appeals shall be filed directly with the Contractor, or its delegated representatives. The Contractor may delegate this authority to an Appeal committee, but the delegation shall be in writing.

11.5.6 The Appeals process shall provide the Enrollee, the Enrollee's Authorized Representative, or the Provider acting on behalf of the Enrollee with the Enrollee's written consent, a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing. The Contractor shall inform the Enrollee of the limited time available to provide this in case of expedited review.

11.5.7 The Appeals process shall provide the Enrollee, the Enrollee's Authorized Representative, or the Provider acting on behalf of the Enrollee with the Enrollee's written consent, opportunity, before and during the Appeals process, to examine the Enrollee's case file, including Medical Records, and any other documents and records considered during the Appeals process as well as any new or additional evidence considered, relied upon or generated by Contractor, and provide copies of documents contained therein without charge and sufficiently in advance of the resolution timeframe for the Appeal.

11.5.8 The Appeals process shall include as Parties to the Appeal the Enrollee, the Enrollee's Authorized Representative, the Provider acting on behalf of the

Enrollee with the Enrollee's written consent, or the legal representative of a deceased Enrollee's estate.

11.5.9 The Contractor shall resolve each standard Appeal and provide written notice of the disposition, as expeditiously as the Enrollee's health condition requires but no more than thirty (30) Calendar Days from the date the Contractor receives the Appeal.

11.5.10 The Contractor shall establish and maintain an expedited review process for Appeals, subject to prior written approval by ASES, when the Contractor determines (based on a request from the Enrollee) or the Provider indicates (in making the request on the Enrollee's behalf) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function. The Enrollee, the Enrollee's Authorized Representative, or the Provider acting on behalf of the Enrollee with the Enrollee's written consent, may file an expedited Appeal either orally or in writing.

11.5.11 The Contractor shall resolve each expedited Appeal and provide a written Notice of Disposition, as expeditiously as the Enrollee's health condition requires, but no longer than seventy-two (72) hours after the Contractor receives the Appeal and make reasonable efforts to provide oral notice.

11.5.12 If the Contractor denies an Enrollee's request for expedited review, it shall utilize the timeframe for standard Appeals specified herein and shall make reasonable efforts to give the Enrollee prompt oral notice of the denial, and follow-up within two (2) Calendar Days with a written notice. If the Enrollee disagrees with the decision to extend the prescribed timeframe, he or she shall be informed of the right to file a Grievance and the Grievance shall be resolved within twenty-four (24) hours. The Contractor shall also make reasonable efforts to provide oral notice for resolution of an expedited review of an Appeal.

11.5.13 The Contractor may extend the timeframe for standard or expedited resolution of the Appeal by up to fourteen (14) Calendar Days if the Enrollee, Enrollee's Authorized Representative, or the Provider acting on behalf of the Enrollee with the Enrollee's written consent, requests the extension or the Contractor demonstrates (to the satisfaction of ASES, upon its request) that there is need for additional information and how the delay is in the Enrollee's interest. If the Contractor extends the timeframe, it shall, for any extension not requested by the Enrollee:

11.5.13.1 Make reasonable efforts to provide Enrollee prompt oral notice of the delay;

11.5.13.2 Give the Enrollee written notice of the reason for the delay within two (2) Calendar Days;

11.5.13.3 Inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with the decision to extend the timeframe; and

11.5.13.4 Resolve the Appeal as expeditiously as the Enrollee's health condition requires, and no later than the date the extension expires.

11.5.14 The Contractor shall provide written Notice of Disposition of an Appeal to the Enrollee (and the Provider, if the Provider filed the Appeal on the Enrollee's behalf) as well as a copy to ASES within two (2) Business Days of the resolution.

11.5.15 The written notice of Disposition shall be in a format and language that, at a minimum, meets applicable notification standards and include:

11.5.15.1 The results and date of the Appeal resolution; and

11.5.15.2 For decisions not wholly in the Enrollee's favor:

11.5.15.2.1 The right to request an Administrative Law Hearing;

11.5.15.2.2 How to request an Administrative Law Hearing;

11.5.15.2.3 The right to continue to receive Benefits pending an Administrative Law Hearing;

11.5.15.2.4 How to request the continuation of Benefits; and

11.5.15.2.5 Notification that if the Contractor's Adverse Benefit Determination is upheld in a hearing, the Enrollee may liable for the cost of any continued Benefits.

11.6 Administrative Law Hearing

11.6.1 The Contractor is responsible for explaining the Enrollee's right to and the procedures for an Administrative Law Hearing, including that the Enrollee must exhaust the Contractor's Grievance, Complaints, and Appeals process before requesting an Administrative Law Hearing. However, if the Contractor fails to adhere to all notice and timing requirements set forth in 42 CFR 438.408, the Enrollee is deemed to have exhausted the Contractor's Appeals process and may proceed with initiating an Administrative Law Hearing.

11.6.2 The parties to the Administrative Law Hearing include the Contractor as well as the Enrollee or his or her Authorized Representative, or the representative of a deceased Enrollee's estate.

11.6.3 If the Contractor makes an Adverse Benefit Determination, the Enrollee appeals the Adverse Benefit Determination and the resolution of the Appeal is not in the Enrollee's favor, and the Enrollee requests an Administrative Law Hearing,

ASES shall grant the Enrollee such hearing. The right to such Administrative Law Hearing, how to obtain it, and the rules concerning who may represent the Enrollee at such hearing shall be explained to the Enrollee and by the Contractor.

11.6.4 ASES shall permit the Enrollee to request an Administrative Law Hearing within one hundred and twenty (120) Calendar Days of the Notice of Resolution of the Appeal.

11.6.5 Before the Administrative Law Hearing, the Enrollee and the Enrollee's Authorized Representative, if applicable, can ask to look at and copy the documents and records the Contractor will use at the Administrative Law Hearing or that the Enrollee may otherwise need to prepare his/her case for the hearing. The Contractor shall provide such documents and records at no charge to the Enrollee.

11.6.6 The Administrative Law Hearing resolution shall be:

11.6.6.1 For standard resolution: within ninety (90) Calendar Days of the date the Enrollee filed the appeal with the Contractor (excluding the days the Enrollee took to subsequently file for an Administrative Law Hearing).

11.6.6.2 For an expedited resolution: within three (3) Business Days from agency receipt of an Administrative Law Hearing request for a denial of a service.

11.6.7 The Contractor shall comply with all determinations rendered as a result of Administrative Law Hearings. Nothing in this Section 11.6 shall limit the remedies available to ASES or the Federal government relating to any non-compliance by the Contractor with an Administrative Law Hearing determination or by the Contractor's refusal to provide disputed services.

11.6.8 The decision issued as a result of the Administrative Law Hearing is subject to review before the Court of Appeals of Puerto Rico.

11.6.9 The Contractor shall comply with all determinations rendered as a result of Administrative Law Hearings. Nothing in this Section 11.6 shall limit the remedies available to the Puerto Rico or the Federal government relating to any non-compliance by the Contractor with an Administrative Law Hearing determination or by the Contractor's refusal to provide disputed services.

11.7 Continuation of Benefits while the Appeal and Administrative Law Hearing are Pending

11.7.1 As used in this Section, "timely" filing means filing on or before the later of the following:

11.7.1.1 Within ten (10) Calendar Days of the Contractor mailing the Notice of Adverse Benefit Determination; or

11.7.1.2 The intended effective date of the Contractor's proposed Adverse Benefit Determination.

11.7.2 The Contractor shall continue the Enrollee's Benefits if the Enrollee or the Enrollee's Authorized Representative files the Appeal within sixty (60) Calendar Days following the date on the Adverse Benefit Determination notice;; the Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized Provider; the period covered by the original authorization has not expired; and the Enrollee timely files for continuation of the Benefits.

11.7.3 If, at the Enrollee's request, the Contractor continues or reinstates the Enrollee's Benefits while the Appeal or Administrative Law Hearing is pending, the Benefits shall be continued until one of the following occurs:

11.7.3.1 The Enrollee withdraws the Appeal or request for the Administrative Law Hearing.

11.7.3.2 The Enrollee does not request an Administrative Law Hearing with continuation of Benefits within ten (10) Calendar Days from the date the Contractor sends the Notice of Adverse Benefit Determination. An administrative law judge issues an Administrative Law Hearing decision adverse to the Enrollee.

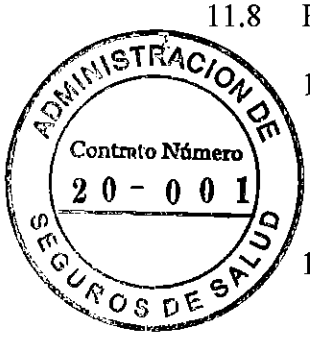
11.7.3.3 The time period or service limits of a previously authorized service has been met.

11.7.4 If the final resolution of Appeal or Administrative Law Hearing is adverse to the Enrollee, that is, upholds the Contractor's Adverse Benefit Determination, the Contractor may recover from the Enrollee the cost of the services furnished to the Enrollee while the Appeal / Administrative Law Hearing was pending, to the extent that they were furnished solely because of the requirements of this Section.

11.7.5 If the Contractor or ASES reverses a decision to deny, limit, or delay services that were not furnished while the Appeal / Administrative Law Hearing was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the date the Contractor receives notice reversing the determination.

11.7.6 If the Contractor or ASES reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the Appeal / Administrative Law Hearing was pending, the Contractor shall pay for those services. The Contractor shall submit evidence of compliance.

11.8 Reporting Requirements



11.8.1 The Contractor shall log and track all Complaints, Grievances, Notices of Adverse Benefit Determination, Appeals, including extensions of time granted by the Contractor for these items, as well as Administrative Law Hearing requests.

11.8.2 ASES may publicly disclose summary Information regarding the nature of Complaints, Grievances, and Appeals and related dispositions or resolutions in consumer Information materials.

11.8.3 The Contractor shall submit quarterly Grievance and Appeal System reports to ASES using a format prescribed by ASES and incorporate the findings of these reports into its Quality Strategy.

11.9 Remedy for Contractor Non-Compliance with Advance Directive Requirements. In addition to the Complaint, Grievance, and Appeal rights described in this Article, an Enrollee may lodge with ASES a Complaint concerning the Contractor's non-compliance with the Advance Directive requirements stated in Section 5.4 of this Contract.

ARTICLE 12 ADMINISTRATION AND MANAGEMENT

12.1 General Provisions

12.1.1 The Contractor shall be responsible for the administration and management of all requirements of this Contract, and consistent with the Medicaid Managed Care regulations of 42 CFR Part 438.

12.1.2 All costs and expenses related to the administration and management of this Contract shall be the responsibility of the Contractor.

12.2 Data Certification

12.2.1 The Contractor shall certify all Data pursuant to 42 CFR 438.606. The Data that must be certified include, but are not limited to, Enrollment Information, Encounter Data, and other Information required by ASES and contained in Contracts, the Contractor's Proposal, and related documents. The Data must be certified by one of the following: the Contractor's Chief Executive Officer ("CEO"), the Contractor's Chief Financial Officer ("CFO"), or an individual who has delegated authority to sign for, and who reports directly to the Contractor's CEO or CFO. The certification must attest, based on best knowledge, Information, and belief, as follows:

12.2.1.1 To the accuracy, completeness and truthfulness of the Data; and

12.2.1.2 To the accuracy, completeness, and truthfulness of the documents specified by ASES.

12.2.2 The Contractor shall submit the certification concurrently with the certified Data.

ARTICLE 13 PROVIDER PAYMENT MANAGEMENT

13.1 General Provisions

13.1.1 The Contractor shall administer an effective, accurate and efficient Provider payment management function that (i) under this Contract's risk arrangement adjudicates and settles Provider Claims for Covered Services that are filed within the timeframes specified by this Article 13 and in compliance with all applicable Puerto Rico and Federal laws, rules, and regulations; (ii) processes PMPM Payments to applicable Providers within the timeframes specified by this Article; and (iii) performs Claims payment administrative functions for all Providers as specified by this Article 13.

13.1.2 The Contractor shall maintain a Claims management system that can accurately identify the date of receipt (the date the Contractor receives the Claim as indicated by the date-stamp), real-time-accurate history of actions taken on each Provider Claim (i.e. paid, denied, suspended, appealed, etc.), and the date of payment (the date of the check or other form of payment).

13.1.3 To the extent feasible, the Contractor shall implement an Automated Clearinghouse ("ACH") mechanism that allows Providers to request and receive Electronic Funds Transfer ("EFT") of Claims payments. The Contractor shall encourage its Providers, as an alternative to the filing of paper-based Claims, to submit and receive Claims Information through Electronic Data Interchange ("EDI"), i.e., electronic Claims. Electronic Claims must be processed in adherence to Information exchange and Data management requirements specified in Article 14. As part of this electronic Claims management ("ECM") function, the Contractor shall also provide on-line and phone-based capabilities to obtain Claims processing status Information.

13.1.4 If the Contractor does not receive Claims through an EDI system, the Contractor shall either provide a central address to which Providers must submit Claims; or provide to each Network Provider a complete list, including names, addresses, electronic mail and phone number, of entities to which the Providers must submit Claims.

13.2 To be processed, all Claims submitted for payment shall comply with the Clean Claim standards as established by Federal regulation (42 CFR 447.46), and with the standards described in Section 13.10.2 of this Contract.

13.3 The Contractor shall generate explanations of benefits and remittance advices in accordance with ASES standards for formatting, content, and timeliness.

13.4 The Contractor shall not pay any Claim submitted by a Provider during the period of time when such Provider is excluded or suspended from the Medicare, Medicaid, CHIP or

Title V Maternal and Child Health Services Block Grant programs for Fraud, Waste, or Abuse or otherwise included on the Department of Health and Human Services Office of the Inspector General exclusions list, or employs someone on this list, and when the Contractor knew, or had reason to know, of that exclusion, after a reasonable time period after reasonable notice has been furnished to the Contractor. The Contractor shall not pay any Claim submitted by a Provider that is on Payment Hold.

13.5 The Contractor is prohibited from paying for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

13.6

13.7 Submission of Encounter Data

13.7.1 Providers shall furnish Encounter Data to the Contractor in order to enable Contractor to prepare and submit Encounter Data to ASES on a monthly basis. The Data shall be submitted regardless of the payment arrangement, capitated or otherwise, agreed upon between the Contractor and the Provider. Encounter Data for all items and services provided by Network Providers, even if the Network Provider is reimbursed on a Capitated basis, must be submitted with the paid field indicating the allowed amount, even if the amount is zero (0) dollars.

13.8 Relationship with Pharmacy Benefit Manager (PBM)

13.8.1 The Contractor shall work with their PBM to facilitate the processing of pharmacy services Claims submitted by the PBM, as provided in Section 5.3.8.

13.8.2 To facilitate Claims processing, the Contractor shall send to the PBM, on a Daily Basis, the Enrollee Data described in Section 5.3.8.

13.9 Timely Payment of Claims

13.9.1 Contractor shall make payments to health care providers for items and services included in the Contractor's Medicare Platino Plan on a timely basis, consistent with the claims payment procedures established in Act Number 104 of July 19, 2002, known in Spanish as "Ley de Pago Puntual de Reclamaciones a Proveedores de Servicios de Salud Puerto Rico", as amended by Law 150 of July 27, 2011. The Contractor shall also comply with the timely processing of Claims standards contained in Section 1902(a)(37) of the Social Security Act and Federal regulations at 42 CFR 447.46.

13.9.1.1 The Contractor must pay ninety percent (90%) of all clean claims from Providers, i.e. who are in individual or group practice or who practice in shared health facilities, within thirty (30) days of the date of receipt.

13.9.1.2 The Contractor must pay ninety-nine percent (99%) of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within ninety (90) days of the date of receipt.

13.9.2 For the purposes of this Section 13.9, the date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim and the date of payment is the date of the check or other form of payment.

13.9.3

13.10 Contractor Recovery from Providers

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13.10.1 When the Contractor determines after the fact that it has paid a Claim incorrectly, the Contractor may request applicable reimbursement from the Provider through written notice, stating the basis for the request. The notice shall list the Claims and the amounts to be recovered.

13.10.2 The Provider will have a period of sixty (60) Calendar Days to make the requested payment, to agree to Contractor retention of said payment, or to dispute the recovery action.

13.11 ASES Review of Contractor, Subcontractor, and Provider Use of Puerto Rico and Federal Funds

13.11.1 The Contractor shall cooperate fully and diligently with ASES and/or its auditors in their review of the use of Puerto Rico and Federal funds provided to the Contractor under the Medicare Platino Program. The Contractor, its Subcontractors, and Network Providers shall, upon request, make available to ASES and/or its auditors any and all administrative, financial, and Medical Records relating to the administration of and the delivery of items or services for which Puerto Rico and Federal monies are expended. In addition, the Contractor and its Subcontractors including Network Providers shall provide ASES and/or its auditors with access during normal business hours to its respective place of business and records.

13.12 ASES Recovery from Contractor

13.12.1 ASES and the Contractor shall diligently work in good faith together to resolve any audit findings identified through audits by ASES. All audit findings shall be resolved, or a Corrective Action Plan shall be implemented within ninety (90) Calendar Days of issuance of a final audit report. Any Overpayment remittance due to ASES from the Contractor will be offset from future payments to the Contractor or invoiced by ASES to the Contractor.

ARTICLE 14 INFORMATION MANAGEMENT AND SYSTEMS

14.1 General Provisions

14.1.1 The Contractor shall have Information management processes and Information Systems (hereafter referred to as Systems) that enable it to meet Medicare Platino and GHP requirements, ASES and Federal reporting requirements, all other Contract requirements, and any other applicable Puerto Rico and Federal laws, rules and regulations including but not limited to the standards and operating rules in Section 1104 of the PPACA and associated regulations, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Health Information Technology for Economic and Clinical Health Act (HITECH) and associated regulations and 42 CFR 438.242.

14.1.2 The Contractor shall file a statement of certification with the U.S. Department of Health and Human Services (HHS) no later than start of this Contract, certifying that the Contractor's Data and Systems are in compliance with the standards and operating rules for EFT, eligibility, Claim status and health care payment/remittance advice transactions, in accordance with Section 1104 of the PPACA and associated regulations.

14.1.3 The Contractor's Systems shall possess capacity sufficient to handle the workload projected for the start of the program and will be scalable and flexible, so they can be adapted as needed, within negotiated timeframes, in response to program or Enrollment changes.

14.1.4 The Contractor's Systems shall have the capability of adapting to any future changes necessary as a result of modifications to the service delivery system and its requirements, including Data collection, records and reporting based upon unique Enrollee and Provider identifiers to track services and expenditures across funding streams. The Systems shall be scalable and flexible, so they can be adapted as needed, within negotiated timeframes, in response to changes in Contract requirements, increases in Enrollment estimates, etc. The System architecture shall facilitate rapid application of the more common changes that can occur in the Contractor's operation, including but not limited to:

14.1.4.1 Changes in pricing methodology;

14.1.4.2 Rate changes;

14.1.4.3 Eligibility criteria changes;

14.1.4.4 Changes in Utilization Management criteria;

14.1.4.5 Additions and deletions of Provider types; and

14.1.4.6 Additions and deletions of procedure, diagnosis and other service codes.

14.1.4.7 Changes in the Enrollment methodology.

14.1.5 The Contractor shall provide secure, online access to select system functionality to at least three (3) ASES personnel to facilitate resolution of Enrollee inquiries and to research Enrollee-related issues as needed.

14.1.6 The Contractor shall participate in systems work groups organized by ASES. The Systems work groups will meet on a designated schedule as agreed to by ASES and the Medicare Platino MAOs.

14.1.7 The Contractor shall provide a continuously available electronic mail communication link (E-mail system) with ASES. This system shall be:

14.1.7.1 Available from the workstations of the designated Contractor contacts; and

14.1.7.2 Capable of attaching and sending documents created using software products other than Contractor systems, including the Government's currently installed version of Microsoft Office and any subsequent upgrades as adopted.

14.2 Global System Architecture and Design Requirements

14.2.1 The Contractor shall comply with Federal and Puerto Rico policies, standards and regulations in the design, development and/or modification of the Systems it will employ to meet the aforementioned requirements and in the management of information contained in those Systems. Additionally, the Contractor shall adhere to ASES and Puerto Rico-specific system and Data architecture standards and/or guidelines.

14.2.2 The Contractor's Systems shall meet Federal and industry standards of architecture, including but not limited to the following requirements:

14.2.2.1 Conform to HIPAA standards for Data and document management;

14.2.2.2 Contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly by and mutually agreed upon by the Contractor and ASES; and

14.2.2.3 Partner with ASES in the development of transaction/event code set, Data exchange and reporting standards not specific to HIPAA or other Federal efforts and will conform to such standards as stipulated in the plan to implement the standards.

14.2.3 Where web services are used in the engineering of applications, the Contractor's Systems shall conform to World Wide Web Consortium (W3C) standards such as XML, UDDI, WSDL and SOAP so as to facilitate integration of these Systems with ASES and other Government systems that adhere to a service-oriented architecture.

14.2.4 Audit trails shall be incorporated into all Systems to allow information on source Data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

14.2.4.1 Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

14.2.4.2 Have the date and identification "stamp" displayed on any on-line inquiry;

14.2.4.3 Have the ability to trace Data from the final place of recording back to its source Data file and/or document shall also exist;

14.2.4.4 Be supported by listings, transaction reports, update reports, transaction logs, or error logs;

14.2.4.5 Facilitate auditing of individual Claim records as well as batch audits; and

14.2.4.6 Be maintained for ten (10) years in either live and/or archival systems. The duration of the retention period may be extended at the discretion of and as indicated to the Contractor by ASES as needed for ongoing audits or other purposes.

14.2.5 The Contractor shall house indexed images of documents used by Enrollees and Providers to transact with the Contractor in the appropriate database(s) and document management systems so as to maintain the logical relationships between certain documents and certain Data. The Contractor shall follow all applicable requirements for the management of Data in the management of documents.

14.2.6 The Contractor shall institute processes to insure the validity and completeness of the Data it submits to ASES. At its discretion, ASES will conduct general Data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: Enrollee ID, date of service, Provider ID, category and sub category (if applicable) of service, diagnosis codes, procedure codes, revenue codes, date of Claim processing, and date of Claim payment.

14.2.7 Where a System is herein required to, or otherwise supports, the applicable batch or on-line transaction type, the system shall comply with HIPAA-standard transaction code sets.

14.2.8 The Contractor shall assure that all Contractor staff is trained in all HIPAA requirements, as applicable.

14.2.9 The layout and other applicable characteristics of the pages of Contractor websites shall be compliant with Federal "Section 508 standards" and Web Content Accessibility Guidelines developed and published by the Web Accessibility Initiative.

14.3 System and Data Integration Requirements

14.3.1 The Contractor's applications shall be able to interface with ASES's systems for purposes of Data exchange and will conform to standards and specifications set by ASES. These standards and specifications are subject to change. Current standards and specifications are detailed in Appendix K to this Contract.

14.3.2 The Contractor's System(s) shall be able to transmit and receive transaction Data to and from ASES's systems as required for the appropriate processing of Claims.

14.3.2.1 The Contractor will be required to perform any necessary changes to update interfaces to ASES's systems, including those required by the expected implementation of Medicaid Management Information System (MMIS) as well as new Eligibility and Enrollment processes. This interface changes may require changes in the Contractors' core systems.

14.3.3 Each month the Contractor shall generate Encounter Data files from its Claims management system(s) and/or other sources. Such files must be submitted in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the ASC X12N 835 format as appropriate. The files will contain settled Claims and Claim adjustments and Encounter Data from Providers for the most recent month for which all such transactions were completed. The Contractor shall provide these files electronically to ASES and/or its Agent at a frequency and level of detail to be specified by CMS and ASES based on program administration, oversight, and program integrity needs, and in adherence to the procedure, content standards and format indicated in Appendix K to this Contract. The Contractor shall make changes or corrections to any systems, processes or Data transmission formats as needed to comply with Encounter Data quality standards as originally defined or subsequently amended.

14.3.4 The Contractor's System(s) shall be capable of generating files in the prescribed formats for upload into ASES Systems used specifically for program integrity and compliance purposes.

14.3.5 The Contractor's System(s) shall possess mailing address standardization functionality in accordance with USA Postal Service conventions.

14.3.6 To comply with MAGI requirements, the Contractor must update its Information Systems in accordance with the procedures and timelines set forth in Appendix K to this Contract and any other subsequent guidance issued by ASES.

14.4 System Access Management and Information Accessibility Requirements

14.4.1 The Contractor's System shall employ an access management function that restricts access to varying hierarchical levels of system functionality and Information. The access management function shall:

14.4.1.1 Restrict access to information on a "need-to-know" basis, e.g. users permitted inquiry privileges only will not be permitted to modify information;

14.4.1.2 Restrict access to specific System functions and Information based on an individual user profile, including inquiry only capabilities; global access to all functions will be restricted to specified staff jointly agreed to by ASES and the Contractor; and

14.4.1.3 Restrict attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.

14.4.2 The Contractor shall make System information available to duly Authorized Representatives of ASES and other Puerto Rico and Federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

14.4.3 The Contractor shall have procedures to provide for prompt transfer of System Information upon request to other Network or Out-of-Network Providers for the medical management of the Enrollee in adherence to HIPAA and other applicable requirements.

14.4.4 All Information, whether Data or documents, and reports that contain or make references to said Information, involving or arising out of this Contract, are owned by ASES. The Contractor is expressly prohibited from sharing or publishing ASES Information and reports without the prior written consent of ASES. In the event of a dispute regarding the sharing or publishing of Information and reports, ASES's decision on this matter shall be final and not subject to appeal.

14.5 Systems Availability and Performance Requirements

14.5.1 The Contractor shall ensure that critical systems, including but not limited to the Enrollee and Provider portal and/or phone-based functions and information, such as confirmation of Contractor Enrollment ("CCE") and electronic Claims management (ECM), Enrollee services and Provider services, are available to the applicable System users twenty-four (24) hours a day, seven (7) Calendar Days a Week, except during periods of scheduled System Unavailability agreed upon by ASES and the Contractor. Unavailability caused by events outside of a Contractor's Span of Control is outside of the scope of this requirement.

14.5.2 The Contractor shall ensure that at a minimum all non-critical system functions and information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m. Monday through Friday (Atlantic Time).

14.5.3 The Contractor shall develop an automated method of monitoring critical systems on at least a thirty (30) minute basis twenty-four (24) hours a day, seven (7) days per Week.

14.5.4 Upon discovery of any problem within its Span of Control that may jeopardize System availability and performance as defined in this Section of the Contract, the Contractor shall notify the applicable ASES staff in person, via phone, and/or electronic mail. The Contractor shall deliver notification as soon as possible but no later than 7:00 pm (Atlantic Time) if the problem occurs during the Business Day and no later than 9:00 am (Atlantic Time) the following Business Day if the problem occurs after 7:00 pm (Atlantic Time).

14.5.5 Where the operational problem results in delays in report distribution or problems in on-line access during the Business Day, the Contractor shall notify the applicable ASES staff within fifteen (15) minutes of discovery of the problem, in order for the applicable work activities to be rescheduled or be handled based on System Unavailability protocols.

14.5.6 The Contractor shall provide to appropriate ASES staff information on System Unavailability events, as well as status updates on problem resolution. These up-dates shall be provided on an hourly basis and made available via electronic mail, telephone and, if applicable, the Contractor's website.

14.5.7 The following rules govern unscheduled System Unavailability.

14.5.7.1 CCE Functions

14.5.7.1.1 Unscheduled System Unavailability of CCE functions caused by the failure of systems and telecommunications technologies within the Contractor's Span of Control will be resolved, and the restoration of services implemented, within thirty (30) minutes of the official declaration of System Unavailability.

14.5.7.1.2 Throughout the Contract Term, the Contractor shall have in place a method to validate eligibility manually twenty-four (24) hours per day, seven (7) days a Week as a contingency to any unscheduled Systems Unavailability for CCE functions.

14.5.7.2 ECM Functions. Unscheduled System Unavailability of ECM functions caused by the failure of systems and technologies within the Contractor's Span of Control will be resolved, and the restoration of services implemented, within sixty (60) minutes of the official declaration of System Unavailability, if unavailability occurs during normal business hours; or within sixty (60) minutes of the start of the next Business Day, if unavailability occurs outside business hours.

14.5.7.3 All Other Contractor System Functions. Unscheduled System Unavailability of all other Contractor System functions caused by systems and telecommunications technologies within the Contractor's Span of Control shall be resolved, and the restoration of services implemented:

14.5.7.3.1 Within four (4) hours of the official declaration of Unscheduled System Unavailability, when unavailability occurs during business hours, and

14.5.7.3.2 Within two (2) hours of the start of the next Business Day, when unavailability occurs during non-business hours.

14.5.8 Cumulative System Unavailability caused by systems and telecommunications technologies within the Contractor's Span of Control shall not exceed one (1) hour during any continuous five (5) Calendar Day period for functions that affect Enrollees and services. For functions that do not affect Enrollees, cumulative System Unavailability caused by systems and telecommunications technologies within the Contractor's Span of Control shall not exceed four (4) hours during any continuous five (5) Business Day periods.

14.5.9 The Contractor shall not be responsible for the availability and performance of systems and telecommunications technologies outside of the Contractor's Span of Control.

14.5.10 For any System outage that is not corrected within the required time limits, the Contractor shall provide full written documentation that includes a Corrective Action Plan, describing how the problem will be prevented from occurring again, within five (5) Business Days of the problem's occurrence.

14.5.11 Regardless of the architecture of its Systems, the Contractor shall develop and be continually ready to invoke a Business Continuity and Disaster Recovery ("BC-DR") plan that at a minimum addresses the following scenarios: (i) the central computer installation and resident software are destroyed or damaged;

(ii) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage; (iii) System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of Data maintained in a live or archival system; and (iv) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or Data maintained in a live or archival system but does prevent access to the System, i.e. causes unscheduled System Unavailability. This BC-DR plan must be prior approved by ASES.

14.5.12 The Contractor shall on an annual basis test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to ASES that it can restore System functions per the standards outlined elsewhere in this Section 14.5 of the Contract. The results of these tests shall be reported to ASES within thirty (30) Calendar Days of completion of said tests.

14.5.13 In the event that the Contractor fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Contract, the Contractor shall be required to submit to ASES a Corrective Action Plan that describes how the failure will be resolved. The Corrective Action Plan will be delivered within five (5) Business Days of the conclusion of the test.

14.6 System Testing and Change Management Requirements

14.6.1 The Contractor shall absorb the cost of routine maintenance, inclusive of defect correction, System changes required to effect changes in Puerto Rico and Federal statute and regulations, and production control activities, of all Systems within its Span of Control.

14.6.2 The Contractor shall respond to ASES reports of System problems not resulting in System Unavailability according to the following timeframes:

14.6.2.1 Within five (5) Calendar Days of receipt, the Contractor shall respond in writing to notices of System problems.

14.6.2.2 Within fifteen (15) Calendar Days, the correction will be made, or a requirements analysis and specifications document will be due.

14.6.3 The Contractor shall correct the deficiency by an effective date to be determined by ASES.

14.6.4 The Contractor's Systems will have a system-inherent mechanism for recording any change to a software module or subsystem.

14.6.5 The Contractor shall put in place procedures and measures for safeguarding ASES from unauthorized modifications to the Contractor's Systems.

14.6.6 Unless otherwise agreed to in advance by ASES, scheduled System Unavailability to perform System maintenance, repair and/or upgrade activities to Contractor's CCE systems shall take place between 11 p.m. on a Saturday and 6 a.m. on the following Sunday (Atlantic Time).

14.6.7 The Contractor shall work with ASES pertaining to any testing initiative as required by ASES.

14.6.8 The Contractor shall provide sufficient System access to allow verification of System functionality, availability and performance by ASES during the times required by ASES during the implementation and duration of the Contract Term.

14.7 System Security and Information Confidentiality and Privacy Requirements

14.7.1 The Contractor shall provide for the physical safeguarding of its Data processing facilities and the Systems and Information housed therein. The Contractor shall provide ASES with access to Data facilities upon ASES's request. The physical security provisions shall be in effect for the life of this Contract.

14.7.2 The Contractor shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

14.7.3 The Contractor shall include physical security features designed to safeguard processor site(s) through required provision of fire-retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

14.7.4 The Contractor shall ensure that the operation of all of its Systems is performed in accordance with Puerto Rico and Federal regulations and guidelines related to security and confidentiality of the protected information managed by the Contractor and shall strictly comply with HIPAA Privacy and Security Rules, as amended, and with the Breach Notification Rules under the HITECH Act.

14.7.5 The Contractor will put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the Data communications network inside of a Contractor's Span of Control.

14.7.6 The Contractor shall ensure compliance with:

14.7.6.1 42 CFR Part 431 Subpart F (confidentiality of information concerning applicants and enrollees of public medical assistance programs);

14.7.6.2 42 CFR Part 2 (confidentiality of alcohol and drug abuse records); and

14.7.6.3 Special confidentiality provisions in Puerto Rico or Federal law related to people with HIV/AIDS and mental illness.

14.7.7 The Contractor shall provide its Enrollees with its HIPAA Notice of Privacy Practices that conforms to all applicable Federal and State laws. The Contractor shall provide ASES with a copy of this Notice.

14.8 Information Management Process and Information Systems Documentation Requirements

14.8.1 The Contractor shall ensure that written System Process and Procedure Manuals document and describe all manual and automated system procedures for its information management processes and Information Systems. These manuals shall be provided to ASES Immediately upon request.

14.8.2 The System User Manuals shall contain information about, and instructions for, using applicable System functions and accessing applicable system Data.

14.8.3 When a System change that would alter the conditions and services agreed upon in this Contract is subject to ASES sign off, the Contractor shall draft revisions to the appropriate manuals prior to ASES sign off of the change.

14.8.4 Updates to the electronic version of these manuals shall occur in real time; updates to the printed version of these manuals shall occur within ten (10) Business Days of the update taking effect.

14.8.5 ASES reserves the right to audit the Contractor's policies and procedures manuals and protocols compliance related to its Information Systems.

14.9 Reporting Functionality Requirements

14.9.1 The Contractor's Systems shall have the capability of producing a wide variety of reports that support program management, policymaking, quality improvement, program evaluation, analysis of fund sources and uses, funding decisions and assessment of compliance with Federal and Puerto Rico requirements.

14.9.2 The Contractor shall support a mechanism for obtaining service and expenditure reports by funding source, Provider, Provider type or other characteristic; and Enrollee, Enrollee group/category or other characteristic.

14.9.3 The Contractor shall extend access to this mechanism to select ASES personnel in a secure manner to access Data, including program and fiscal information regarding Enrollees served, services rendered, etc. and the ability for said personnel to develop and/or retrieve reports. This requirement could be met by the provision of access to a decision support system/Data warehouse. The Contractor shall provide training in and documentation on the use of this mechanism.

14.9.4 Within five (5) Calendar Days upon ASES's request, the Contractor will deliver a copy of the then current ASES's System information to ASES in a mutually acceptable form and format.

14.10 Disaster Recovery, Disaster Declaration, Data Content Delivery to ASES

14.10.1 Contractor shall maintain a disaster recovery and business recovery plan in effect throughout the term of the Contract. The disaster recovery plan shall be subject to ASES review upon reasonable notice to Contractor. Contractor shall maintain reasonable safeguards against the destruction, loss, intrusion and unauthorized alteration of printed materials and data in its possession. At a minimum, Contractor shall perform (i) incremental daily back-ups, (ii) weekly full backups, and (iii) such additional back-ups as the Contractor may determine to be necessary to maintain such reasonable safeguards.

14.10.2 Both Parties recognize that a failure by the Contractor's Network may adversely impact ASES business and operations, as the responsible party for the Medicare Platino Program. Therefore, in the event that the Contractor's Network designed to deliver the services herein contemplated becomes unable, or is anticipated to become unable, to deliver such services on a timely basis, Contractor shall Immediately notify ASES by telephone, and shall work closely with ASES to fix the problem. In the event that Contractor fails to provide such required notice to ASES and such delay in the notification has a material and adverse effect upon ASES and/or Enrollees, ASES may terminate this Contract for cause as provided in Article 30 of this Contract.

14.10.3 Within five (5) Calendar Days upon ASES's request, Contractor will deliver a copy of the then current ASES's Data Content to ASES in a mutually acceptable form and format which is useable and readable and understandable by ASES.

14.11 Health Information Organization (HIO) and Health Information Exchange (HIE) Requirements

14.11.1 The Contractor shall initiate the active participation in any Health Information Organization (HIO) that offers Health Information Exchange services, in order to integrate the Enrollees' Personal Health Information, facilitate access to and retrieval of their clinical Data to provide safer and more timely, efficient, effective, and equitable patient-centered care. The HIO participation is also required to support the analysis of the health of the population. As required by ASES, the Contractor shall be active in a HIO and cooperate with this effort.

14.11.2 ASES shall retain the right to request from the Contractor the active participation in the Puerto Rico Health Information Exchange Corporation (PRHIEC), the Puerto Rico HIO State Designated Entity, in order to achieve the effective alignment of activities across Medicaid and Government public health programs, to avoid duplicate efforts and to ensure integration and support of a unified approach to information exchange for the Medicare Platino Program.

14.11.3 The Contractor shall verify that the HIO complies with all Information System standards and requirements for interoperability and security capabilities dictated by ONCHIT, and other Federal and Puerto Rico regulations.

14.11.4 The Contractor shall work with Network Providers and staff to encourage-an active participation in an HIO.

ARTICLE 15 REPORTING

15.1 General Requirements

15.1.1 ASES may, at its discretion, require the Contractor to submit additional reports both ad hoc and recurring. If ASES requests any revisions to the reports already submitted, the Contractor shall make the changes and re-submit the reports, according to the time period and format specified by ASES.

15.1.2 The Contractor shall timely and accurately submit all reports to ASES in the manner and format prescribed by ASES. The submission of late, inaccurate, or otherwise incomplete reports constitutes failure to report. "Timely submission" shall mean that the report was submitted on or before the date it was due. "Accurately" shall mean the report was prepared according to the specific written guidance, including report template, provided by ASES to the Contractor. All elements must be met for each required report submission.

15.1.3 The Contractor shall review, as part of its continuous improvement activities, timeliness and accuracy of reports submitted to ASES to identify instances and patterns of non-compliance. The Contractor shall perform an analysis identifying any patterns or issues of non-compliance and shall implement quality improvement activities to improve overall performance and compliance.

15.1.4 Extensions to report submission dates will be considered by ASES after the Contractor has contacted the ASES designated point of contact via email at least twenty-four (24) hours in advance of the report due date.

15.1.5 Anytime a report is rejected for any reason, the Contractor shall resubmit the report within ten (10) Business Days from notification of the rejection or as directed by ASES.

15.1.6 The Contractor shall submit all reports electronically to ASES's FTP site unless directed otherwise by ASES. ASES shall provide the Contractor with access to the FTP site. The email generated by the FTP upload will be used as the time stamp for the submission of the report(s).

15.1.7 All reports in the reporting templates provided to the Contract require Contractor certification. The Authorized Certifier or an equivalent position as delegated by the Contractor and approved by ASES, shall review the accuracy of language, analysis, and Data in each report prior to submitting the report to ASES. The Authorized Certifier shall include a signed attestation each time the

report is submitted. The attestation must include a certification, based on best knowledge, information, and belief, as to the accuracy, completeness and truthfulness of the Data in the report. Reports will be deemed incomplete if an attestation is not included.

15.1.8 The Contractor Data transfers shall occur in standard format as prescribed by ASES and will be compliant with HIPAA and Federal regulations. The Contractor shall submit in formats as prescribed by ASES so long as ASES's direction does not conflict with any Federal law.

15.2 Specific Requirements

15.2.1 The following section provides an overview and description of all reports required by this Contract. The details and requirements of the reports are subject to change at the discretion of ASES.

15.2.1.1 The Contractor shall submit a quarterly *Fraud, Waste, and Abuse Report* that provides information regarding suspicious activity, Fraud, Waste, and Abuse cases, recoupments, Cost Avoidance, Referrals, and other information as directed by ASES. At a minimum, the report shall include: (i) Enrollee name and ID number; (ii) Provider name, Provider type and NPI; (iii) source and date of Complaint; (iv) nature of Complaint (including alleged persons or entities involved, category of services, factual explanation of the allegation and dates of contact); (v) all communications between the Contractor and the Provider about the Complaint; (vi) approximate dollars involved or amount paid to the Provider during past three (3) years (whichever is greater); (vii) disciplinary measures imposed, if any; and (viii) legal disposition of the case. The Contractor shall also include in the report as a qualitative analysis; information regarding investigative activities, corrective actions, prevention efforts and the results of prevention efforts.

15.2.1.2 The Contractor shall submit *Encounter Data* in a standardized format as specified by ASES and transmitted electronically to ASES on a monthly basis. The Contractor shall provide any information and/or Data requested in a format to be specified by ASES as required to support the validation, testing or auditing of the completeness and accuracy of Encounter Data submitted by the Contractor.

15.2.1.3 The Contractor shall submit within thirty (30) Business Days of the close of the quarter a *National Provider List (NPL) Report* that provides information on Network Providers of Medicare Platino Covered Services who have executed a provider agreement with the Contractor to serve Medicare Platino Enrollees.

15.2.1.4 The Contractor shall submit a quarterly *Grievances and Appeals Report* within thirty (30) Business Days of the close of the quarter. Relevant information includes all Provider and Enrollee Grievances (informal and formal), Appeals, Notices of Actions and Administrative Law Hearings utilizing the ASES-provided reporting templates and codes. The report will also capture Enrollee comments and inquiries made through the Contractor's website.

15.2.1.5 The Contractor shall submit an annual *QAPI Program Report* that shall include information on all quality assessment and performance improvement projects, including a program overview, methodology, performance measures and analysis of the respective programs.

15.2.1.6 The Contractor shall submit a quarterly *Unaudited Financial Statement Report* no later than forty-five (45) Business Days after the close of each quarter. The Contractor shall submit (i) a separate accounting of activities relating to each Service Region, and (ii) a consolidated section accounting for all Medicare Platino Program activities.

15.2.1.7 The Contractor shall submit an annual *Physician Incentive Plan Report* that provides adequate information about the Contractor's monitoring activities for the Physician Incentive Plan as described in Section 20.4. The Contractor shall submit, at a minimum: (i) description of the Physician Incentive Plan; (ii) description of incentive arrangements; (iii) description and Data on percentage of Withhold or bonus attached to the plan; and (iv) the number of Providers participating in the plan and the number of Enrollees affected.

15.2.1.8 The Contractor shall submit annual *Audited Financial Statements*. The Contractor shall provide ASES with copies of its audited financial statements following Generally Accepted Accounting Principles ("GAAP") and generally accepted auditing standards in the US, at its own cost and charge, for the duration of the Contract, and as of the end of each fiscal year during the Contract Term, regarding the financial operations related to the Medicare Platino Program. The statements shall provide (i) a separate accounting of activities relating to each Service Region, and (ii) a consolidated section accounting for all Medicare Platino Program activities. These reports shall be submitted to ASES no later than ninety (90) Calendar Days after the close of the fiscal year.

15.2.1.9 The Contractor shall submit an annual *Disclosure of Information on Annual Business Transactions*, which shall include information on any loans, business transactions, and other special arrangements between the Contractor and any Network Provider, Subcontractor, or

other Party in Interest, as defined by Section 1318(b) of the Public Health Service Act.

15.2.1.10 The Contractor shall submit an annual *Report to Puerto Rico Insurance Commissioner's Office* in the format agreed upon by the National Association of Insurance Commissioners (NAIC).

ARTICLE 16 ENFORCEMENT – INTERMEDIATE SANCTIONS

16.1 General Provisions

16.1.1 In monitoring Contractor's compliance with the terms of the Contract, ASES may impose intermediate sanctions, and/or liquidated damages, and/or fines pursuant to Puerto Rico Act No. 134 of 2013, for Contractor's failure to comply with the terms and conditions of this Contract.

16.1.2 In the event the Contractor incurs any proscribed conduct or otherwise is in default as to any applicable term, condition, or requirement of this Contract, and in accordance with any applicable provision of 42 CFR 438.700 and Section 4707 of the Balanced Budget Act of 1997, at any time following the Effective Date of the Contract, the Contractor agrees that, in addition to the terms of Section 30.1.1 of this Contract, ASES may impose intermediate sanctions against the Contractor for any such default in accordance with this Article 16. ASES may impose intermediate sanctions against the Contractor for any such default in accordance with this Article 16. ASES may impose both intermediate sanctions and fines pursuant to Puerto Rico Act No. 72-1993 and ASES Regulation 8446. The assessment or non-assessment of intermediate sanctions under this Contract cannot and will not limit the power or authority of ASES to impose any other fines, civil money penalties, sanctions, or other remedies recognized by Puerto Rico or Federal laws or regulations, including, but not limited to, Puerto Rico Act No. 72-1993 and ASES Regulation No. 8446.

16.1.3 Notwithstanding any intermediate sanctions imposed upon the Contractor under this Article 16, other than Contract termination, the Contractor shall continue to provide all Covered Services and other Benefits under this Contract.

16.1.4 ASES shall have the right impose the following intermediate sanctions:

16.1.4.1 **Civil Money Penalty** – ASES may impose a civil money penalty for the following categories of events.

16.1.4.1.1 **Category 1** - A civil money penalty in accordance with any applicable provision of 42 CFR 438.700 up to one-hundred thousand dollars ($100,000) per determination shall be imposed for this category. The following constitute Category 1 events:

16.1.4.1.1.1 Acts that discriminate among Enrollees on the basis of their health status or need for health care services. This includes termination of Enrollment or refusal to reenroll a Potential Enrollee, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage Enrollment by beneficiaries whose medical or Behavioral Health condition or history indicates probable need for substantial future medical or Behavioral Health Services. Notwithstanding the foregoing, ASES may impose a civil money penalty in the amount of fifteen thousand dollars ($15,000) per each (i) Potential Enrollee that was not enrolled because of discriminatory practices as described above and/or (ii) discriminatory practices imposed on Enrollees, subject to the overall limit of one-hundred thousand dollars ($100,000) per each determination.

16.1.4.1.1.2 The misrepresentation or falsification of information submitted to ASES and/or CMS.

16.1.4.1.2 **Category 2** - A civil money penalty in accordance with any applicable provision of 42 CFR 438.700 up to twenty-five thousand dollars ($25,000) per determination shall be imposed for this category. The following constitute Category 2 events:

16.1.4.1.2.1 Failure by the Contractor to substantially provide Medically Necessary Services that the Contractor is required to provide, under applicable law or under this Contract, to an Enrollee under this Contract.

16.1.4.1.2.2 Misrepresentation or falsification by the Contractor of information that it furnishes to an Enrollee, Potential Enrollee, or Provider.

16.1.4.1.2.3 Failure by the Contractor to comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR 422.208 and 422.210.

16.1.4.1.2.4 The distribution by the Contractor, directly or indirectly through any Agent or independent contractor, of Marketing Materials that have not been prior approved by ASES or that contain false or materially misleading information.

16.1.4.1.3 **Category 3** – Pursuant to 42 CFR 438.704 (c), ASES may impose a civil money penalty for the Contractor's imposition of premiums or charges in excess of the amounts permitted under the Medicaid program. The maximum amount of the penalty is the greater of twenty-five thousand dollars ($25,000) or double the amount of the excess charges. ASES will deduct from the penalty the amount of overcharge and return it to the affected Enrollees.

16.1.4.2 **Temporary Management** - ASES may appoint temporary management for the Contractor's Medicare Platino operations, as provided in 42 C.F.R. 438.702 and 42 C.F.R. 438.706 as a result of Contractor's:

16.1.4.2.1 Continued egregious behavior, including but not limited to behavior described in Categories 1 through 3 of this Article 16;

16.1.4.2.2 Behavior that is contrary to, or is non-compliant with, Sections 1903(m) or 1932 of the Social Security Act, as amended, found at 42 U.S.C. §§ 1396b (m) and 1396u-2;

16.1.4.2.3 Actions which have caused substantial risk to an Enrollee's health; and/or

16.1.4.2.4 Behavior that has led ASES to determine that temporary management is necessary to ensure the health of Contractor's Enrollees while improvements to remedy Category 1 through 3 violations are being made, or until the Contractor's orderly termination or reorganization.

16.1.4.2.5 If temporary management is appointed for any reason specified in Sections 16.1.4.2 above, such temporary management will cease once ASES has, in its discretion, determined that the sanctioned behavior will not re-occur.

16.1.4.3 **Enrollment Termination** – ASES may grant Enrollees the right to terminate Enrollment without cause, and notify the affected Enrollees of their right to disenroll when:

16.1.4.3.1 The Contractor has engaged in continued egregious behavior, including but not limited to behavior described in Categories 1 through 3 of this Article 16;

16.1.4.3.2 The Contractor has engaged in behavior that is contrary to, or is non-compliant with, Sections 1903(m) or 1932 of the Social Security Act, as amended, found at 42 U.S.C. §§ 1396b (m) and 1396u-2;